VEHICULAR DEATHS

Background

Vehicular deaths include deaths of children involving all types of vehicles including cars, trucks, campers, boats, all-terrain vehicles, farm vehicles, motorcycles and bicycles as well as pedestrians. Motor vehicle crashes are the leading cause of unintentional injury-related death among children ages 14 years and younger in the United States. Several factors known to contribute to the risk of motor vehicle fatalities include alcohol, speeding and failure to use a restraint device, notably seat belts and child restraints. Nationally in 2000, 56 percent of children under age 14 killed in motor vehicle crashes were completely unrestrained. When child restraint devices are properly used for infants and toddlers, the risk of vehicular deaths can be reduced by 71 percent. For teenage drivers, inexperience and errors of judgment lead to a higher rate of single-vehicle accidents for this age group. Young drivers constitute nearly 7 percent of the driving population, yet they account for 14 percent of all fatal crashes in the United States.

In 2003, the Child Fatality Review Advisory Committee recommended that a state-level workgroup be formed to look more closely at vehicular deaths. The report of that workgroup was included in the 2004 CFR Annual Report. An expanded analysis of the data related to vehicular deaths continued this year.

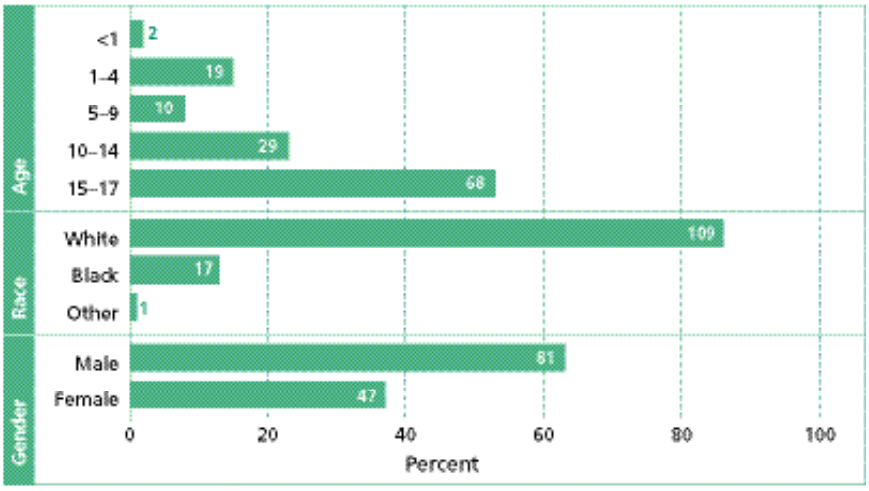
Vital Statistics

Ohio Vital Statistics preliminary data reported 148 vehicular deaths to children in 2003. Fifty-one percent (76) of the deaths were to children in the 15-17 year age group.

CFR Findings

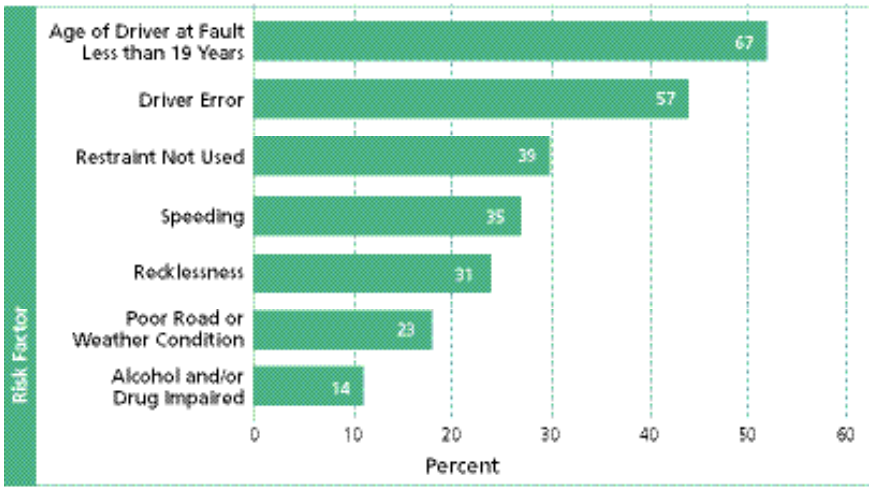
Local CFR boards reviewed 128 deaths to children from vehicular crashes in 2003. This represents 9 percent of the total 1,483 deaths reviewed. Fifty-three percent of the deaths occurred to 15–17–year-olds. There were greater percentages of vehicular deaths among boys (63 percent) relative to their representation in the general population (51 percent).

