PREVENTING CHILD DEATHS

Report and Recommendations on the Review of 2011 Child Deaths

Mahoning County Child Fatality Review Board

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 child deaths that occur in Mahoning County in order to develop an understanding of the causes and incidences of those deaths*
- *Recommending local services 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*

Dedication

The Ohio General Assembly established the Child Fatality Review program in July 2000 to identify potential risk factors that lead to child deaths and to offer recommendations for preventing similar deaths in the future. Each county is required to establish a CFR Board that must review the deaths of children under 18 years of age residing in that county. The Mahoning County District Board of Health coordinates the CFR Board and mandated members of the board include the county coroner, a chief of police or sheriff, the children services agency, a public health official, a representative of the board of alcohol, drug addiction, and mental health services, a physician, and additional members are included as necessary for a complete review. The Mahoning County CFR Board reviews all child deaths in the county but a more thorough review is prepared and discussed on all child deaths that occur under the following conditions:

- A death which has been investigated by the coroner, which includes any death unattended by a physician and a death due to an injury, either intentional or unintentional
- When a review is requested by any Child Fatality Review Board participant

Each CFR Board is required to develop an annual report detailing their review of the childhood deaths that occurred in their jurisdiction.

This report contains information from the Mahoning County Child Fatality Review (CFR) Board's review of child deaths that occurred in Mahoning County in 2011. It reflects the work of many dedicated professionals in the community who have committed themselves to gaining a better understanding of how and why children die. Their work is driven by a desire to protect and improve the lives of young children. Each child's death represents a tragic loss for the family, as well as the community. We dedicate this report to the memory of these children and to their families. *(Ohio Child Fatality Review, Twelfth Annual Report, September 2012).*

Key Findings of 2011 Child Deaths

In 2011, 26 child deaths occurred in Mahoning County. Of the child deaths, 53.8% were among white children, 42.3% were black, and in one case, the race was undetermined. Figure 1, below, represents the age distribution of the child deaths. The majority of deaths (61.5%, n=16) were residents of the city of Youngstown, 3 deaths were residents of Boardman, and one death occurred in each of the following communities: Alliance, Austintown, Campbell, Canfield, Lake Milton, New Middletown, and Poland.

Natural deaths accounted for the majority of deaths (53.8%), accidental (unintentional injuries) deaths accounted for 26.9%, homicide accounted for 15.4% of the deaths, and the manner of one death (3.8%) was undetermined. See Figure 2 for a comparison of the manner of deaths between 2010 and 2011 and for a comparison with the State of Ohio for 2010 *(Ohio Child Fatality Review, Twelfth Annual Report, September 2012).*

Figure 1: Age of Child Deaths, Mahoning County, Birth to 17 Years of Age, 2011

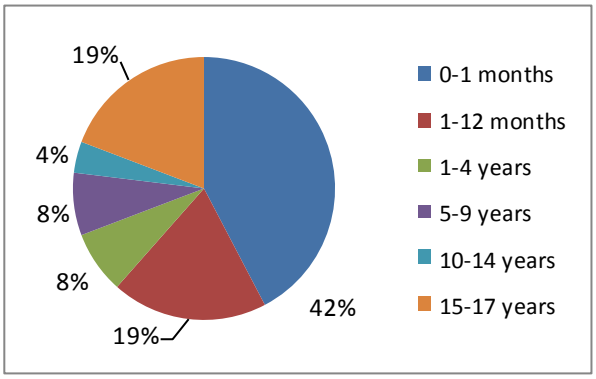


Figure 2: Manner of Child Deaths, Mahoning County, Birth to 17 Years of Age, 2010-2011 Comparison

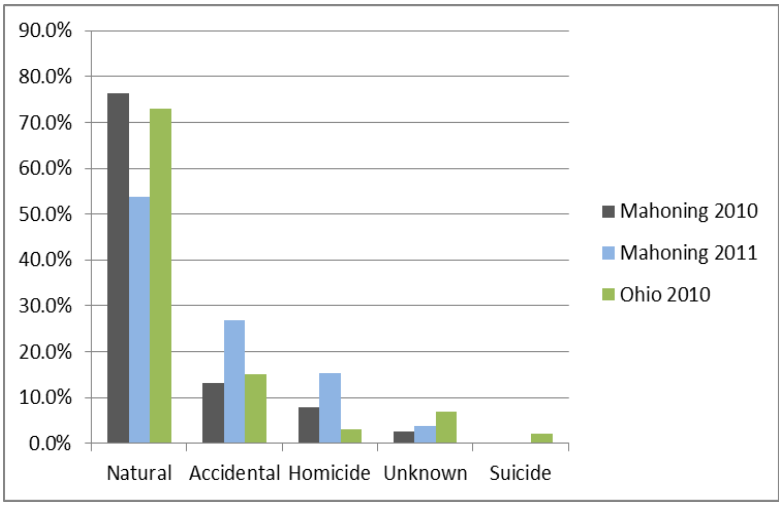


Table 1 summarizes each of the 26 child deaths in 2011. **Prematurity and birth defects** are equally represented as the cause of natural deaths. V**ehicular crashes** and **asphyxia in a sleep environment** were the most frequent cause of accidental deaths with one additional death due to drowning. Four children died from **homicide** and one child died due to an unknown cause.

