

Report of Child Deaths 1992-2001

MAHONING COUNTY
CHILD FATALITY REVIEW BOARD

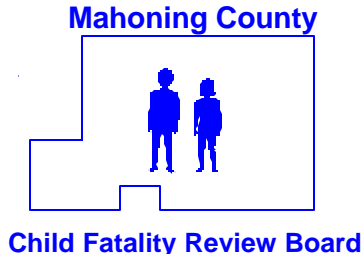
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June 2002

Matthew Stefanak
Mahoning County Health Commissioner



June 25, 2002

Dear Community Leader:

The death of a child is a singularly tragic event. Last year 46 children in Mahoning County did not survive to adulthood. We know that the deaths of many of these children were preventable. In January 2000, a group of individuals committed to preventing the needless loss of these young lives began to meet and review the circumstances around each child death.

This group, known as the Child Fatality Review Board, invites you to a presentation of its second annual report, on **Monday, June 24th, 2002, from 8:30 – 10:00 a.m.**, in the Oakhill Renaissance Center Auditorium (the old Southside Medical Center). Breakfast will be served at 8:30 a.m. and the presentation will begin at 8:45 a.m.

This report on child deaths in Mahoning County in 2001 represents an organized attempt to identify potential risk factors that led to the deaths and offer recommendations for preventing similar child deaths in the future.

Child fatality review boards have helped to identify preventable risk factors for child deaths in many communities around the State and nation. We hope that you will attend this presentation and find our recommendations helpful in addressing risk factors that contributed to the deaths of these 46 children so that the lives of other children may be saved. Please RSVP to 330-270-2855 extension 149 (voice) or email mchealth@cboss.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew A. Stefanak".

Matthew A. Stefanak
Mahoning County Health Commissioner

A handwritten signature in black ink, appearing to read "Jesse C. Giles, M.D.". The signature is written in a cursive style.

Jesse C. Giles, M.D.
Deputy Coroner

Times of Life

God puts everyone on this earth and gives everyone a life for a reason.

But sometimes I wonder why did he put me on this earth and give me a life to live?

He gave me good times and bad, happy and sad, also, easy and tough times to live through.

And in those times I've learned a lot. I've learned that the littlest things can mean a lot to someone.

I've learned not to take things for granted and that if I just be myself, I can have the best time of my life.

I also learned even if you just want to give up and not even want to live anymore, to keep going because nothing is worth losing your life for. Even if you don't think you can make it.

But through all these times when you think you are alone, you really aren't because God is guiding and helping us through life together.

Because if He didn't put us through these times in life, there really wouldn't be much of a life to live.

Learn to live to life's fullest, smile, don't take things for granted, or worry, or right. Appreciate all life, because you do not know when your time will be.

Written by Renee Elizabeth Romito on 6/7/2000

Renee died in a motor vehicle crash on 7/23/2000 that also claimed the life of a friend. They were both 15 years old at the time of their death.

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Importance of the Child Fatality Review Process

Approximately 50,000 children die in the United States each year. Infants die primarily of problems associated with prematurity; adolescents die largely of trauma following violence or injury, most commonly motor vehicle injury. An estimated 2,000 children in the United States die of child abuse and neglect each year; approximately 40 percent of them are younger than a year old, and the majority are younger than 5 years.

Historically, responsibility for preventing and examining child deaths fell on law enforcement, public safety, and public health agencies working in isolation. However, in recent years, as sensitivity to child abuse and other violence against children has grown among the public and policymakers, these agencies have begun to explore ways to work together as a team to share resources and information. The Child Fatality Review Team process was developed in 1978 in California.

House Bill 448 in Ohio establishes a procedure for reviewing child deaths occurring in each county of the state and special review boards to conduct these reviews. Local child fatality review teams tend to be similar in structure and process. Core membership generally includes representatives from the coroner's office, law enforcement, prosecutorial agencies, child protective services, and public health agencies. The teams examine all child fatalities, especially those deaths in which a coroner's services are involved.

Child Fatality Review Teams have been called "a gold mine for injury prevention and control." Effective teams not only provide ongoing systematic review of child deaths, but they also help to document important epidemiological data. Additionally, Child Fatality Review Teams are capable of accelerating progress in the understanding of sudden infant death syndrome (SIDS), missed cases of fatalities resulting from child abuse and neglect, familial genetic diseases, inadequate health care, and other potential public health threats. Finally, Child Fatality Review Teams are in a position to provide data that could initiate policy changes and the development of effective educational programs.

Mission

The mission of the Mahoning County Child Fatality Review Board is to decrease the incidence of preventable fetal and child deaths by:

- Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities that serve families and children
- Maintaining a comprehensive database of all fetal and child deaths that occur in Mahoning County in order to develop an understanding of the causes and incidences of those deaths
- Recommending and developing plans for implementing local service and program changes to the groups, professions, agencies, or entities that serve families and children that might prevent fetal and child deaths.
- Advising the Ohio Department of Health of aggregate data, trends, and patterns concerning child deaths.

Representatives from the following agencies have participated in the Child Fatality Review Board:

- Austintown Police Department
- Forum Health Tod Children's Hospital
- Mahoning County Alcohol and Drug Addiction Services Board
- Mahoning County Children Services Board
- Mahoning County Coroner's Office
- Mahoning County District Board of Health
- Mahoning County Mental Health Board
- Mahoning County Prosecutor's Office
- Mahoning Valley Funeral Directors Association
- Saint Elizabeth Health Center
- Youngstown City Health District
- Youngstown Fire Department
- Youngstown Police Department

The Child Fatality Review Board meets quarterly to review fetal and child deaths from the previous quarter and issues an annual report of its findings and recommendations in April of each year. Between 80-100 fetal and child deaths occur in Mahoning County every year.

Structure of the Report

This report is intended to provide a summary of the available information regarding child deaths in our community. It is hoped that, by collecting this information, patterns will emerge that may suggest intervention strategies, and that make it possible to identify areas of child health and safety that have the greatest impact on child deaths. In addition, the effect of intervention strategies implemented may be measured.

The report is divided into three main sections. The first presents data over the ten-year period of 1992-2001. This section provides important insight into child fatality trends in the community and allows the reader to determine if there have been any improvements overall and within groups of interest. The cases are broken down into sub-groups based on either membership (age, gender, race, etc.) or cause of death (natural, injury-related).

The second section of the report includes only deaths that occurred in 2001. An in-depth look at infant mortality for 2001 is also included.

The third and final section of the report provides recommendations from the Child Fatality Review Board on intervention strategies for specific causes of death and offers recommendations for the data collection process.

Sources of Data

The following sources of data have been used in compiling this report:

- Healthy People 2010
- The Mahoning County Child Fatality Review Board
- The Mahoning County District Board of Health – Health Promotion and Assessment Unit
- Office of Juvenile Justice and Delinquency Prevention
- Ohio Department of Health – Data Warehouse
- 1990 and 2000 U.S. Census
- The Youngstown City Health District – Office of Vital Statistics

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Mahoning County Child Mortality Trends 1992-2001

To understand child mortality in the county, it is important to examine the trends over time. The following tables and graphs demonstrate that while there has been some variability over time in the numbers of child deaths, there has been little significant change during the ten years from 1992 through 2001.

When reviewing the following data it is important to distinguish between infant mortality (under one year of age) and all other child deaths (1 to 17 years). Infant deaths traditionally occur during the neonatal period (2/3 of all infant deaths). Because infant deaths contributed almost 61% of the total child deaths in the county, it is important to examine more closely the deaths that occur among infants.

