PREVENTING CHILD DEATHS

Mahoning County Child Fatality Review Board
2007 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*

Child deaths are often regarded as an indicator of the how healthy a community is. 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 others.

In Mahoning County, **Gary Folkwein**, a counselor from the **Mahoning County Family and Children First Council** and **Jan Baharis** from **Family Service Agency – Daybreak** coordinated reviews of 2007 child deaths that occurred 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 reviewers presented their research findings to the Child Fatality Review Board, which meets periodically as required by Ohio law. These organizations participated in the review of 2007 child deaths:

Help Me Grow
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 County Sheriff's Department
Mahoning Safe Communities
Saint Elizabeth Health Center
Akron Children's Hospital
Youngstown City Health District
Youngstown Police Department

The Board reviewed 18 of the 36 Mahoning County resident child deaths that occurred in 2007. Five of these children were murdered, 3 died in a motor vehicle crash, 3 died of drowning, fire or other injuries, 2 died of SIDS or overlay, and 5 died of medical conditions warranting a coroner's investigation. A table describing all 36 child deaths in 2007 is found at the end of this report.

Several of these child deaths received special attention from the Board:

On March 18, 2007, four-year-old Sarah Bundy of Struthers was reaching into the upper drawer of her bedroom dresser for a pair of pull-ups. The dresser fell over on her and Sarah was killed.

Sarah's tragic death is one among the 18 deaths that occur each year on average in the U.S. due to furniture or TV tip-over. The U.S. Consumer Product Safety Commission (CPSC) estimates that more than 80 percent of these deaths involve young children. Tip-over injuries are surprisingly common - according to the CPSC at least 3,000 children younger than five were treated in U.S. hospital emergency rooms in 2005 because of tip-over injuries.

These injuries and deaths frequently take place when kids climb onto, fall against or pull themselves up on shelves, bookcases, dressers, desks, chests and television stands. In some cases, televisions placed on top of furniture tip over and cause a child to suffer a traumatic and sometimes fatal injury.

After Sarah's death family friend **Brenda Pavlicko** contacted the Child Fatality Review Board to find out how she could help prevent future tragedies. The Board was able to arrange for the distribution of child safety flyers explaining how to anchor furniture that could present a risk of tip-over to the more than 750 new mothers in Mahoning County who receive a nurse home visit each year from **Help Me Grow**. In addition, Board member and pediatrician Dr. **Ron Dwinnells** provided an advisory letter to physicians about tip-over risk that was distributed by the District Board of Health's Health Alert Network to area pediatricians and family practitioners.

Tips to prevent furniture tip-overs:

- Verify that furniture is stable on its own. For added security, attach to the wall or anchor to the floor all entertainment units, TV stands, bookcases, shelving and bureaus using appropriate hardware, such as brackets, screws or toggles.
- Place the TV on sturdy furniture appropriate for the size of the TV or on a low-rise base.
- Push the TV as far back as possible.
- Place electrical cords out of a child's reach, and teach kids not to play with them.
- Remove items that might tempt kids to climb, such as toys and remote control, from top of the TV and furniture.

For more information about furniture tip-overs

On May 9, 2007, a seven-month-old Youngstown infant suffocated while sleeping with her mother in her mother's bed. The infant had a crib in her home but it was not being used. A three-month-old Austintown girl died in similar circumstances on September 1, 2007.

The Board had issued an earlier report in 2004 observing that in the five years between 2000-2004, 18 of the 116 infants who died in Mahoning County died of SIDS and other sleep-related conditions such as suffocation and maternal overlay. *These sleep-related deaths accounted for 16% of - or one in six – infant deaths in Mahoning County during this five-year period.*

Despite stepped-up local efforts by the **Mahoning County Family and Children First Council** to educate parents and caregivers about safe sleep practices since then, sleep-related deaths like these two in 2007 continue to occur. The board once again urges health care and social service providers to reinforce these safe sleep practices with parents and caregivers of newborns and infants:

Infant Safe Sleep Practices

- Infants should be put to sleep on their backs only
- Infants should sleep in a crib with a firm mattress in the same room as their mother
- Caregivers should keep soft objects and loose bedding out of the crib
- Offer a pacifier at nap and bed time
- Mothers should not smoke during or after pregnancy
- Adults should not expose infants to secondhand smoke

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

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Mahoning County Child Fatality Review Board reports from 2000 through 2007 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 2007

Ages

- 36 child deaths in 2007
- 21 (58%) deaths were infants (birth-1 year)
  - 12 infant deaths (57%) were neonates (birth-28 days)
  - 9 infant deaths (43%) were post-neonate (29 days-1 year)
- 6 deaths (17%) were preschool-age (1-4 years)
- 2 deaths (6%) were 5-9 years
- 1 death (3%) was 10-14 years
- 5 deaths (14%) 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	9	3					12
Birth defects	2		2				4
Homicide		2	1	1		1	5
Motor vehicle accidents		1		1		1	3
Drowning		1					1
Fire					1		1
Other accident			1				1
SIDS/overlay		2					2
Cancer			2				2
Pneumonia	1	1					2
Pulmonary embolism						2	2
Heart disease						1	1
Total	12	10	6	2	1	5	36

Residence

- 17 in Youngstown (58%)
- 4 in Boardman (13%)
- 3 in Austintown (10%)
- 2 in Beloit (3%)
- 2 in Canfield (3%)
- 1 each in Beaver Township, Campbell, Milton Township, Sebring, Smith Township, Springfield Township, Struthers, Washingtonville

Race

- 20 were white (56%); 16 were black (44%)

Sex

- 18 were boys (50%); 18 were girls (50%)

Source: Mahoning County District Board of Health