The four homicide victims were all black males between the ages of 15-17 and in most of the cases young black males were also charged with or are suspects in these deaths. Whether or not the child was the intended victim, each of these homicides resulted from a shooting that was due to a personal vendetta or possible gang retaliation.

Table 1: Manner and Medical Cause of Deaths by Age Group, 2011

Manner	Cause	0-1 Months	1-12 Months	1-4 Years	5-9 Years	10-14 Years	15-17 Years	Total (Percentage)
Natural								**14 (54%)**
	Birth Defects	4	1	2				**7**
	Prematurity	6	1					**7**
Accidental								**7 (27%)**
	Drowning				1			**1**
	Sleep Related/Asphyxia	1	2					**3**
	Vehicular				1	1	1	**3**
Homicide	**Firearm**						**4**	**4 (15%)**
Unknown			1					**1 (4%)**
Total (Percentage)		**11 (42%)**	**5 (19%)**	**2 (8%)**	**2 (8%)**	**1 (4%)**	**5 (19%)**	**26**

Trends in Child Deaths

Figure 3 depicts the child death treads in Mahoning County since 1992 and demonstrates the decrease of child deaths since the high of 69 in 1993. The 26 child deaths in 2011 represent a 32% decrease as compared to 2010. Preliminary data, though, for 2012 do not indicate a continuation of this downward trend.

Figure 3: Number of Child Deaths in Mahoning County, Birth to 17 Years of Age, 1992 -2011

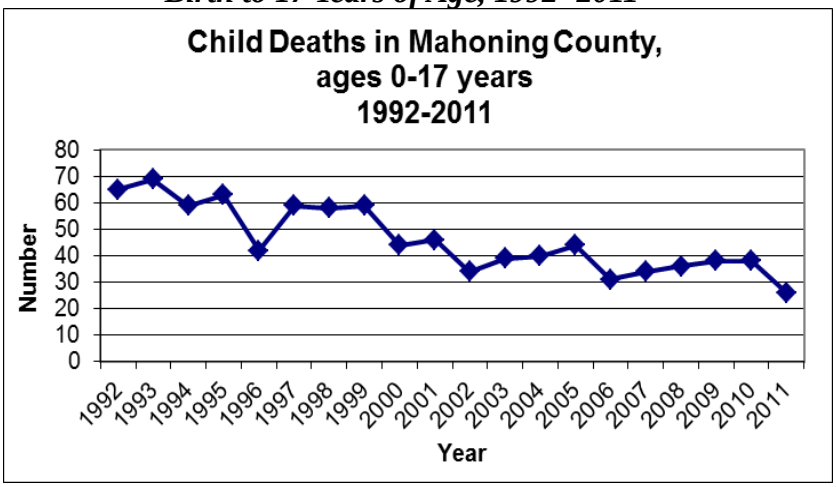


Table 2, below, lists cumulative Mahoning County child death data from 2004 to 2011 by manner and medical cause of death by age group.

Table 2: Manner and Medical Cause of Deaths by Age Group, 2004 - 2011

Manner	Cause	0-1 Months	1-12 Months	1-4 Years	5-9 Years	10-14 Years	15-17 Years	Total (percentage)
Natural								**201 (69%)**
	Neurological			1	1		1	**3**
	Cancer		1	2	4	6	2	**15**
	SIDS		7					**7**
	Cardiovascular			2		1	5	**8**
	Pneumonia and other Infections	3	6	1	1	1		**12**
	Birth Defects	21	12	10	4	1		**48**
	Prematurity	96	10	2				**108**
Accidental								**46 (16%)**
	Fall or Crush			1				**1**
	Poisoning			1		1	1	**3**
	Drowning		1		2		1	**4**
	Fire or Burn					2		**2**
	Vehicular		1	1	4	3	11	**20**
	Asphyxia or Positional Asphyxia	2	13		1			**16**
Homicide			**2**	**6**	**4**	**2**	**17**	**31 (11%)**
Suicide						**1**	**5**	**6 (2%)**
Unknown		**1**	**3**	**1**				**5 (2%)**
Total		**123**	**56**	**28**	**21**	**18**	**43**	**289**

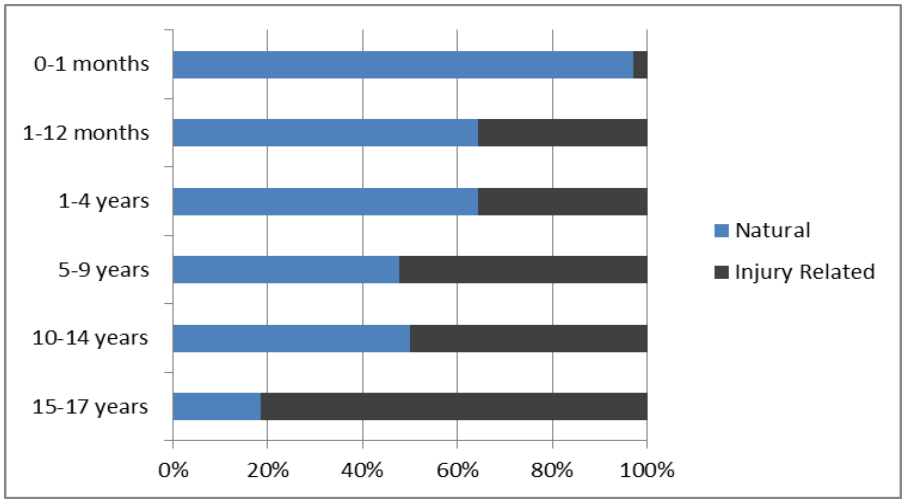
(Percentage)		**(43%)**	**(19%)**	**(10%)**	**(7%)**	**(6%)**	**(15%)**	