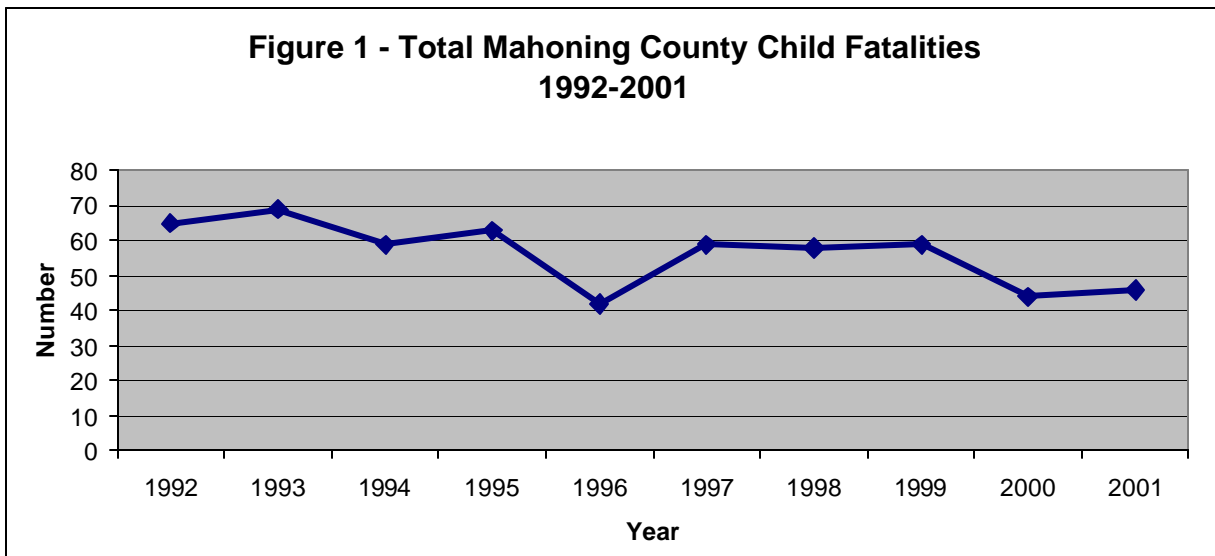


Table 1 – Total Child Deaths by Age Group per Year

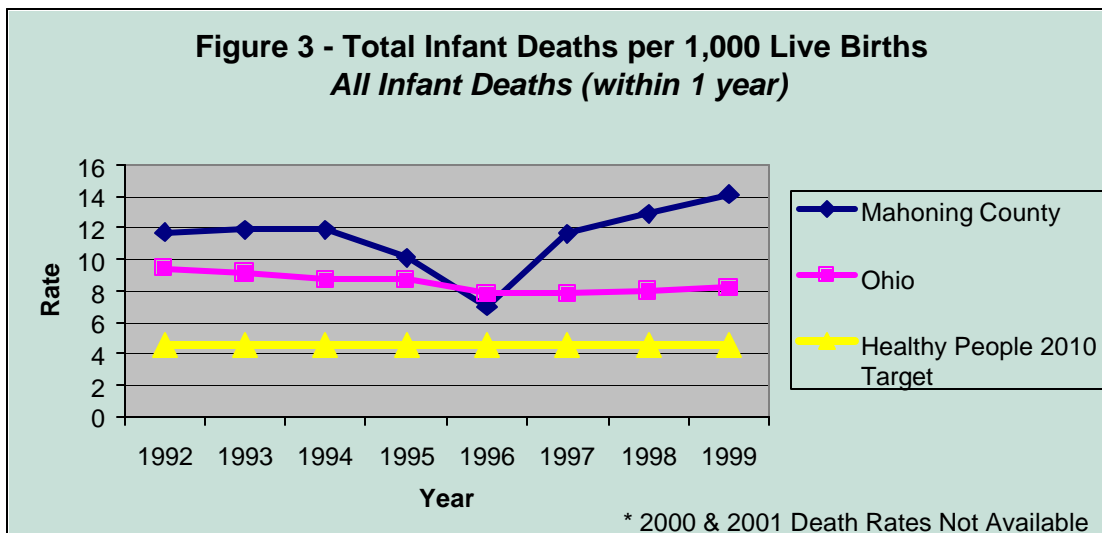
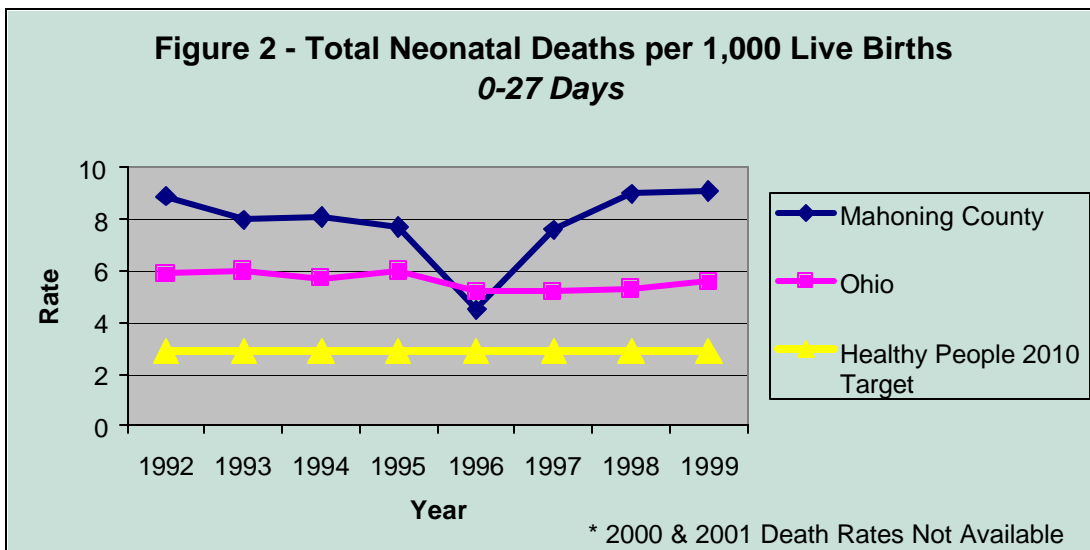
	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	Total
0-27 days	32	27	27	26	14	22	28	27	16	18	237
28 days-1 year	10	14	14	8	8	12	11	15	5	13	110
1-4 years	9	10	3	4	5	8	6	4	3	3	55
5-9 years	2	6	3	2	1	1	2	2	3	0	22
10-14 years	5	2	2	4	4	4	6	3	8	5	43
15-17 years	7	10	10	19	10	12	5	8	9	7	97
Total	65	69	59	63	42	59	58	59	44	46	564

Figure 1 combines infant and child death and clearly shows a slight downward trend in the total number of child deaths in the county over the last ten years. The sharp decreases in 1996 and 2000 resulted from fewer infant deaths in those same years, as shown in Table 1.

