

Trumbull County Child Fatality Review Board

2012 Annual Report

Submitted by: Randee Shoenberger R.N.

During the year of 2011, 23 deaths occurred to children in Trumbull County. These deaths were reviewed by a 3 member sub-committee before presenting the cases to the full board. The full board meets on a quarterly basis.

Upon reviewing these cases the various agencies of Trumbull County work together to educate the public on preventable deaths. We also encourage community and individual involvement in recognizing risk factors that may contribute to child deaths.

The 3 member sub-committee met to gather data, review the deaths and select cases for full review by the full board. There were 23 deaths to children below the age of 18 years in Trumbull County during 2011. (23 cases were reviewed)

The breakdown of deaths:

- ◆ 3 Homicides
- ◆ 4 Accidental (smoke inhalation, possible drug toxicity)
- ◆ 5 SIDS
- ◆ 1 Pneumonia
- ◆ 3 Prematurity



Meetings and activities attended:

Ohio Child Fatality Review New Board Chair/Coordinator Orientation

Ohio Infant Mortality Summit

“What Every Grandparent Should Know” a presentation given to seniors who care for their grandchildren

“Child Abuse and Neglect-Recognition and Reporting”

Community Campaigns:

“T-dap” for professionals delivered to OB/GYN and pediatrician offices

Safe Sleep posters delivered to OB/GYN, pediatrician offices and Safe Sleep signs on public transportation

*Save-A-Life Smoke Alarm-“SALSA”
Warren City Fire Department providing smoke alarm systems to Warren City residents.*

Future Plans:

Task force for “Severe Child Injury/Child Death Scene Investigation”
This team will utilize the “doll re-enactment” for infant deaths. It will be an off-shoot of the homicide task force presently in place.

Design a campaign that will address premature births.

