

C HILD
F ATALITY
R EVIEW

FOURTH ANNUAL REPORT
(APRIL 2005)

CHILD DEATHS
FOR THE YEAR 2003

REPORT PREPARED BY:

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HEALTH COMMISSIONER

&

CHRISTINA GRUBER, RN, BSN, MS

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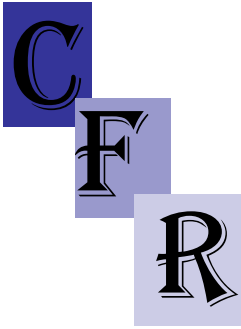
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Stark County Child Fatality Review Board

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Greetings:

For the fourth year in row the Child Fatality Review Board has completed its work of reviewing childhood deaths in Stark County. Dedicated professionals from public health, children services, health care, law enforcement, safety forces, mental health, and other social and community services have diligently been working to review the deaths from the year 2003 and to bring forth recommendations to the community.

In the previous three years, recommendations in the Child Fatality Review Board's Annual Reports have been taken up by various community groups. Programs have been initiated to address these concerns. That is the key to this being a successful effort. For without the response from the community, the information contained in this report is nothing more than another report that gathers dust on a shelf.

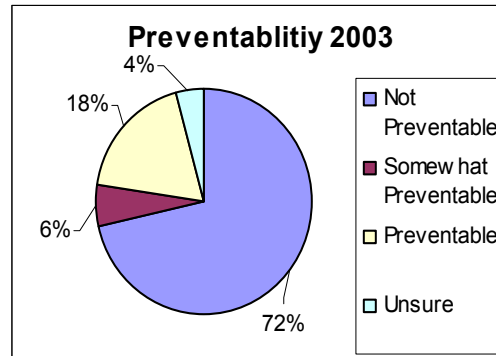
Although it is a very somber task, each member of the CFR Board takes this responsibility to heart. We feel that even if one child death is avoided in Stark County, then all of our time and effort has been well worth it. It is with that positive feeling of accomplishment that we have completed our work and present this year's annual report to the Stark County community.

Sincerely,

William J. Franks, MPH, Chair
Stark County Child Fatality Review Board

STARK COUNTY CHILD FATALITY REVIEW OF 2003 CHILD DEATHS

Even when the death of a child is from a natural cause, such as cancer or a birth defect, the death is still tragic and devastating to the family. When the death is from a preventable cause such as accidents, homicides, and suicides, the effect on the community can be too difficult for many to comprehend. The Stark County Child Fatality Review Board has been reviewing the deaths of children from birth through 17 years of age for four years. Whether or not a death was preventable is not always easy to determine. During 2004, the Board reviewed the deaths of the 49 children who died in 2003. The graph to the right shows the break down of the deaths by preventability.



PURPOSE

In October of 2000, legislation was enacted that required every county in Ohio to create a Child Fatality Review Board to review the deaths of all children aged 17 and under. The ultimate purpose of this Review Board is to decrease the incidence of preventable child deaths.

- Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities that serve families and children.
- Maintaining a comprehensive database of all fetal and child deaths that occur in Stark County in order to develop an understanding of the causes and incidence of those deaths.
- Making recommendations to local agencies for the development of new programs and changes to current programs that will help to prevent fetal and child deaths.
- Advising the Ohio Department of Health of aggregate data, trends, and patterns concerning child deaths.

CHILD FATALITY TEAM MEMBERS

The mandated board members include: county coroner, chief of police or sheriff, executive director of a public children services agency, public health official, executive director of a board of alcohol, drug addiction, or mental health board, and a physician.

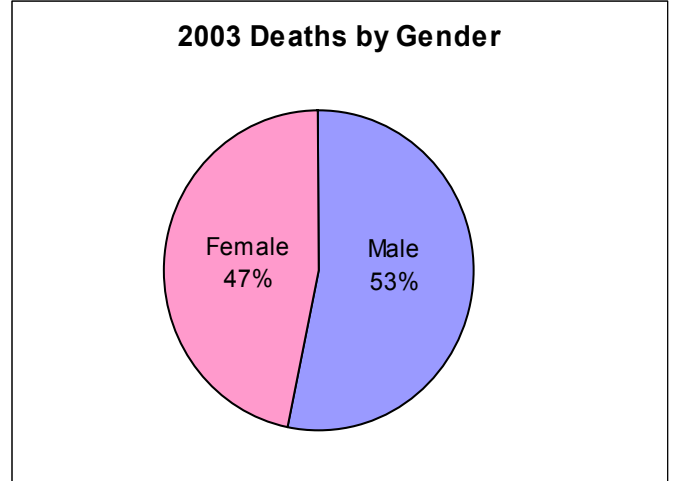
After reviewing the child deaths for the year 2000, the original board members of the Stark County Child Fatality Review Team decided that additional members from various specialty fields would benefit the review process. Individuals from several different agencies from different areas of the county were invited to join the review team.