Vehicular Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Risk Factors Cited in Vehicular Deaths



Note: numerals in bars equal number of cases

Driver error was cited in 44 percent of the deaths; recklessness was cited in 24 percent; speeding was cited in 27 percent. In 47 percent of the deaths, the driver at fault was between 16-18 years of age; 5 percent of the drivers at fault were less than 16 years of age.

Sixty-six percent of the vehicles causing the fatal crashes were cars/vans and 13 percent were trucks/campers. Eighteen percent (23) of the children killed were pedestrians; two percent (2) were on bicycles. All-terrain vehicles (ATVs) were involved in 4 percent (5) of the deaths reviewed.

More than 39 percent of the children killed while in motor vehicles (car/van, truck/camper, sport utility vehicle) were not restrained.
Sixty-two percent (79) of the deaths occurred to children in motor vehicles (car/van, truck/camper, sport utility vehicle), as drivers or as passengers. Forty-three percent (34) of the children killed were driving the vehicle. Of the 79 children killed in motor vehicles, 39 percent (31) were not using proper restraints. Of the 48 15-17-year-olds killed while in motor vehicles, 42 percent (20) were not using proper restraints.

Examples of Local Recommendations

Local CFR boards made more than 35 recommendations for the prevention of vehicular deaths based on the review of local deaths. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen. The recommendations ranged from short-term local initiatives to legislative changes and included:

- Identify the safety of young children as pedestrians and bike riders as a priority by continuing or enhancing programs such as Safety Town;
- Heighten awareness of the dangers of excessive speed, drinking and driving, and of the importance of seatbelt, car seat and helmet use through public education and media campaigns;
- Support continuation and enhancement of current programs such as Students Against Drunk Driving and Prom Promise aimed at teen drivers that promote seatbelt use, safe driving techniques and discourage risk-taking behaviors;
- Educate parents of new drivers of their responsibilities with the graduated driver's licensing and empower parents to set limits for new drivers regarding the number of passengers, driving in inclement weather, time of day for driving, etc;
- Improve road design safety by working with law enforcement and county engineers;
- Urge legislators, dealers and parents to confront the dangers of all-terrain vehicles when operated by children.

Examples of Local Initiatives

- Several county CFR boards partnered with other local safety and school organizations to monitor the use of seatbelts by teen drivers as they left school parking lots at the end of the school day. Both negative and positive reinforcements were used to demonstrate the message that seatbelt use is the expected norm, and that adults are concerned about teen driving safety. For example, a football homecoming-themed program involved a coordinated effort of seatbelt checkpoints, buckle-up cheers, public service announcements and football-themed incentives.
- The Henry County CFR Board presented the "Saved by the Belt Award" to a local teen who survived a serious car crash because she was wearing her seatbelt. The presentation was made at a public assembly where the teen gave her personal testimony about the importance and ease of buckling up.
- The Allen County CFR Board undertook an education and advocacy program to encourage the local taxis to provide seatbelts for securing infant safety seats and to empower young mothers to be assertive in demanding this necessary safety equipment.
- After a second fatality at a railroad crossing, the Ashtabula County CFR Board supported the township's application for grant funds to install railroad warning lights at the site.

Sudden Infant Death Syndrome

Background

Nationally, sudden infant death syndrome (SIDS) is the leading cause of death in infants between 1 month and 1 year of age. SIDS is the diagnosis given the sudden death of an infant under 1 year of age that remains unexplained after the performance of a complete postmortem investigation, including an autopsy; an examination of the scene of death; and review of the infant's health history. While the cause and mechanism of SIDS eludes researchers, several factors appear to put an infant at higher risk for SIDS. Infants who sleep on their stomachs are more likely to die of SIDS than those who sleep on their backs, as are infants whose mothers smoked during pregnancy and who are exposed to passive smoking after birth. There is a large racial disparity, with the SIDS rate for black infants more than twice the rate for white infants.

