



PREVENTING CHILD DEATHS

Mahoning County Child Fatality Review Board 2008 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 volunteer coordinator from **Family Service Agency - Daybreak** prepares a review of all 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 coordinator presents her research findings to the Child Fatality Review Board, which meets periodically as required by Ohio law.

These organizations participated in 2008 child death reviews:

Akron Children's Hospital of the Mahoning Valley
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
Youngstown City Health District
Youngstown Community Health Center
Youngstown Police Department

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 others like it.

2008 deaths

The Board reviewed 14 of the 36 Mahoning County resident child deaths that occurred in 2008. **Prematurity** was responsible for the greatest number of child deaths (15). Seven others were **murdered**, 4 of them in an arson house fire in January 2008. Five children died of **birth defects**, 5 infants died of **SIDS or in a sleep environment**, 2 adolescents were **suicides**, and two children died of other causes. A table summarizing all 36 child deaths in 2008 is on page 4 of this report.

A mother from Youngstown put her five-month-old infant into bed with her on October 30, 2008. Both fell asleep. The mother awakened three hours later to find the infant suffocated. The mother and child were staying with the mother's parents and did not have a crib. Four other infants died in similar circumstances in 2008.

The Board has commented in previous reports on the significant contribution of unsafe sleep environments to the number of infant deaths. *These sleep-related deaths accounted for 11% of - or one in nine - infant deaths in Mahoning County since 2000.*

After the Review Board alerted the **Mahoning County Family and Children First Council** to the number of infant deaths in recent years in the sleep environment, Family First Council raised more than \$4,700 through the sale of 950 cookbooks to purchase portable cribs for Help Me Grow clients who need them.

Despite these efforts by the Family First Council to help families provide a safe sleep environment, sleep-related deaths like these five in 2008 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:***

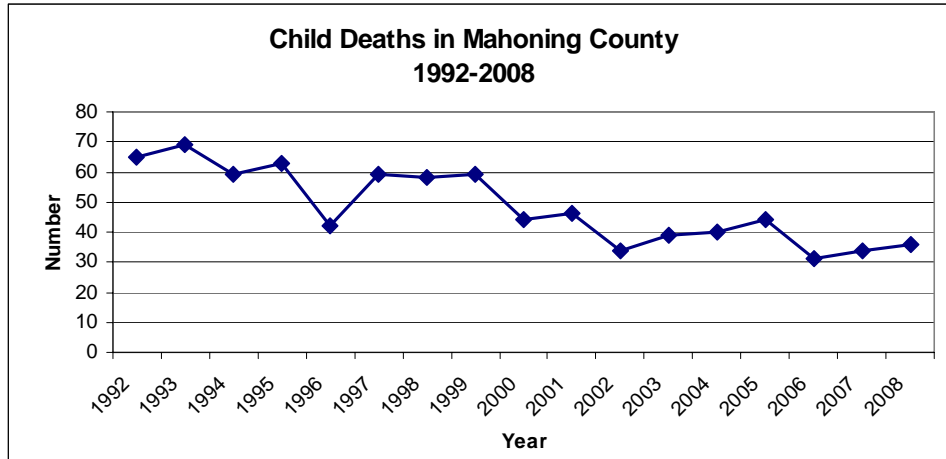
Infant Safe Sleep Practices

- 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



Trends in child deaths

Child deaths declined by 45% in Mahoning County between 1992 and 2008, 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.



Previous Child Fatality Review Board recommendations, 2000-2007

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)

Acknowledgements

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

May 1, 2010

Mahoning County Child Fatality Review Board reports from 2000 through 2008 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 2008

Ages

- 36 child deaths in 2008
- 24 (67%) deaths were infants (birth-1 year)
 - 18 infant deaths (75%) were neonates (birth-28 days)
 - 6 infant deaths (25%) were post-neonates (29 days-1 year)
- 5 deaths (14%) were preschool-age (1-4 years)
- 3 deaths (8%) was 5-9 years
- 1 death (3%) was 10-14 years
- 3 deaths (8%) 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	15						15
Birth defects	3	1		1			5
Homicide			3	2		2	7
Suicide					1	1	2
Motor vehicle accidents							
Cancer							
Infectious disease							
Seizure disorder			1				1
SIDS or sleep-related		5					5
Undetermined/other			1				1
Total	18	6	5	3	1	3	36

Residence

- 17 in Youngstown (47%)
- 9 in Boardman (25%)
- 5 in Austintown (14%)
- 2 in Beloit (6%)
- 1 in Campbell (3%)
- 1 in Canfield (3%)
- 1 in Milton Township (3%)

Race

- 19 were white (53%); 17 were black (47%)

Sex

- 19 were boys (53%); 17 were girls (47%)

Source: Mahoning County District Board of Health