Those agencies that joined the team in 2002 include experts from areas such as hospital administration, public health— Child and Family Health Services, emergency medical services, and fire prevention services. A local retired pediatrician has also volunteered his time to help with the team.

In order to have a more diverse board membership, during 2004, an employee of Stark Metropolitan Housing agreed to join the child fatality review board.

NUMBER OF CHILD DEATHS BY GENDER, AND AGE GROUP

Number of Child Deaths			
Ages	Males	Females	Total Deaths
0-27 days	9	15	24
28 days- 1year	4	2	6
1-4 years	2	1	3
5-9 years	4	2	6
10-14 years	4	2	6
15-17 years	3	1	4
Totals	26	23	49

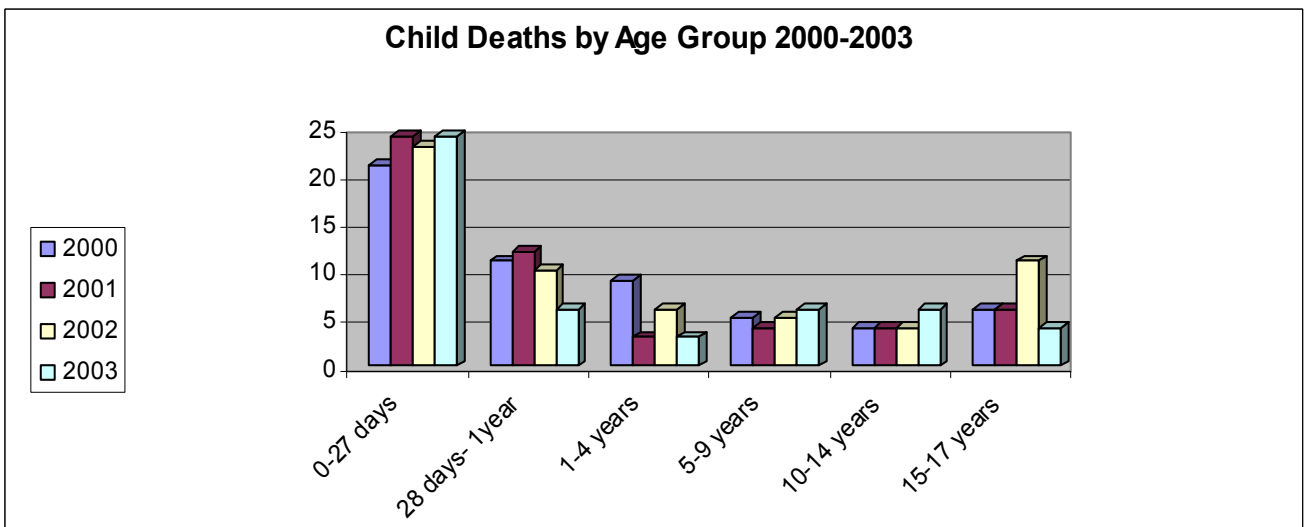
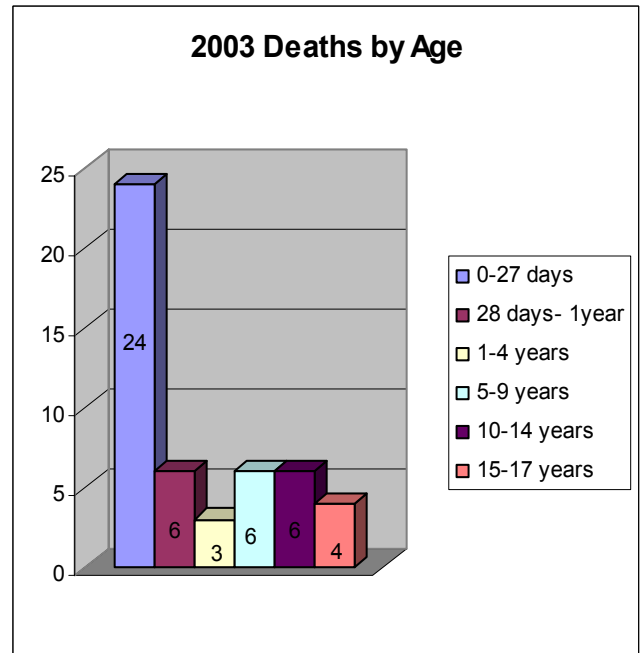


The chart above and the graphs to the right & below show the child deaths by gender, and age.

- 61 % of the child deaths during 2003 were under 1 year of age.
- 67 % of the child deaths during 2003 were under 5 years of age.

From 2000 through 2003, there were a total of 217 deaths of children from birth through 17 years of age.

- 60% were male.
- 40% were female.
- 60% (131) of the 217 deaths were under 1 year of age.



