# *PREVENTING CHILD DEATHS*

## Mahoning County Child Fatality Review Board
## 2006 Report and Recommendations

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

- *Promotion 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 and 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*

In Mahoning County, a licensed counselor from the **Mahoning County Family and Children First Council** coordinates the review of child deaths that occur under these conditions:

- Due to an injury, either intentional or unintentional
- Whose death is unattended by a physician
- Whose death has been investigated by the coroner
- When a review is requested by any child fatality review board participant

The counselor presents his research findings to the Child Fatality Review Board, which meets periodically as required by Ohio law.

These organizations participated in child death reviews in 2006:

Help Hotline Crisis Center
Mahoning County Alcohol and Drug Addiction Services Board
Mahoning County Children Services
Mahoning County Coroner's Office
Mahoning County District Board of Health
Mahoning County Mental Health Board
Mahoning Safe Communities
Saint Elizabeth Health Center
Tod Children's Hospital
Youngstown City Health District
Youngstown Police Department

The Board reviewed 8 of the 31 Mahoning County resident child deaths that occurred in 2006. Five of these children were murdered, 1 died in a motor vehicle crash, 1 died of heart disease, and one died of undetermined causes. A table describing all 31 child deaths in 2006 is found at the end of this report.

## A retrospective of Child Fatality Review Board recommendations, 2000-2006

Since its inception in 2000, the Mahoning County Child Fatality Review Board has each year made recommendations intended to prevent future child deaths. Some of these recommendations are highlighted below:

- Support for school-based adolescent suicide prevention programs (2001, 2005)
- Promoting a safe sleeping environment for infants (2002, 2004)
- Strengthening graduated driver licensing for teens (2001, 2003)
- Enforcement of firearms possession laws (2003)
- Strengthening seat belt and child booster seat laws (2003)
- Involving law enforcement agencies in the child death review process (2001)

## The benefit of child fatality reviews

Child deaths are often regarded as an indicator of the health of a community. While mortality data provide us with an overall picture of child deaths (by number and cause), it is from a careful study of each child's death that we can learn how best to respond to a death and how best to prevent another.

Here are several examples of how the local child death review process has contributed to local and state policy and program initiatives to prevent child deaths:

### Safe Sleep Initiative

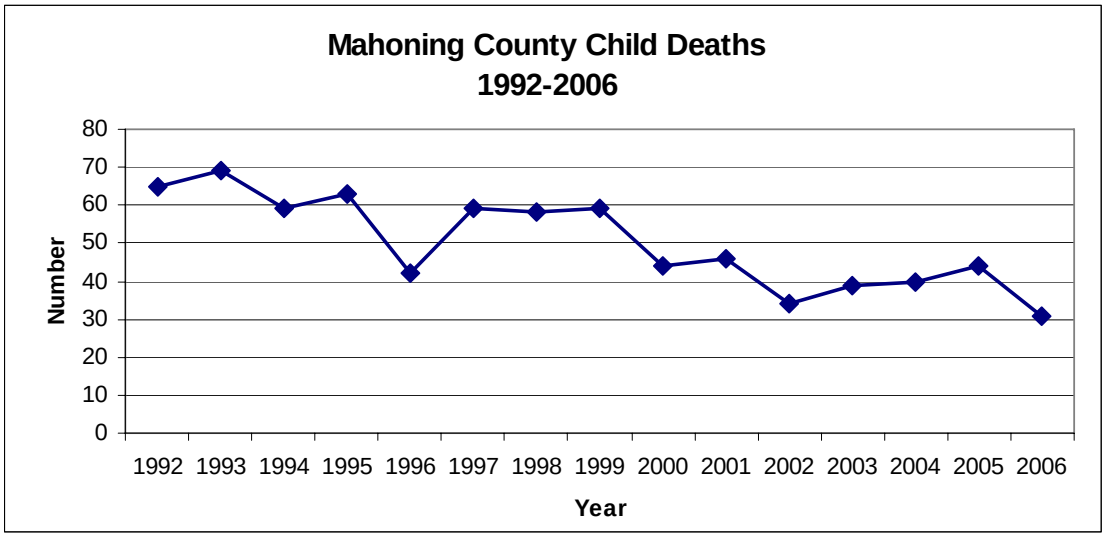
After the Review Board alerted the Mahoning County Family and Children First Council to the high percentage of infant deaths in recent years linked to SIDS or other sleep-related conditions (1 in 6 infant deaths between 2000-2004), Family First Council organized a campaign to promote safe sleep for infants. The message of this campaign is "**babies sleep safest on their backs – and in their own cribs**." Family First Council has offered local training opportunities and media appearances directed at infant caregivers who may be unaware of the importance of a supine sleeping position in a safe sleeping environment. With funding from the local Child & Family Health Services program, Family First Council has been able to distribute a number of portable cribs to needy families through the Help Me Grow and Healthy Babies, Healthy Moms programs.