Trumbull County Child Fatality Review Board Members

Dr. James Enyeart - Board Chair

Trumbull County Health Commissioner

James Dobson

Girard City Health Commissioner

Diane Barber

Assistant Prosecutor to Child Assault Prosecutor Team

Tim Shaftner

Trumbull County Children Services Board

Darleen Shope

Trumbull County Children Services Board

April Caraway

Director of Trumbull County Mental Health and Recovery Board

Robert Pinti

Warren City Deputy Health Commissioner

Dr. Germaniuk

Trumbull County Coroner

Shelley Mazanetz

Chief Forensic Investigator

Dr. Firster

Trumbull County Deputy's Office

Sandy Swann RN BSN

Trumbull County Health Department

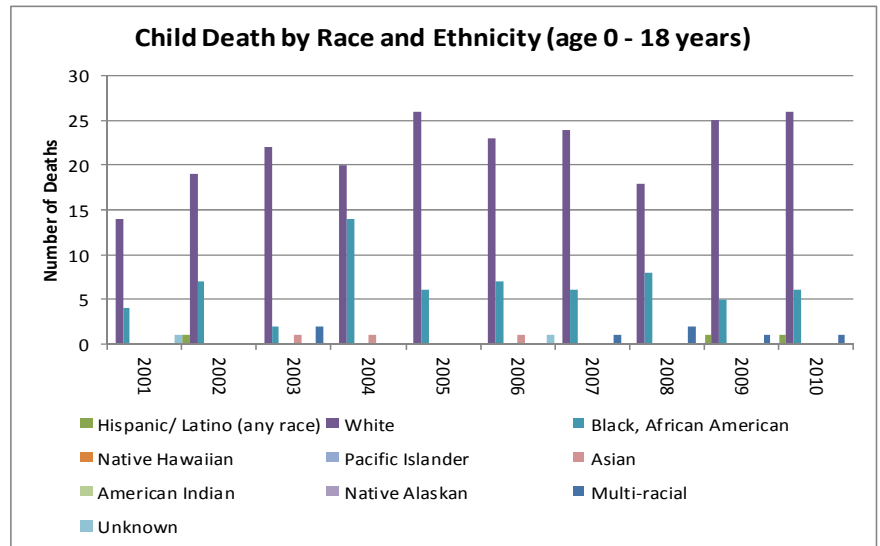
Randee Shoenberger RN

Trumbull County Health Department

A Ten Year Look At Trumbull County Child Deaths

Submitted by: Sandy Swann R.N., B.S.N., Epidemiologist

Figure 1



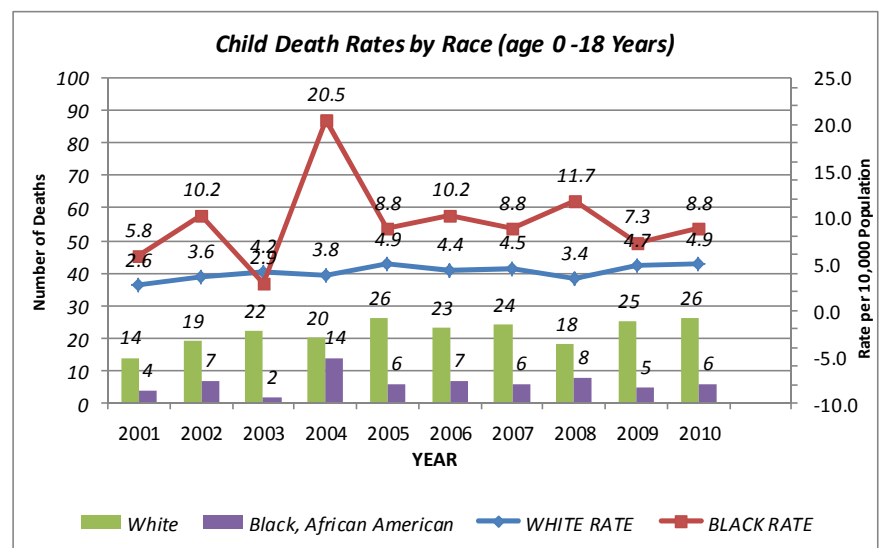
Trumbull County is considered to have a low number of child related deaths as compared to other counties throughout the state of Ohio. Because these numbers are relatively low, a ten year look at child related deaths gives a better picture of disparities and causes of death. The number of child related deaths age 0 to 18 years for Trumbull County has remained relatively constant with a median of 31.5 child deaths occurring from 2001 thru 2010. The least number of deaths occurred in 2011 with 19 child deaths and the most being 35 child deaths in 2004.

Race and ethnicity of child deaths in this age group (Figure 1) show the largest number of child deaths are white followed by black and very few other races. There were only two Hispanic / Latino child deaths during this 10 year period. However, a look at the rate of child death for each race (Figure 2) gives a better picture of the disparities between races. **Minority children are more than twice as likely to die as white children.** This seems to be the case when looking at race rate data for Trumbull County (Figure 2). Greater than twice as many black children died as white children in Trumbull County during 2001 - 2010. This disparity is much similar to what is being seen throughout Ohio and raises the awareness of the need for an intervention. Strategies are needed to eliminate this disparity.

Ohio is 11th in the nation for overall infant mortality. Ohio is 5th in the nation for infant mortality racial disparity.

Figure 2

*(Rates were calculated using the 2000 census data for children <= 19 years of age in Trumbull County)



**TURNING UP THE VOLUME ON INFANT MORTALITY
EVERY BABY MATTERS!**

Sleep Related Deaths 0 to 5 Years of Age

Sleep related deaths accounted for 18% of all child related deaths in Trumbull County for 2001 - 2010.

They are categorized into five causes: Sudden Infant Deaths Syndrome (SIDS); Asphyxia; Medical Condition; Undetermined; and All Other Causes. Asphyxia includes choking, suffocation or strangulation. A medical condition could be congenital or acquired after birth. Examples of "all other causes" are homicide, accident, and prematurity.

Race and ethnicity for sleep related deaths is represented only by white and black races (Figure 3) for Trumbull County during this time period.

There were no sleep related deaths for other races. The number of sleep related deaths were higher for white children in this age group than black children, with the rate for both races relatively close. Except for years 2007 and 2008, racial disparity does not seem to be affected much by sleep related deaths during this ten year period.

Figure 4 shows the rate of sleep related deaths for all causes in Trumbull County. It climbed from 2001 to a peak of 4 deaths per 1000 live births in 2006. Although this graph shows that the number of SIDS cases are few for Trumbull County, it still accounts for 33% or one third of all the sleep related deaths. This fact along with other state data prompted Trumbull County Child Fatality Review Board (CFR) to begin an initiative to educate the public about safe sleep for babies and children. Information was shared by billboards, television, brochures, and presentations. This initiative continues and may be why Trumbull County is seeing a decline in sleep related deaths.

Figure 3

*(Rates were calculated using the 2000 census data for children <= 19 years of age in Trumbull County)