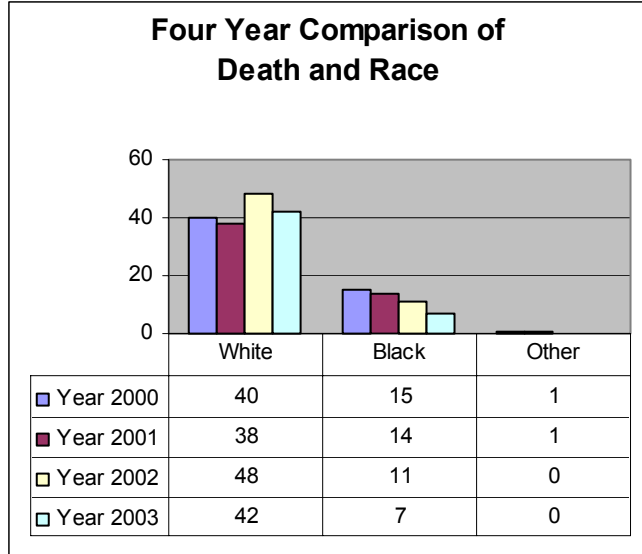
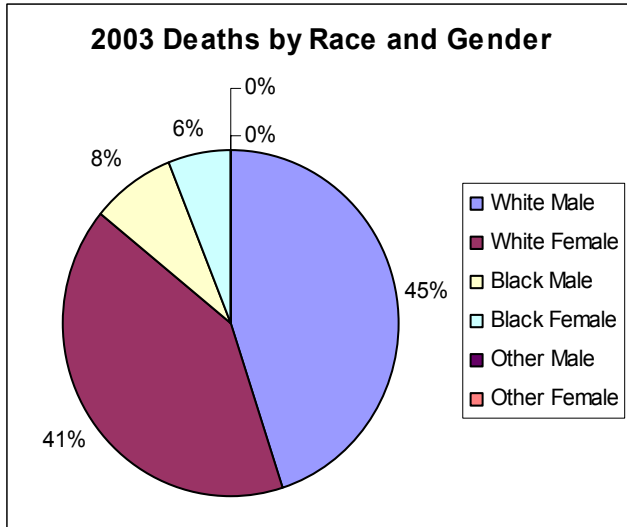
NUMBER OF CHILD DEATHS BY GENDER AND RACE

- For 2003, of the 49 child deaths in Stark County, 86 % were white, and 14 % were black. However, based on the 2000 census information, the death rates per 100,000 population under the age of 18 would be:

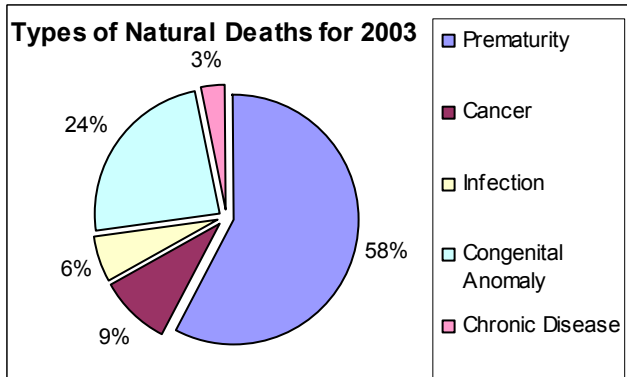
White= 52.8 Black= 75.5

Number of Deaths in specific population X 100,000

*Death rate= Specific Population

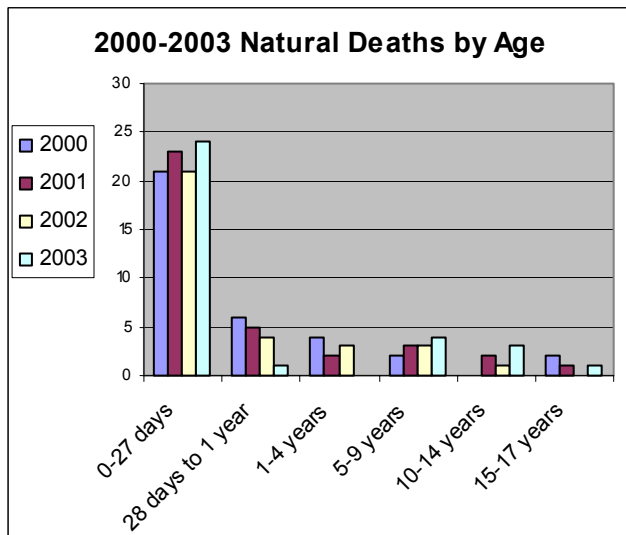
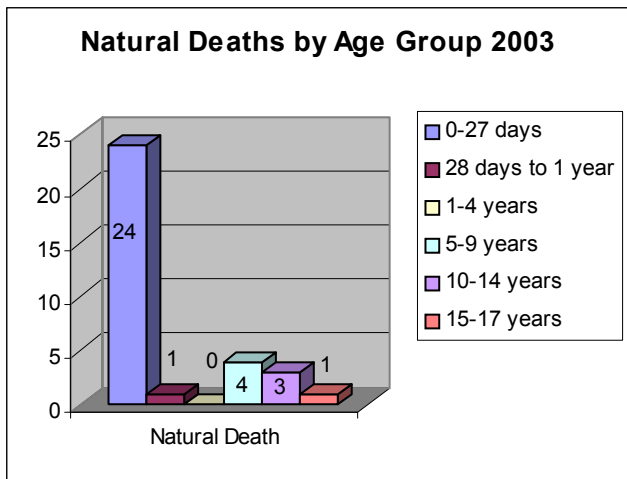