Child Deaths by Age Groups 1992-2001

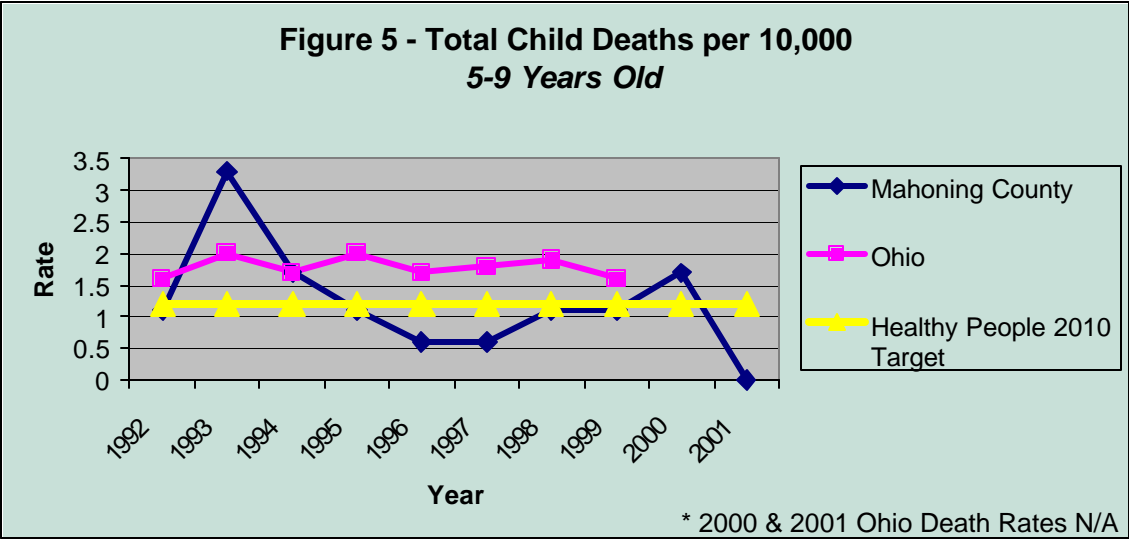
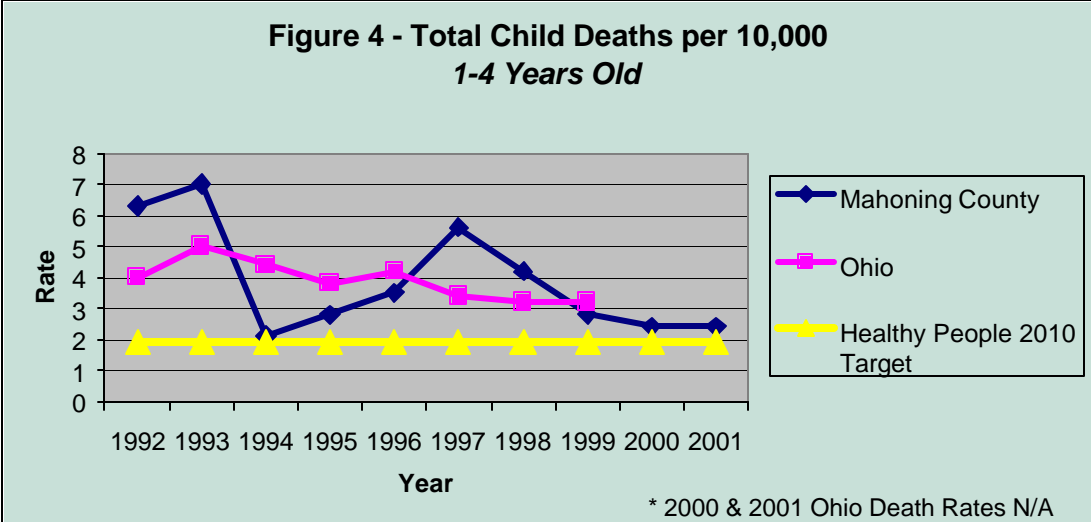
Infant death is a critical indicator of the health of a population. It reflects the overall state of maternal health as well as the quality and accessibility of primary health care available to pregnant women and infants. Despite steady declines in the 1980s and 1990s, the rate of infant mortality in the United States remains among the highest in the industrialized world.

Figures 2 and 3 show the rates of neonatal deaths and all infant deaths for Mahoning County and Ohio, along with the Healthy People 2010 Target. Mahoning County rates are much higher than Ohio rates and are significantly higher than the Healthy People 2010 Target. The rates of infant death have stayed high throughout the decade.



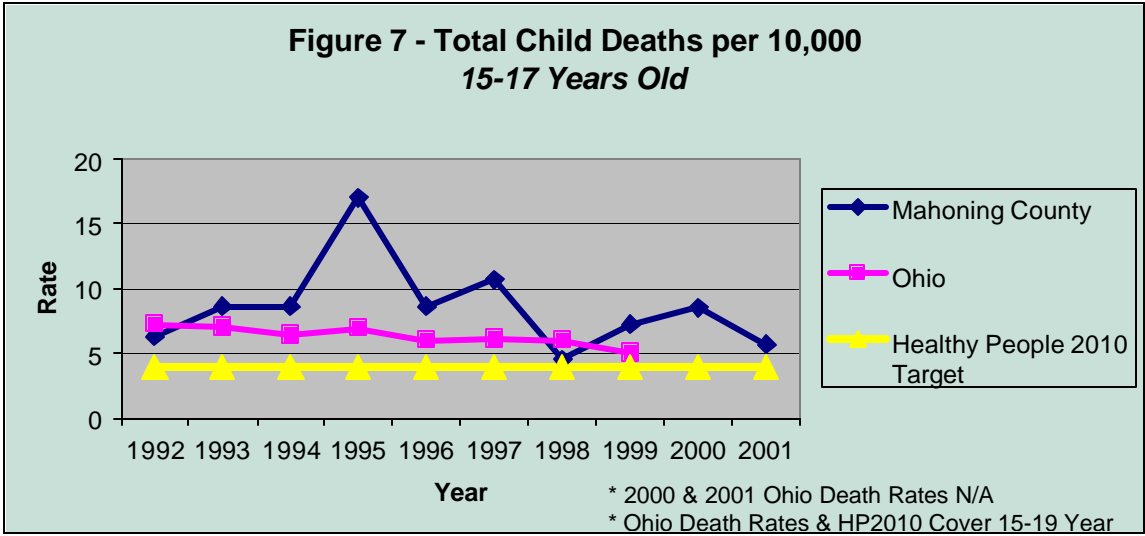
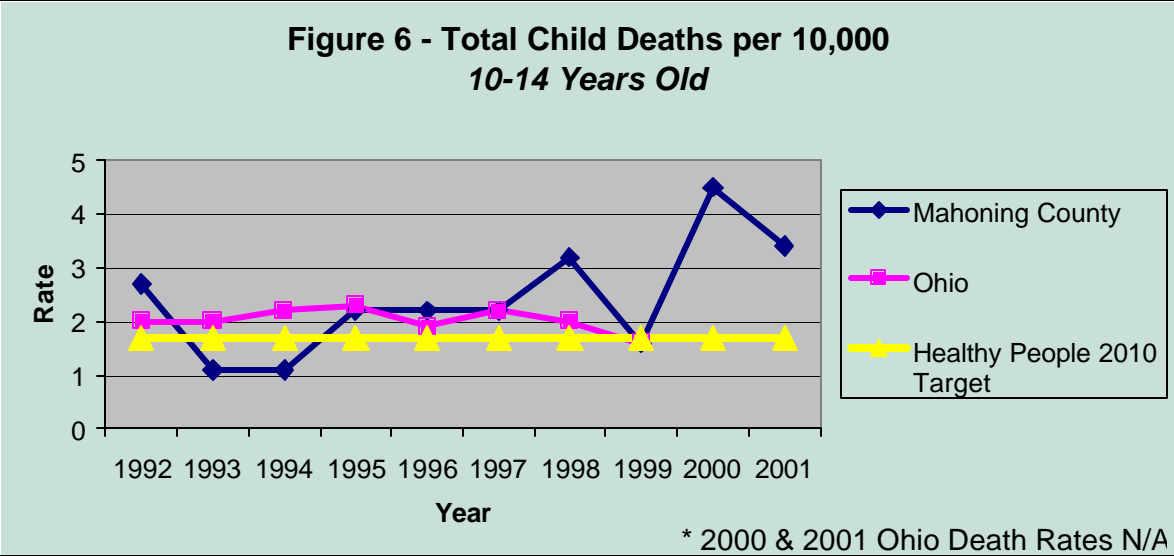
The deaths of children after infancy also present a public health concern and an opportunity for prevention. The leading cause of death for children of all ages is injury. Among children aged 1 to 4 years, the leading injury-related causes of death are motor vehicle crashes, drownings, and fires and burns. Among those aged 5 to 9 years, the leading causes of death include motor vehicle crashes and firearms (including unintentional deaths, homicides, and suicides). These deaths are for the most part, preventable. Other leading causes of death among children that are less likely to be preventable include birth defects, cancer, and diseases of the heart.