Between 2004-2011,

- Nearly 62% of the deaths were of infants less than 1 year of age.
- The top 5 causes of deaths to children under the age of 18 are:
  - Prematurity (37.3%)
  - Birth Defects (16.6%)
  - Homicide (10.7%)
  - Motor Vehicle Crashes (6.9%)
  - Asphyxia and Positional Asphyxia (5.5%)

Further, Figure 4 highlights the shift from deaths due to natural cause to deaths due injury-related causes (intentional and unintentional) as children age.

Figure 4: Natural versus Injury Related Causes of Deaths (Intentional and Unintentional), by Age of Child, Mahoning County, 2004-2011



CFR Board Past Recommendations

Since its inception in 2000, the Mahoning County CFR Board has made yearly recommendations to prevent future child deaths. Past recommendations are highlighted below:

- Promote a safe sleeping environment for infants. (2002, 2004, 2008, 2009, 2010)
- Continue educational and enforcement initiatives to improve safety for motor vehicle passengers and new drivers. (2010)
- Educate on the importance of knowing ones family medical history so health risks are known and it aids in the early diagnosis of potential heart defects. (2010)
- Increased support for school-based adolescent suicide prevention programs. (2001, 2005)
- Strengthen graduated driver licensing for teens. (2001, 2003)
- Enforcement of firearms possession laws. (2003)
- Strengthen seat belt and child booster seat laws. (2003, 2009)
- Involve law enforcement agencies in the child death review process. (2001)

Action Taken Based on 2010 CFR Board Recommendations

The Mahoning County District Board of Health (MCDBOH) received a $4,000 grant from the CJ Foundation for SIDS, the leading Sudden Infant Death Syndrome (SIDS) funding organization in the country. Partnering with the Mahoning County Women, Infant, and Children's (WIC) program and Akron Children's Hospital, WIC staff and clients will receive education to improve their understanding on SIDS risk reduction strategies, what constitutes a safe sleep environment, and how new mothers can provide such an environment

for their infants. The MCDBOH applied for the funding from the CJ Foundation for SIDS due to the high number of infants deaths resulting from accidental asphyxiation, suffocation, strangulation, or an undetermined manner of death in a sleep environment. Case studies conducted as a component of the CFR process revealed that most often the decedent's caregiver was unaware of infant safe sleep best practices.

2011 CFR Board Recommendations

Gang homicides, all too common in the U.S., often involve young adults and adolescents, racial and ethnic minorities, and males. According to a Centers for Disease Control and Prevention (CDC) study, *Gang Homicides – Five U.S. Cites, 2002-2008*, gang homicides were more likely to occur on the streets and with firearms, suggesting that gang homicides are quick, retaliatory reactions to ongoing gang-related conflict. (Gang Homicides-Five U.S. Cities, 2003-2008, MMWR, January 27, 2012/61(03);46-51).

Acknowledging the consistent occurrence of homicide as a cause of child deaths in Mahoning County the CFR Board is recommending that the community take steps to:

1. Prevent gang involvement early in adolescence and increase youth capacity to resolve differences without the deadly consequences of firearm use.
   The CDC study referenced above suggests:
   a. Primary prevention programs which include child training in pro-social skills and self-control.
   b. Secondary prevention programs that intervene when youths have been injured by gang violence to interrupt the retaliatory nature of gang violence and promote youths leaving gangs (e,g, hospital emergency department intervention programs).
   c. Tertiary prevention programs for gang-involved youth that provide family therapy to increase the youth's capacity to resolve conflict.
2. Stress culturally relevant high school courses which teach African and African-American History throughout the year.
3. Provide more emphasis and financial support for conflict resolution programs in the schools.
4. Enforce truancy rules with youth and parents.
5. Increase or reinstate neighborhood street walking patrols by law enforcement to increase trust between citizens and law enforcement.
6. Decrease the processing time when a juvenile referral is received by the Juvenile Courts and when the court system levies consequences.

Acknowledgements

The CFR Board expresses gratitude to the local funeral homes, members of the Mahoning, Trumbull and Columbiana County Funeral Directors Association, and the Youngstown City Health District for providing copies of birth and death certificates. We would also like to thank the members who serve on the CFR board for their professional expertise to work toward preventing future child deaths. Special thanks to Dr. Joseph Ohr and staff of the Mahoning County Coroner's Office, without their expertise and compassion, the CFR Boards work would be much more difficult!

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