NATURAL DEATHS



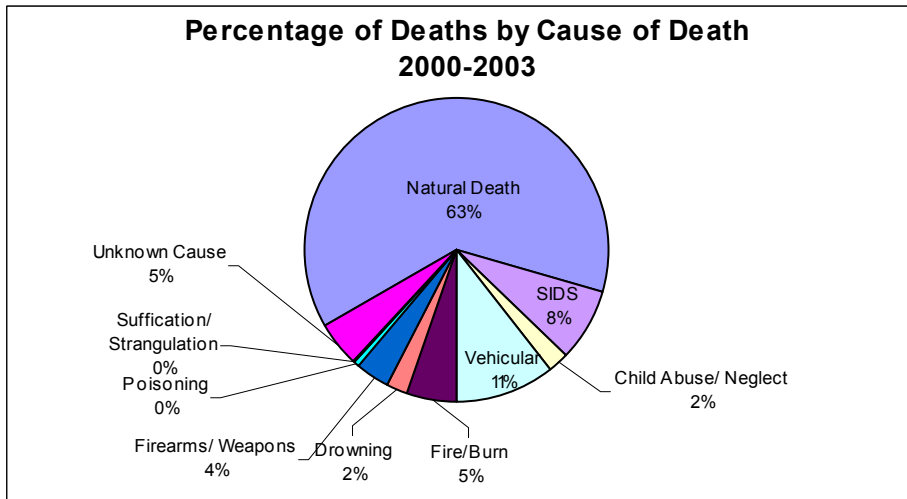
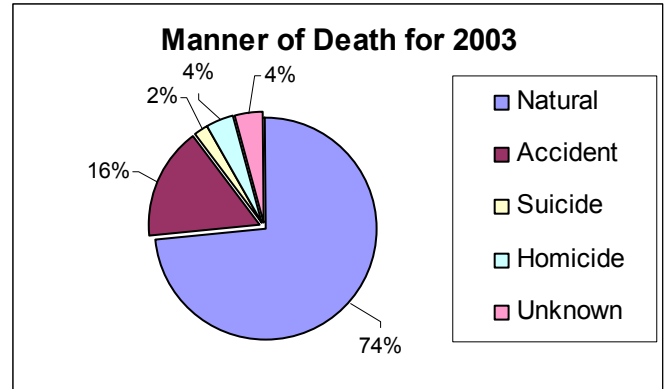
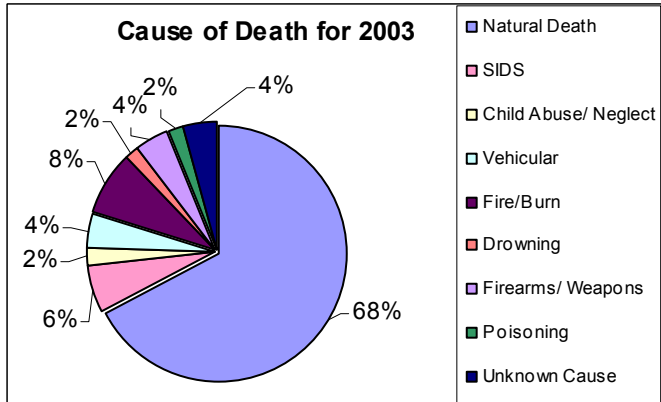
Of the 136 Natural Deaths from 2000-2003

- 77 % were under 1 year of age.
- 52 % prematurity.
- 26 % congenital anomalies.
- 10 % infections.
- 7 % cancer.
- 4 % chronic diseases.
- 1 % various other reasons.



CHILD DEATHS FOR 2003 BY AGE GROUP AND CAUSE OF DEATH

Ages	Natural Death	SIDS	Child Abuse/ Neglect	Vehicular	Fire/Burn	Drowning	Firearms/ Weapons	Poisoning	Unknown Cause	Total
0-27 days	24	0	0	0	0	0	0	0	0	24
28 days to 1 year	1	3	0	1	1	0	0	0	0	6
1-4 years	0	0	1	0	1	0	0	0	1	3
5-9 years	4	0	0	0	1	0	0	0	1	6
10-14 years	3	0	0	1	1	1	0	0	0	6
15-17 years	1	0	0	0	0	0	2	1	0	4
Totals	33	3	1	2	4	1	2	1	2	49



←As you can see by the pie chart to the left Natural Deaths have been by far the leading cause of death to children accounting for 63 % of the deaths over the past four years of review.