In both Figure 4 and 5, the rates of child death in the respective age groups for Mahoning County have shown a steady decrease throughout the decade. In 2001, Mahoning County has met the Healthy People 2010 Target for child deaths among 5-9 year olds and is very close for the 1-4 year old age group.



The deaths of adolescents are more likely to be due to external causes than to congenital conditions. The leading cause of death for adolescents ages 10-14 and 15-17 is motor vehicle crashes followed by other intentional injuries (such as falls and drownings, homicides and suicides). Most of the total deaths in these age groups, therefore, can be attributed to unnecessary (that is, preventable) causes. Other causes of death for these age groups that are less amenable to prevention strategies include cancer, birth defects, diseases of the heart, and a combination of other causes.

Figure 6 shows a rise towards the end of the decade in the child death rates among 10-14 year olds. In Figure 7, there has been no significant improvement in the child death rates among 15-17 year olds. In both age groups, there were a few sharp increases followed by sharp decreases for certain years.



Child Deaths by Sub-Groups – Race

Table 2 – Child Deaths by Race per Year, Number and Rate per 10,000

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	Total
White	43	28	27	28	19	41	30	32	23	29	301
Rate	8.7	5.6	5.4	5.6	3.8	8.3	6.0	6.4	4.6	5.8	
Non-white	22	41	32	35	23	18	28	27	21	17	264
Rate	14.4	26.9	21.0	22.9	15.1	11.8	18.3	17.8	13.8	8.7	

In Mahoning County, non-whites make up only 28% of the population under 18 in the 2000 Census. However, they accounted for 37 percent of child deaths in 2001.

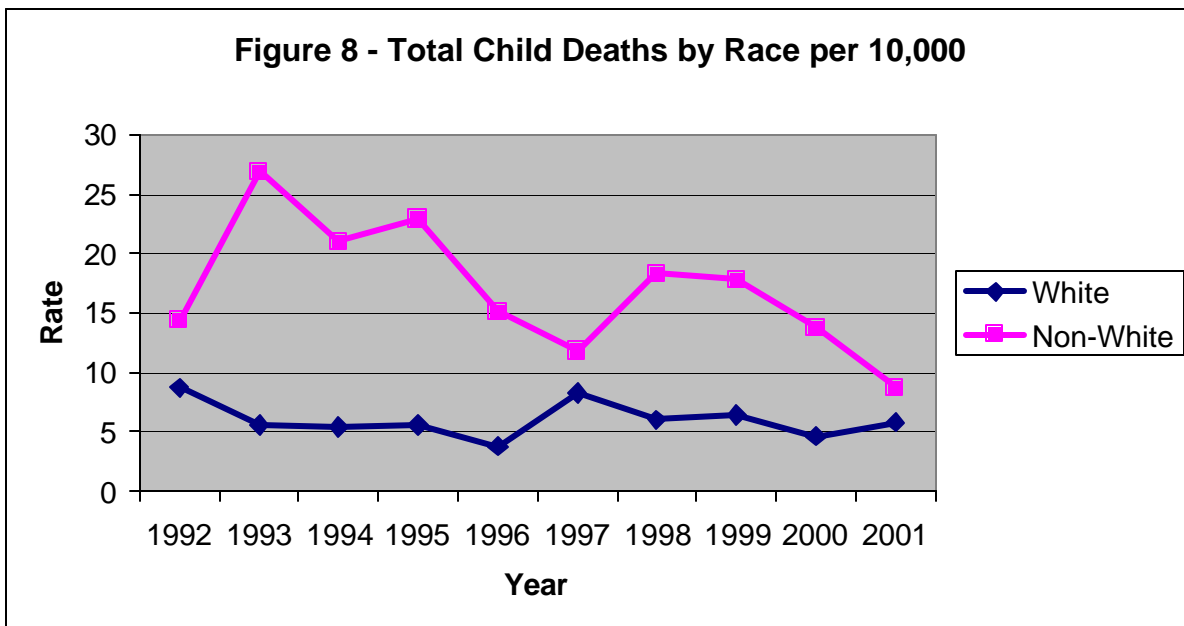


Figure 8 illustrates that a significant racial disparity between whites and non-whites in child fatalities exists. However, the gap has narrowed since 1999.

Child Deaths by Sub-Groups – Gender

Table 3 – Child Deaths by Gender per Year

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	Total
Male	29	41	39	42	25	45	30	32	24	25	332
Female	36	28	20	20	17	14	28	27	20	21	231