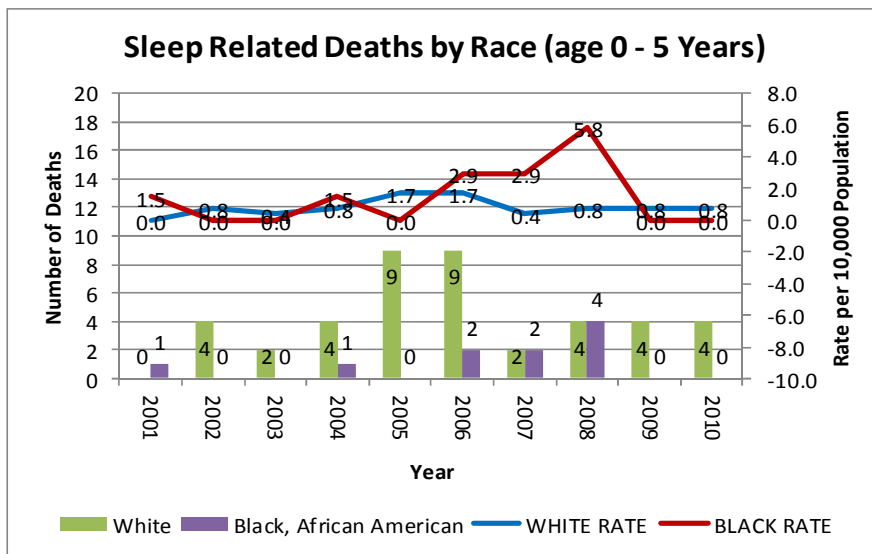
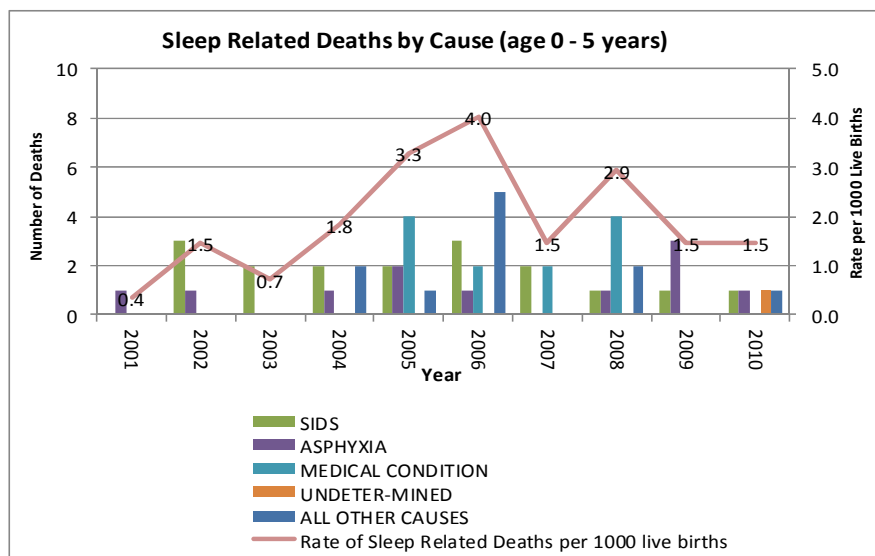


Figure 4

*(Rates were calculated using the 2000 census data for number of live births for Trumbull County)_



All Manner and Causes of Death 0 to 18 Years of Age

294 is the total number of child deaths from all causes for Trumbull County during 2001 - 2010. Ohio classifies these deaths into five major categories: Natural; Accident; Suicide; Homicide and Undetermined. There are several causes of death under each category. For example, Natural would include SIDs, prematurity, and death caused by a medical condition.

Prematurity is the leading cause of infant mortality in Ohio. This is evident for Trumbull County when looking at data for this ten year period (Figure 5.) Natural causes is more than twice as high as all other causes in all of the years for this ten year period. Prematurity accounts for the most number of deaths, at 30% or almost one third of all the deaths, within this category. It is followed by "other medical" at 18% and congenital anomalies at 15%. SIDs is 8% of all the deaths within this category.

Because prematurity is a major cause of death due to natural causes through out Ohio, there are initiatives to reduce this number. The "39 week gestation" project is one initiative that involves measures to avoid deliveries before 39 weeks. Other projects include family planning, better access to prenatal health care, medical intervention, and education.

The next highest cause of death for Trumbull County during this period is Accidents. Asphyxia and motor vehicle accidents accounted equally as the most number of deaths in this category at 23%; followed by fire at 18% and drowning at 14%. Figure 5 shows that accidents peaked in 2006 and declined significantly in 2007. During this time period, the Trumbull County CFR implemented initiatives to reduce accidents, such as Safety Town; pool safety messages; safe sleep and fire safety. The number of accidental deaths increased again in 2008 and remained constant through 2010. Therefore, these initiatives and new ones need to be continued to help eliminate accidents as a cause of death in this age group.

Suicide was 3% and Homicide was 6% for all the categories for this time period. There were 10 suicide cases with 5 (50%) by asphyxia and 3 (30%) by a weapon. There were 17 homicide cases with 11 or 65% because of a weapon. Although these numbers are relatively low compared to other causes of death, children should not die from these causes. Initiatives need to be developed and implemented to prevent these types of deaths from occurring.



Figure 5