It is good to see that the majority of those deaths are from natural causes, however, there are still 37% of the deaths that are from unnatural means, many of which are preventable. The table below lists total number of deaths by cause from 2000-2003.

Deaths by Cause of Death 2000-2003											
	Natural Death	SIDS	Child Abuse/ Neglect	Vehicular	Fire/ Burn	Drowning	Firearms/ Weapons	Poisoning	Suffocation/ Strangulation	Un- known Cause	Total
2000	35	3	2	6	2	3	2	0	0	3	56
2001	36	6	1	5	0	0	1	0	0	4	53
2002	32	5	1	10	5	1	3	0	1	1	59
2003	33	3	1	2	4	1	2	1	0	2	49
Total	136	17	5	23	11	5	8	1	1	10	217

RESIDENCE

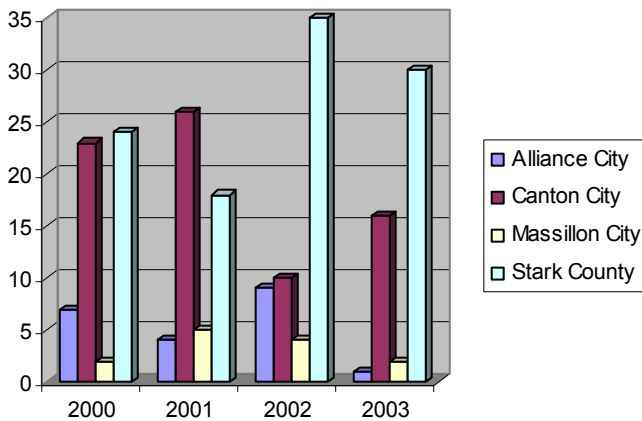
Residence	2003 Deaths	2000 Census Population birth-17 years of age 2000	Rate/1000 Population <18 years of age
Alliance City	1	5,436	0.1839
Canton City	16	21,494	0.7443
Massillon City	2	7,922	0.2524
Stark County	30	59,084	0.5077
Total	49	93,936	0.5216

Stark County townships had the largest number of deaths during 2003. However, Canton City's death rate per 1000 population was the highest of the local jurisdictions, as it is every year.

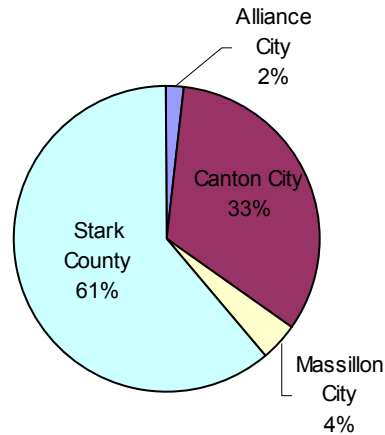
As of February 1, 2005, the Ohio State Child Fatality Review data system showed 1131 deaths during 2003. Using these 1131 deaths for the State of Ohio, and the 49 deaths for Stark County:

- Ohio's death rate (birth –17 years) was 0.3915 per 1,000 population.
- Stark County's death rate (birth—17 years) was 0.5216 per 1,000 population.