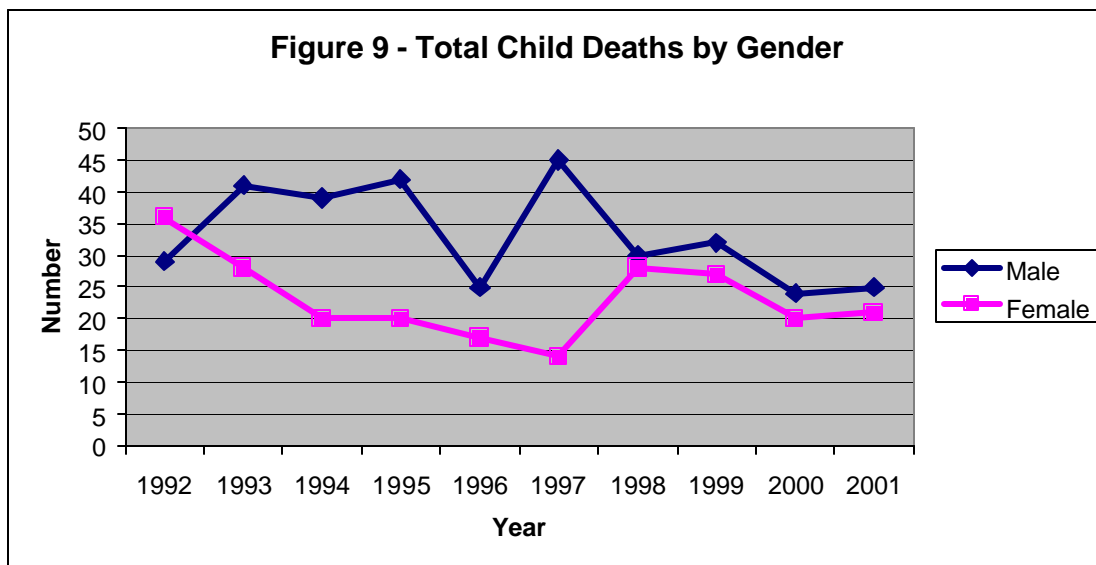


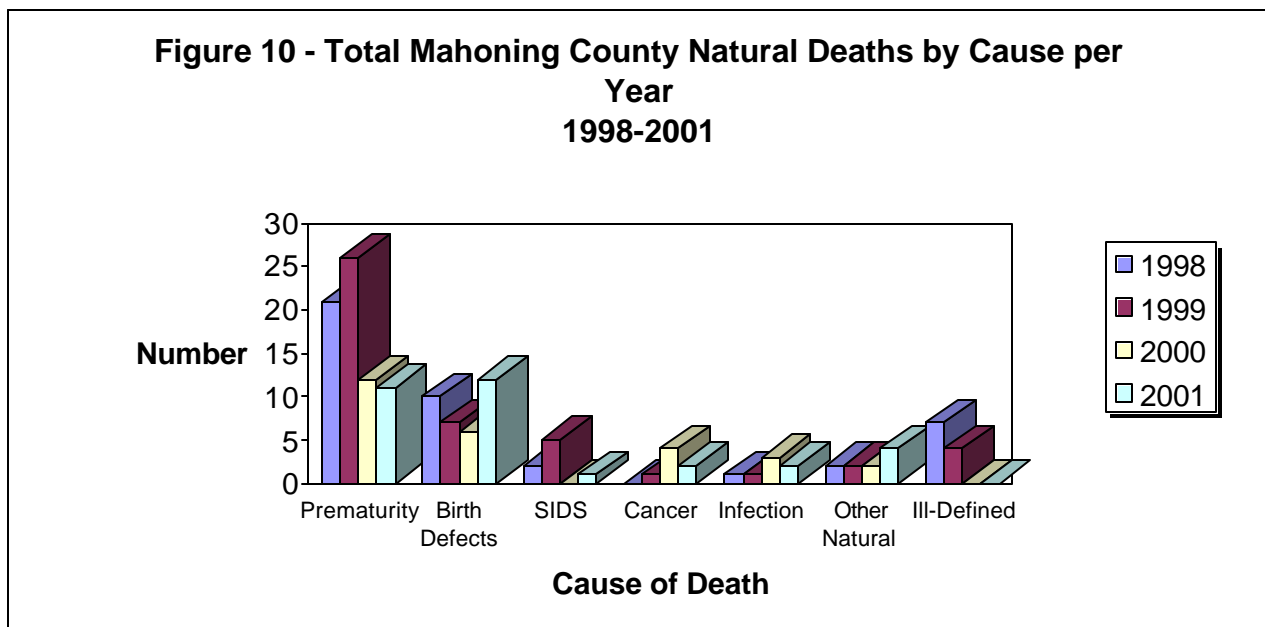
Table 3 and Figure 9 illustrate the gender differences in child deaths. Much of the difference in numbers can be accounted for by the fact that males are known to have poorer survival rates in infancy and suffer more intentional and unintentional injuries in adolescence. In Mahoning County for the years 1992-2001, males accounted for 59 percent of child deaths.

Child Deaths Grouped by Cause – Natural

Table 4 – Numbers of Deaths Due to Natural Causes by Year

Natural Deaths	1998	1999	2000	2001	Total
Prematurity	21	26	12	11	70
Birth Defects	10	7	6	12	35
SIDS	2	5	0	1	8
Cancer	0	1	4	2	7
Infection	1	1	3	2	7
Other Natural	2	2	2	4	10
Ill-Defined	7	4	0	0	11
Total	43	46	27	32	148

Over the four-year period 1998-2001 there were 148 deaths due to natural causes. Prematurity contributed to almost half (47%) of the child deaths due to natural causes over this time period. Birth defects were the second highest contributing to 24% of the total child deaths. There have been decreases in prematurity and birth defects as causes of death; however, cancer and infectious disease deaths rose.



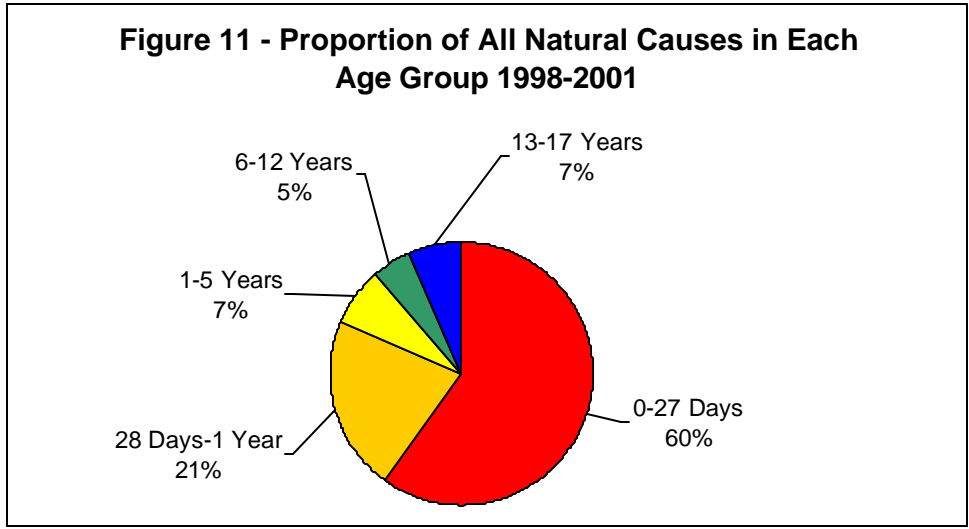


Figure 11 shows that the majority of all natural deaths occur to neonates from 0 to 27 days (60% of all natural deaths). The leading causes of death for neonates during this time period were prematurity and birth defects. Among the 28 older children (1-17 years) birth defects, cancer, and infectious diseases were the most common causes among those deaths classified as natural.

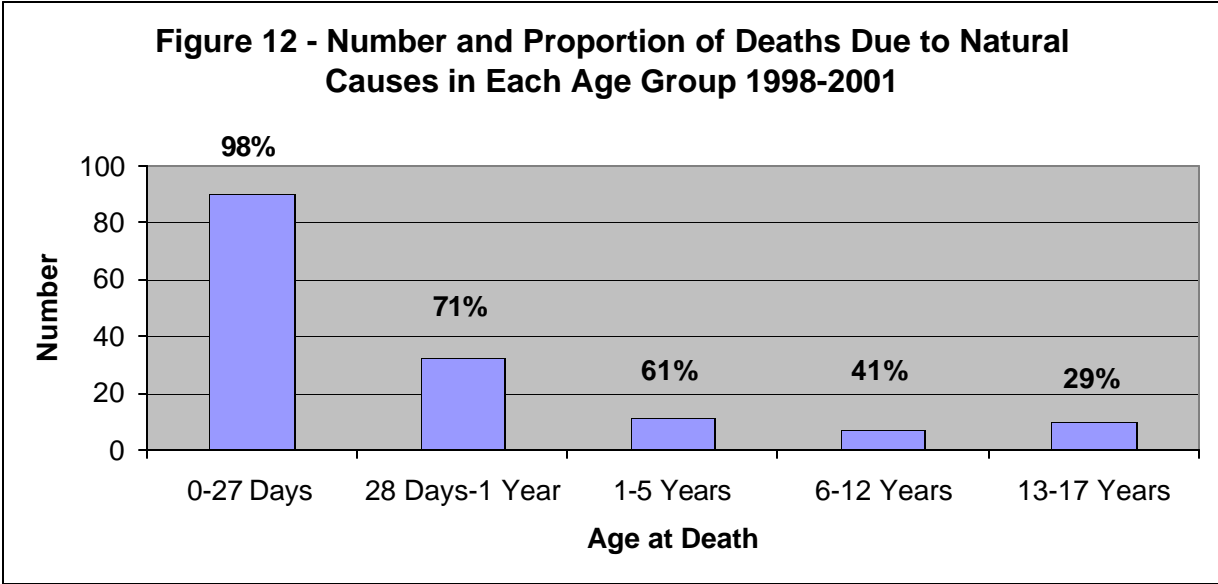
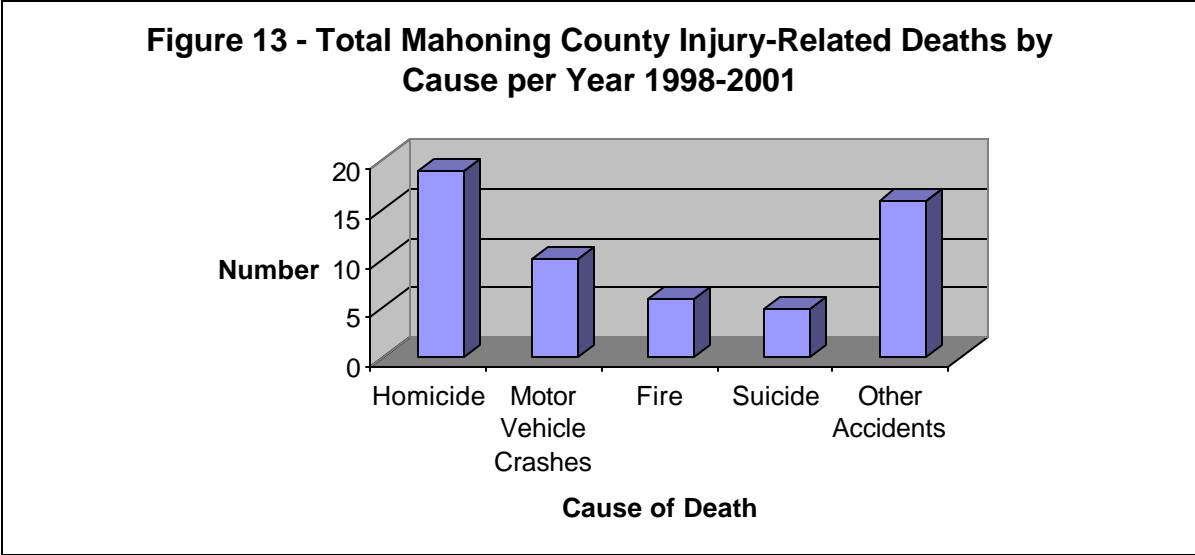