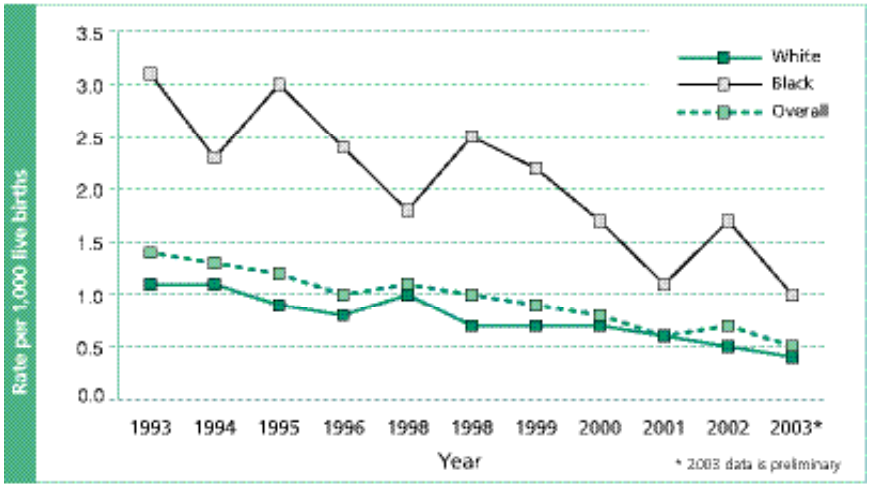
Because SIDS is a diagnosis of exclusion, all other probable causes of death must be eliminated through autopsy, death scene investigation and health history. It is difficult to conclude that a death is due to SIDS in the absence of a thorough investigation. The difficulty is compounded with the presence of known risk factors for other causes of infant death such as suffocation.

In 2003, the Child Fatality Review (CFR) Advisory Committee recommended that a state-level workgroup be formed to look more closely at deaths from SIDS and other sleep-related deaths. The report of that workgroup was included in the 2004 CFR Annual Report. An expanded analysis of the data related to these types of deaths continued this year.

Vital Statistics

Ohio Vital Statistics preliminary data reported 72 SIDS deaths to infants in 2003. According to Ohio Vital Statistics, the Ohio SIDS rate has decreased by 50 percent in the past decade, from 1.4 deaths per 1,000 live births in 1993 to 0.5 in 2003. The disparity between black and white deaths from SIDS continues to be large, with the black SIDS rate 2.5 times higher than the white SIDS rate for 2003.

SIDS Rate per 1,000 Live Births by Race in Ohio, 1993–2003

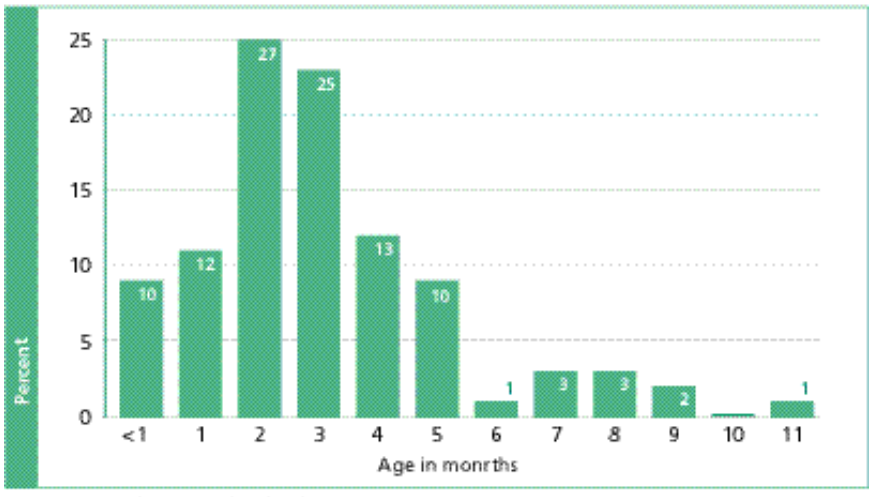


Note: Caution should be used in interpreting rates and trends due to small numbers and due to the updating of pending records

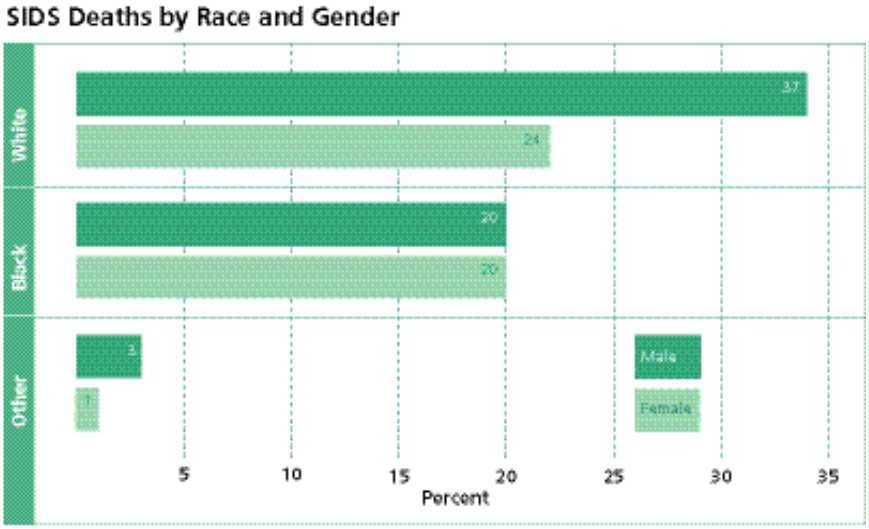
CFR Findings

Local CFR boards reviewed 107 deaths to children from SIDS in 2003. These deaths represent 7 percent of all 1,483 reviews conducted. There were greater percentages of SIDS deaths among boys (58 percent) and among blacks (39 percent) relative to their representation in the general population (51 percent for boys and 16 percent for black children). Ninety-one percent of the SIDS deaths occurred before six months of age.