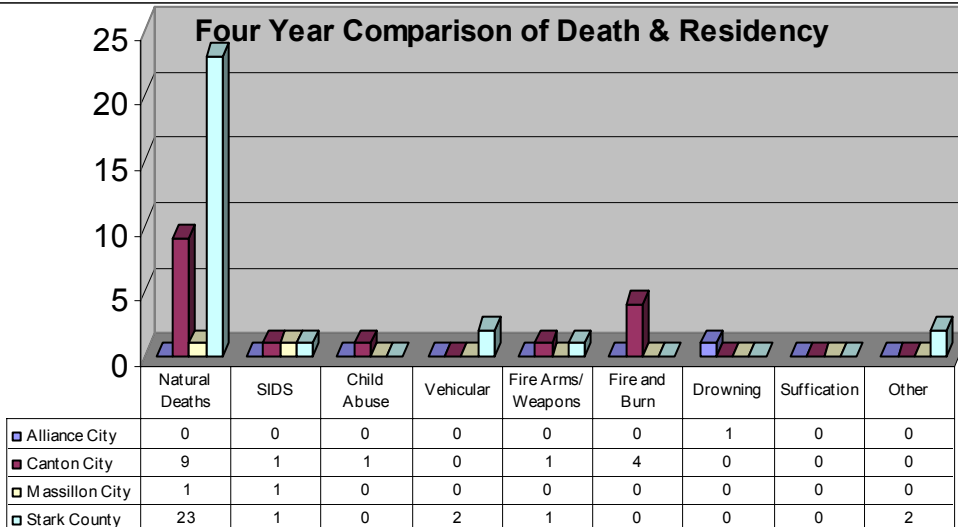
Child Deaths 2000-2003 by Residency



2003 Deaths by Residency



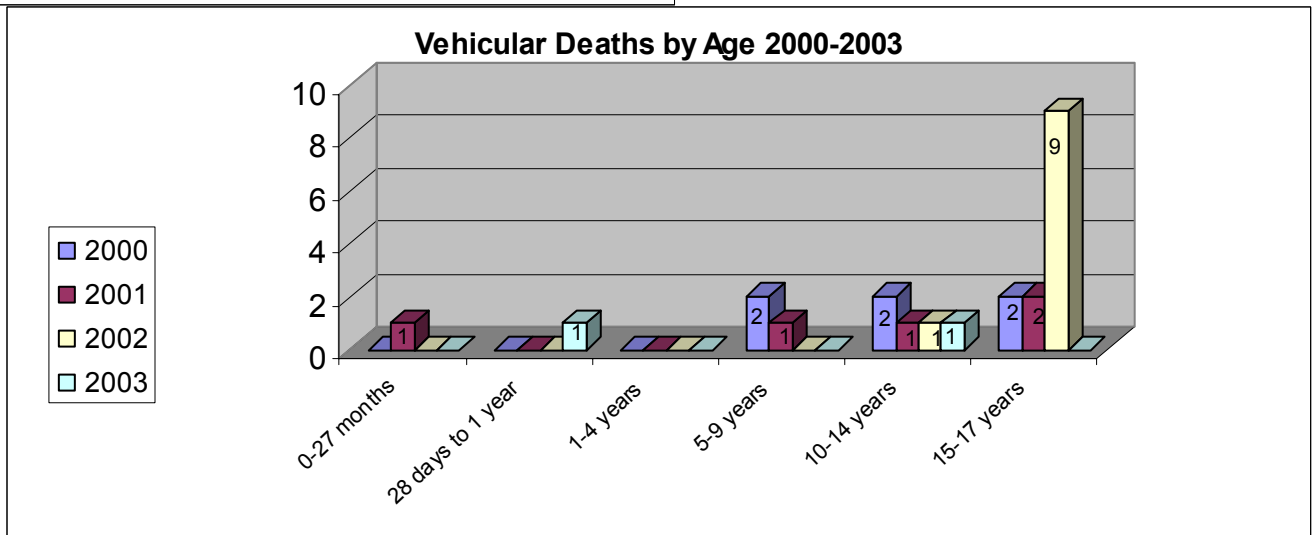
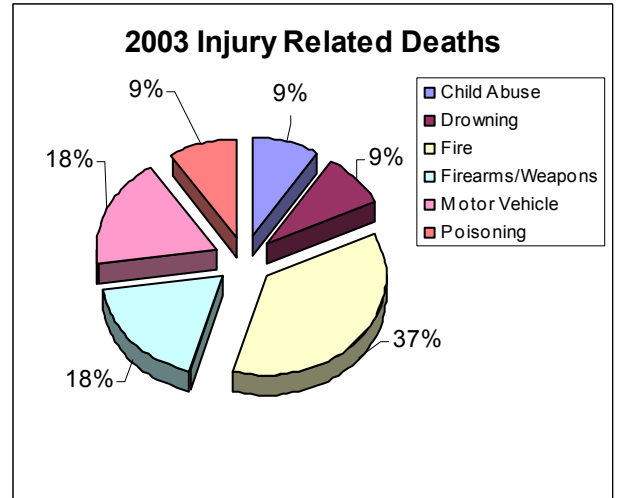
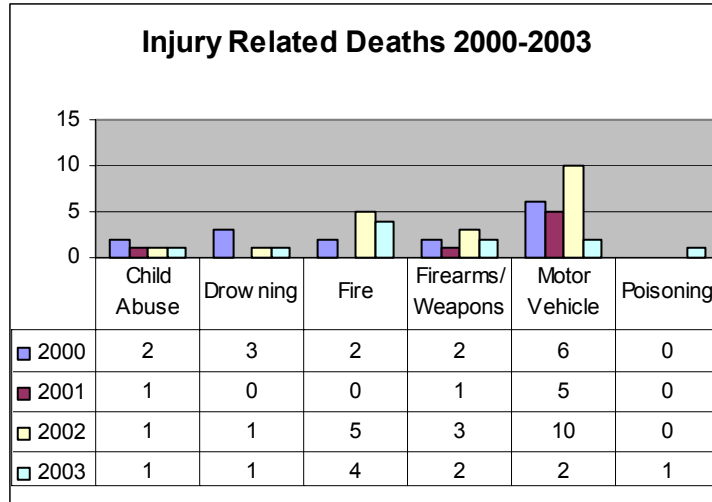
Four Year Comparison of Death & Residency



INJURY RELATED DEATHS

2000-2003

- Injury related deaths were the leading cause of death for children **1-17 years of age**, accounting for 55% of the deaths in that age range. (Natural deaths 36%, and Unknown causes 9%)
- Motor Vehicle accidents were by far the leading cause of injury related death accounting for 23 (43%) of the 53 injury related deaths.
- 18 (78%) of those motor vehicle deaths were to children over the age of 10.