Figure 12 illustrates what proportion of the total deaths (from any cause) in each age category is attributable to natural causes. From this we can see that natural deaths account for almost all deaths to neonates, and continue to play a major role in the deaths of older children.

Child Deaths Grouped by Cause – Injury-Related (Intentional and Unintentional Deaths)



During the years 1998-2001 there were 56 deaths to children from non-natural or injury-related causes. These include homicides, suicides, and accidents. There were 19 homicide deaths which contributed 35% of all injury-related deaths, and 5 suicide deaths which contributed 9% of all injury-related deaths. Among accidental deaths 10 motor vehicle related deaths accounted for 18% of the injury-related deaths, 6 deaths resulting from fires accounted for 11% and another 16 deaths due to other accidents (i.e. drowning, bicycle crashes, suffocation, overlays) accounted for 29%. The table and figures that follow indicate the annual numbers and proportions for some of these leading causes of injury-related deaths.

Table 5 – Total Injury-Related Child Deaths by Cause of Death per Year

Injuries	1998	1999	2000	2001	Total
Homicide	6	5	6	2	19
Motor Vehicle Crashes	3	1	4	2	10
Fire	2	3	1	0	6
Suicide	2	0	2	1	5
Other Accidents	3	4	4	5	16
Total	16	13	17	10	56

Figure 14 - Proportion of All Injury-Related Deaths, Proportion in Each Age Group 1998-2001

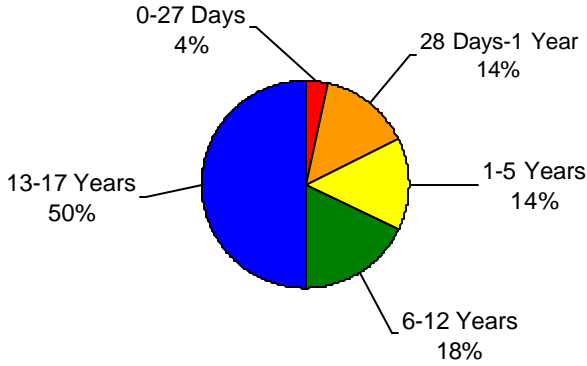
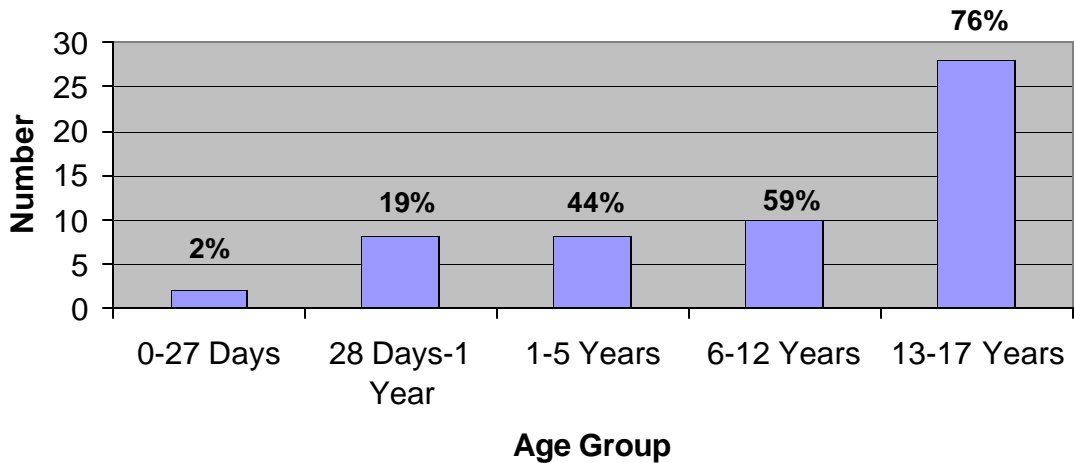


Figure 14 illustrates that most injury-related deaths occur to school-age children and teenagers.

Figure 15 illustrates the proportion of deaths in each age category from any cause that is attributable to injury-related causes. From this we can see that while injury-related deaths account for only about 21% (neonatal and postnatal percentages combined) of all infant deaths, they clearly constitute the majority of deaths to teenagers (76%).

Figure 15 - Number and Proportion of Deaths Due to Injury-Related Causes 1998-2001



MAHONING COUNTY 2001 CHILD DEATHS

The following section provides expanded information on 46 deaths reviewed by the Child Fatality Review Board that occurred among children in 2001 including natural causes, injury-related causes and infant mortality.

Because 67% of all the deaths that occurred this year were to infants, a comprehensive understanding of the full spectrum of infant mortality is critical. To facilitate understanding, one of the sections focuses exclusively on infant deaths.

Summary

During 2001 there were 46 deaths to child residents of Mahoning County. The Child Fatality Review Board completed extended reviews of all of these deaths. Input from the broad spectrum of agencies and organizations represented on the Board allowed for a fuller determination of the circumstances and contributing factors surrounding the deaths of these children.

Table 6 – Total Child Deaths by Age Group by Cause in 2001

Cause	0-27 days	28 days-1 year	1-4 years	5-9 years	10-14 years	15-17 years	Total
NATURAL							32
Prematurity	10	1					11
Birth Defects	4	3	2		2	1	12
Cancer			1		1		2
SIDS		1					1
Infection	2						2
Other Natural	2	2					4
INJURY-RELATED							10
Motor Vehicle Crashes						2	2
Homicide		1				1	2
Suicide						1	1
Drowning		1			1		2
Other Accidents					1	2	3
PENDING INVESTIGATION		4					4
TOTAL	18	13	3	0	5	7	46

From Table 6 we can see that 32 or 70% of the deaths that occurred during the year were related to natural causes. The majority of these natural deaths (78%) were to infants less than one year of age. Overall infant deaths account for 67% of all child fatalities for the year. Among the infant deaths there were 35% due to prematurity, 23% related to congenital anomalies or birth defects, 6% due to infection, 3% due to SIDS, and 13% with other natural.