### Ohio's New Teen Driver and Child Restraint Law

Motor vehicle crashes are the 2nd leading cause of injury death for children in Mahoning County. The Review Board joined other county review boards from around the State in urging passage of a stricter graduated motor vehicle driver licensing law in Ohio. House Bill 343, which took effect in early 2007, enacted some of these licensing provisions into law. The new law requires that 16-year-old drivers be limited to no more than one passenger and be restricted from driving between midnight and 6 a.m. All children ages 4 to 15 must be restrained in either an approved child-restraint system or in a seat belt under the new law.

## Trends in child deaths

Child deaths declined by more than 50% in Mahoning County between 1992 and 2006, as the chart below shows. Organized community efforts like the child fatality review process can lead to public policy changes and programs that will sustain this slow but steady improvement in child survival.




## Acknowledgements

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*Matthew Stefanak*
*Health Commissioner*
*General Health District in Mahoning County*
*Chair, Mahoning County Child Fatality Review Board*

*April 1, 2008*

*Mahoning County Child Fatality Review Board reports from 2000 through 2006 may be found on the Mahoning County District Board of Health website at http://www.mahoning-health.org/healthreports-annualreports.asp*

# Child Deaths in Mahoning County 2006

*Ages*

- 31 child deaths in 2006
- 13 (42%) deaths were infants (birth-1 year)
  - 12 infant deaths (92%) were neonates (birth-28 days)
  - 1 infant death (8%) was a post-neonate (29 days-1 year)
- 5 deaths (16%) were preschool-age (1-4 years)
- 1 death (3%) was 5-9 years
- 3 deaths (10%) were 10-14 years
- 9 deaths (29%) were teens (15-17 years)

*Deaths by Age Group by Cause*

| Cause | 0-1 Month | 1-12 Months | 1-4 Years | 5-9 Years | 10-14 Years | 15-17 Years | Total |
|---|---|---|---|---|---|---|---|
| Prematurity | 8 | 1 | | | | | 9 |
| Birth defects | 2 | | 2 | | | | 4 |
| Homicide | | | 1 | | 1 | 3 | 5 |
| Motor vehicle accidents | | | | 1 | | 3 | 4 |
| Cancer | | | | | 2 | 1 | 3 |
| Infectious disease | 1 | 1 | 1 | | | | 3 |
| Seizure disorder | | | | | | 1 | 1 |
| Undetermined/other | | | 1 | | | 1 | 2 |
| Total | 11 | 2 | 5 | 1 | 3 | 9 | 31 |

*Residence*

- 18 in Youngstown (58%)
- 4 in Boardman (13%)
- 3 in Austintown (10%)
- 1 in Beaver Township (3%)
- 1 in Canfield Township (3%)
- 1 in Goshen Township (3%)
- 1 in Milton Township (3%)
- 1 in Smith Township (3%)
- 1 in Springfield Township (3%)

*Race*

- 16 were white (52%); 15 were black (48%)

*Sex*

- 21 were boys (68%); 10 were girls (32%)

*Source: Mahoning County District Board of Health*