SUICIDE

Year	Deaths
2000	1
2001	2
2002	1
2003	1

According to Columbia University Teen Screen Program

- Suicide is the third leading cause of death in 15-19 year olds.
- 3.4 million (17%) 15-19 year olds thought about suicide.
- 3.3 million (16%) 15-19 year olds thought about suicide with a plan.
- 1.8 million (9%) 15-19 year olds attempted suicide.
- 63% of teen suicide victims exhibit psychiatric symptoms for more than 1 year prior to death.
- For every completed suicide, an estimated 8-25 attempts occur.

Even though the number of deaths from suicide in this county has been low in comparison to the other causes of death, the statistics above show us that we still need to pay close attention to this cause of death and do whatever is possible to prevent suicides from occurring.

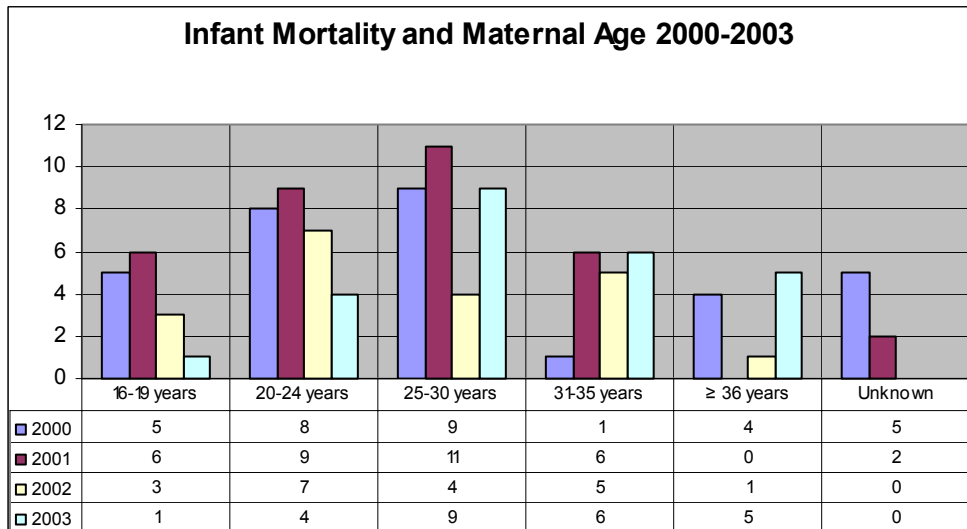
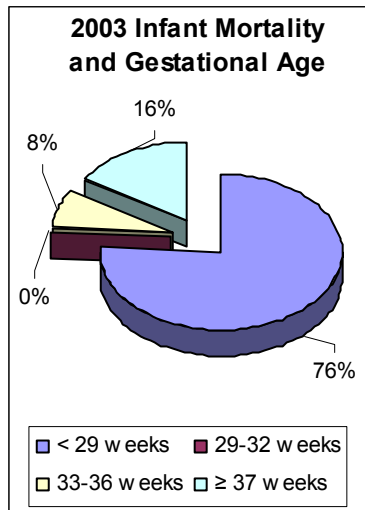
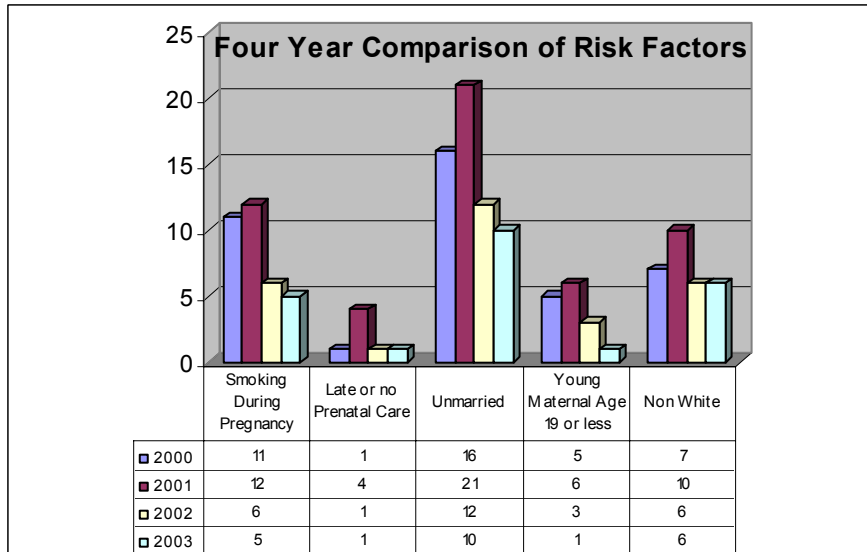
In 4 of the 5 suicides guns were used.

INFANT MORTALITY

As seen in the graph to the right, the risk factors for infant mortality have decreased over the four year period 2000-2003.