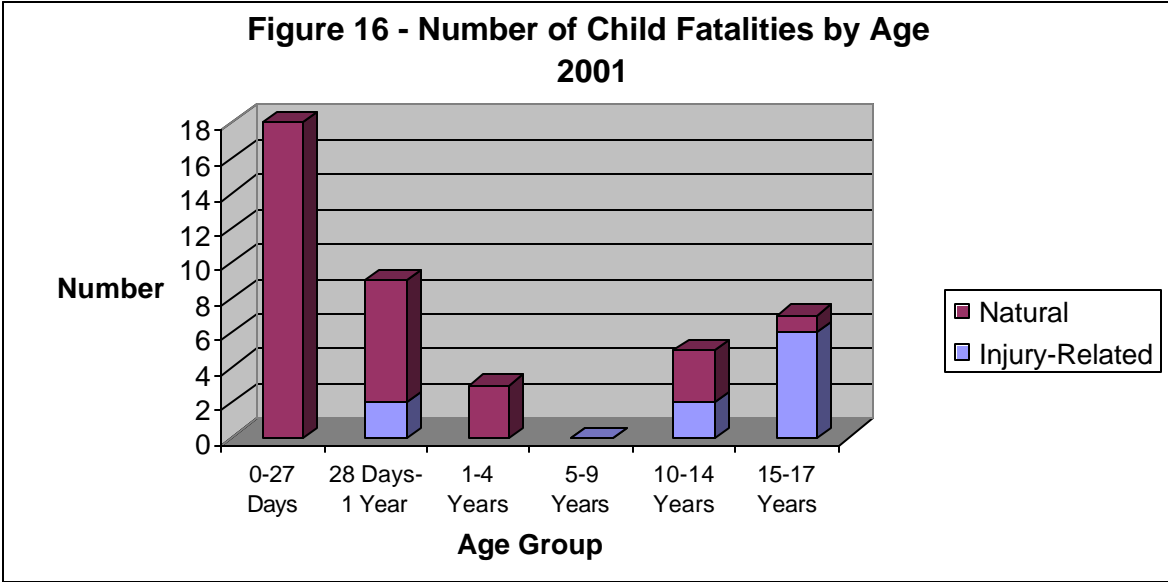
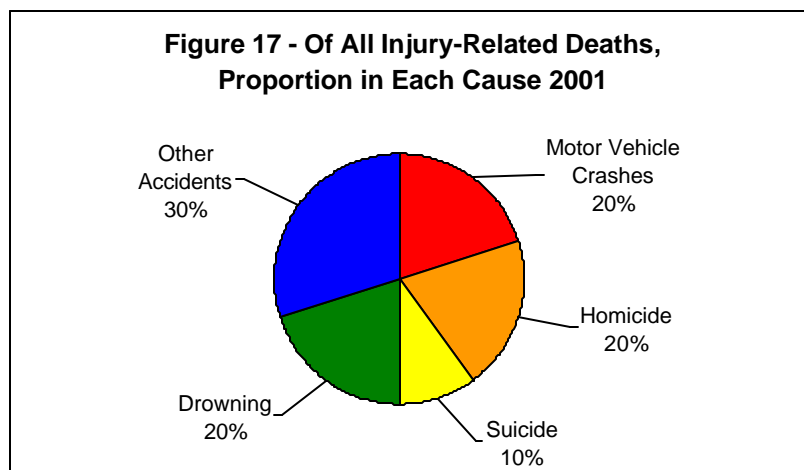


Figure 16 displays the information found in Table 6 in a way that highlights the shift from deaths due to natural causes to deaths from injury-related causes. We can see clearly from this graph that the overwhelming majority of deaths due to natural causes are among infants, while deaths due to injury-related causes are more prevalent with older children (i.e. teenagers).

Injury-Related (Intentional and Unintentional) Deaths

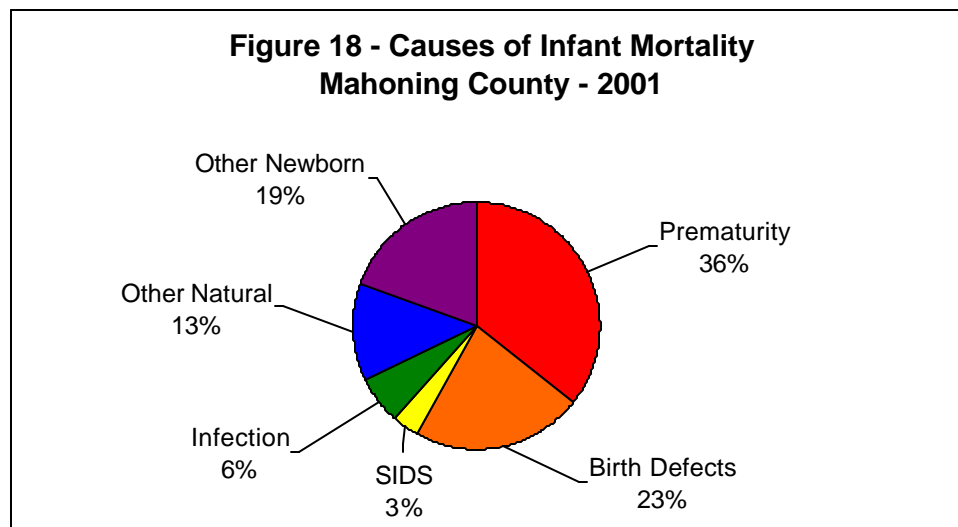


In 2001 there were 10 non-natural or injury-related deaths: 2 motor vehicle crashes, 2 homicides, 2 drownings, 3 other accidents (i.e. undetermined, suffocation, and unintentional gunshot), and 1 suicide.

There is a decrease in injury-related deaths from all categories (except drownings) from last year.

Infant Mortality 2001

Infant mortality is defined as the death of any child, which occurs between the moment he or she is born alive and his or her first birthday. The legal definition of a live birth in Ohio is, “any products of conceptions, completely expelled from the mother, showing any spontaneous signs of life, including a cord pulse.” Because this definition is very inclusive, many infant deaths in the community can occur to babies less than one hour of age. These infants are born alive but die quickly.



NOTE: At the time of completion of this report, there are still 4 child deaths pending investigation.

During 2001 there were 31 deaths to infants in Mahoning County. This represents 67% of all deaths to children for the year. From this pie chart it is apparent that prematurity contributes the greatest number of deaths (11 of the 31 deaths).

Prematurity is followed by birth defects, infection, and SIDS. Included in the category “other newborn” is homicides and drownings. The category “other natural” contains such conditions as spontaneous abortion, twin-to-twin transfusion, and complications of labor and delivery.

Unfortunately, using death certificate data, there is little else that can be determined about the contributing factors to infant deaths in Mahoning County. The death certificate does not contain any information about the age of the mother, the course of pregnancy or even the baby’s gestational age at delivery. Because prematurity is such an important contributor to infant mortality and to the overall picture of child deaths, obtaining data from birth certificates on known risk factors and contributors helps to devise prevention and intervention strategies. Birth certificates were available for 29 of the 31 infant deaths in 2001.

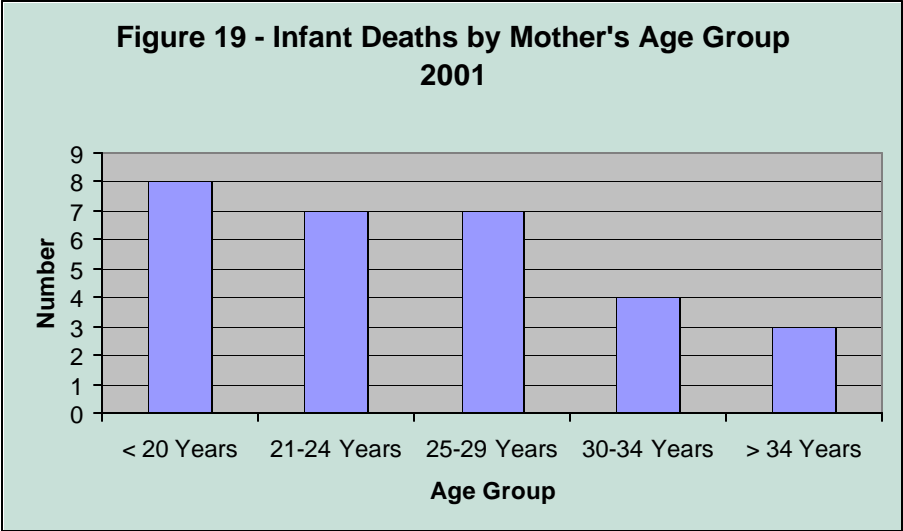


Figure 19 shows that 28% of all the Mahoning County infants who died in 2001 were born to teen mothers, which is the highest group for this year. Even though this number is slightly less than last year (38%), efforts are still needed to reduce the number of teen pregnancies. This is particularly important because pregnancy and infant loss in a woman’s teen years are often strong predictors of future losses.

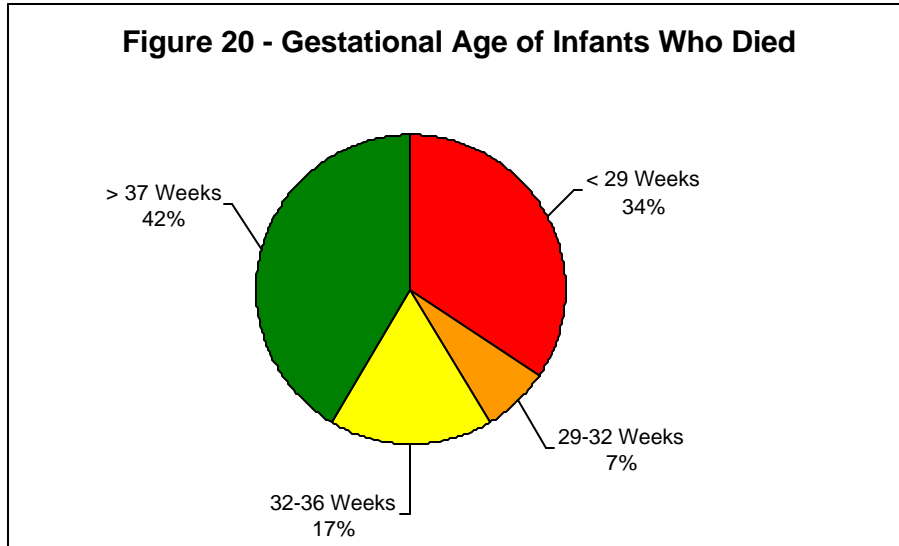


Figure 20 illustrates another important predictor of infant mortality. Infants delivered before the 29th week of gestation accounted for 34% of infant deaths. Infants delivered before the 29th week of gestation have extremely poor survival rates.

The health of mothers, infants, and children is of critical importance, both as a reflection of the current health status of a large segment of the U.S. population and as a predictor of the health of the next generation. Table 7 contains additional information about the prevalence of known risk factors for prematurity and infant mortality.

Prenatal care includes three major components: risk assessment, treatment for medical conditions or risk reduction, and education. Each component can contribute to reductions in perinatal illness, disability, and death by identifying and mitigating potential risks and helping women to address behavioral factors, such as smoking and alcohol use that contribute to poor outcomes. Prenatal care is more likely to be effective if women begin receiving care early in pregnancy. Maternal age also is a risk factor for infant death. Mortality rates are highest among infants born to teenagers. Finally, many of these conditions and risk factors disproportionately affect certain racial and ethnic groups. The disparities between white and non-white groups in infant death are wide and, in many cases, are growing.

Table 7 – Infant Mortality Risk Factors in 2001

Risk Factor	Deaths With Risk Factor 2001	All Births Mahoning Co. 1998
Inadequate prenatal care	17%	15.3%
Cigarette use during pregnancy	28%	19.7%
Unmarried mother	62%	41.4%
Teenage mother	21%	14.8%
Non-white mother	57%	25.0%

Recommendations

The compilation of child death statistical information for 2001 reveals two age groups with disproportional numbers of deaths: children under age one and teenagers. Thus, the Child Fatality Review Board’s recommendations for this year focus on those two age groups and the related causes of death that have been identified. In addition, there are recommendations for an enhanced process to provide more comprehensive information relative to all child deaths in future years.

➤ **Regarding deaths of teens ages 15-17:**

	<u>2001 #</u>
Motor Vehicle Crashes	2
Homicide	1
Suicide	1
Other Accidents *	2

** Undetermined and Unintentional Gunshots*

- Implement and enforce curfew restrictions for youth.
- Assure that suicide prevention and post-suicide intervention are provided in the schools.
- Increase youth driver experience through driver education and graduated licensing so that seatbelt use increases and driver distractions from passengers are reduced.
- Change driver licensure laws to prohibit school-age teen drivers from transporting other teens without an adult in the vehicle.
- Provide seatbelt education on how to wear the seatbelt to prevent “seatbelt syndrome” (wearing the belt too high).

➤ **Regarding deaths to children under age one:**

	<u>2001 #</u>
Prematurity	11
Birth Defects	7
SIDS	1
Other Natural	4
Homicide	1
Drowning	1

- All persons and entities who reach pregnant women and parents of newborns, should convey consistent and strong messages regarding:
 - The importance of early and adequate prenatal care to reduce low birth weight and shortened gestation risk

- The risks of certain behaviors during pregnancy and parenting, especially smoking and alcohol use
 - Support resources which are available
 - Education new parents of the importance of using cribs for infants instead of sharing a bed with them.
 - Provide childcare education for teenage mothers and fathers.
 - Supervise young children in the bathtub at all times.
 - Place babies on their backs to sleep to reduce the risk of SIDS.
- **The lack of complete and comprehensive information about all child deaths limits the Child Fatality Review Board's ability to make specific conclusions and recommendations. The Team recommends the following:**
 - Initiate an investigation of every unattended child death by the local police departments.
 - All sudden unexpected child deaths should undergo an autopsy.
 - Local police departments should receive training in child death scene investigation.
 - Request that local police departments and the prosecutor's office become more involved in the child fatality review process in order to provide important information regarding child death cases.
 - The Child Fatality Review Board should receive additional training in review of complex cases involved with multiple health and social service providers.
- **Other recommendations:**
 - Public health authorities should assure that public pools and bathing beaches are in compliance with rules and recommendations, especially for depth markers, water quality, diving areas, lifeguard supervision and CPR training, and access to an emergency phone.
 - Explore strategies to limit youth access to firearms.
 - Educate gun owners about safe gun storage in the home and emphasize the use of gun locks.
 - Children who witness homicides should be offered mental health counseling.

APPENDICES

- ◆ Child Deaths in Mahoning County Factsheet – 2001
- ◆ 2001 Child Fatality Review Board Participants

Child Deaths in Mahoning County, 2001

Ages

- 46 child deaths in 2001
 - 31 (67%) deaths were infants (birth-1 year)
 - 18 infant deaths (58%) were neonates (birth-28days)
 - 13 infant deaths (42%) were post-neonates
 - 3 deaths (7%) were pre-school age (1-4 years)
 - 0 deaths (0%) were 5-9 years
 - 5 deaths (11%) were 10-14 years
 - 7 deaths (15%) were teens (15-17 years)

Deaths by Age Group by Cause

Cause	0-27 days	28 days-1 year	1-4 years	5-9 years	10-14 years	15-17 years	Total
Prematurity	10	1					11
Birth Defects	4	3	2		2	1	12
Cancer			1		1		2
SIDS		1					1
Infection	2						2
Other Natural	2	2					4
Motor Vehicle Crashes						2	2
Homicide		1				1	2
Suicide						1	1
Drowning		1			1		2
Other Accidents					1	2	3
Pending Investigation		4					4
TOTAL	18	13	3	0	5	7	46

Residence

- 27 in Youngstown (59%)
- 4 in Boardman (9%)
- 2 in Austintown (4%)
- 2 in Campbell (4%)
- 2 in Poland (4%)
- 2 in Struthers (4%)
- 1 in Canfield, Diamond, Greenford, New Middletown, North Jackson, Salem, and Sebring (2% each)

Race

- 29 were white (63%); 17 were non-white (37%)

Sex

- 25 were boys (54%); 21 were girls (46%)

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