Preterm births continue to be an issue with infant mortality. In 2003, 76% of the infants who died <1 month of age were born <29 weeks gestation.

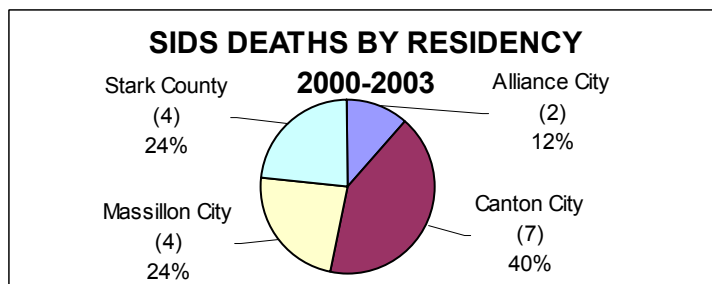
YEAR	<29 wks	Total Infant Mortality
2000	14	32
2001	18	36
2002	17	22
2003	19	25



SUDDEN INFANT DEATH SYNDROME

YEAR	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Totals
2000	1	1	0	1	0	0	3
2001	4	0	1	1	0	0	6
2002	1	2	1	1	0	0	5
2003	2	1	0	0	0	0	3
Totals	8	4	2	3	0	0	17

According to the Office of Minority Health at the CDC, SIDS accounts for approximately 3,000 infant deaths each year in the United States. SIDS death rates have been declining overall, however, there is still disparity in the rates of certain populations. In the U.S., the rate of African American infants dying from SIDS is twice the rate of white infants.



From 2000-2003 in Stark County, there were a total of 12 white infants and 5 black infants who died from SIDS. An average of 3 white, and 1.25 black deaths occur each year in Stark County from SIDS. When comparing the number of SIDS deaths and the population figures, the rate of black SIDS deaths is much higher per population than that of white SIDS deaths.

RECOMMENDATIONS

- Eleven children have died over the four year period 2000-2004, in Stark County from house fires. Continued education for both parents and children on escaping from their home in the event of a fire is recommended. Education on the dangers of open flame candles, and the need for smoke detectors in all residences is also a recommendation.
- A safe sleep environment continues to be an issue for Stark County infants. The board again recommends the continued education on the back to sleep program, and encourages agencies to not only discuss the need to place infants on their back to sleep but to emphasize the need for a safe sleep environment (placing infant in crib or playpen to sleep, not on a couch, adult bed, or in a boppy pillow unsupervised; as well as, no blankets or stuffed animals in the crib with the infant).
- With five swimming related deaths over the four year period 2000-2003, community education on safety and swimming is recommended again. The issues over the last four years with swimming safety include: improper swimming attire (wearing heavy baggy clothing while swimming), unsafe swimming locations (swimming in spillways, off unguarded piers, and in high storm waters), and improper or lack of adult supervision.
- With the differences in education levels of parents today, it is important that all agencies involved with the care of sick children, provide specialized instruction to all parents about the use, care, and medical necessity for every piece of medical equipment being left in the home. It is also the recommendation of this board that when medical equipment is being removed from the home, without a physician's order, that the ordering physician be notified. This will ensure that a referral to the Department of Children Services can be made if the removal of this equipment puts the child's life at risk.
- One suicide death in 2003, making a total of 5 suicide deaths from 2000-2004 demands that the board again recommend some form of suicide prevention/screening program in our local schools. According to Columbia University's Teen Screen Program, for every completed suicide, an estimated 8-25 attempts occur. This would mean that in our county alone from 2000-2004 there would have been an estimated 40-125 suicide attempts.

STATE OF OHIO CHILD FATALITY REPORT ON 2002 DEATHS

Motor Vehicle Crashes

According to the Ohio CFR report, during 2002 Ohio CFR boards reported 153 deaths from motor vehicle crashes.

- 17% of these motor vehicle crashes were alcohol related.
- In 53% of the deaths, the driver of the vehicle was 16-18 years of age.
- Drivers 16 -18 years of age exhibited the largest number of risk factors for motor vehicle crashes (175 (57%) of the 308 risk factors listed).

Natural vs. Injury Related Deaths

2002 Deaths	Natural Cause		Injury Related		Unknown	
	Number of Deaths	Percentage of Deaths	Number of Deaths	Percentage of Deaths	Number of Deaths	Percentage of Deaths
State of Ohio	949	70%	367	27%	43	3%
Stark County	37	63%	21	36%	1	1%

2002 Manner of Death State of Ohio vs. Stark County

Manner of Death	State of Ohio 2002 Deaths	Stark County 2002 Deaths
Natural	949 (70%)	37 (63%)
Accident	268 (20%)	12 (20%)
Homicide	68 (5%)	2 (2%)
Suicide	31 (2%)	1 (2%)
Undetermined	43 (3%)	7 (12%)
Total	1359	59

STARK COUNTY CHILD FATALITY REVIEW

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