SIDS Deaths by Age at Time of Death

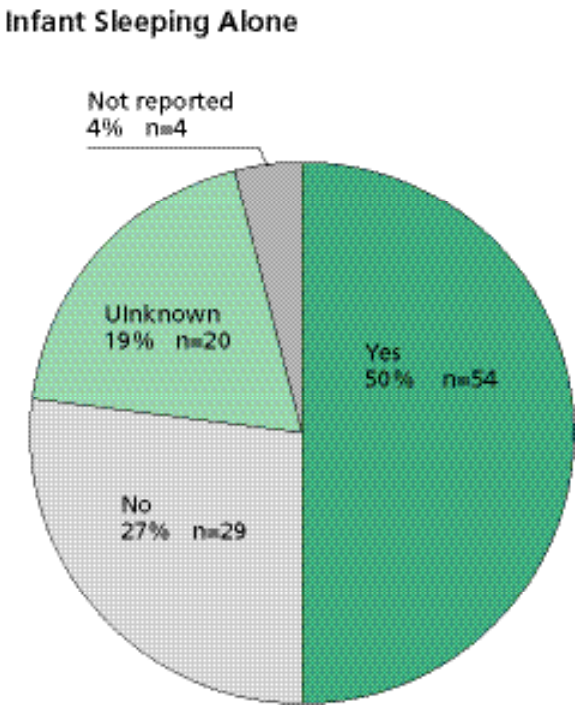


Note: numerals in bars equal number of cases

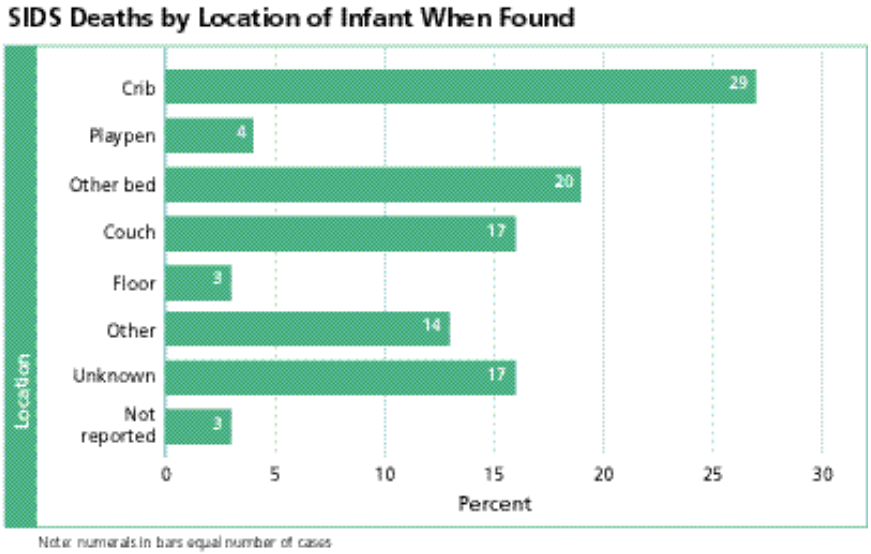


The CFR data reporting tool includes items surrounding the death that can lead to better understanding of the circumstances of SIDS deaths, so that policy and interventions can be developed to prevent future deaths. In spite of diligent efforts, CFR boards were not able to consistently supply information regarding normal infant sleeping position; breastfeeding status; overheating; heavy bedding; or sleep surface firmness.

Information about the location of the infant when found and bedsharing status was reported with sufficient frequency for analysis. Only 27 percent of SIDS deaths occurred in cribs, while 35 percent of SIDS deaths occurred in locations considered unsafe: in other types of beds and on couches. Twenty-seven percent of infants who died of SIDS were known to be sleeping with someone else at the time of death. Forty-three percent of infants who died of SIDS before age three months were sleeping with someone else at the time of death.



At least 47 percent (50) of the children who died of SIDS were exposed to cigarette smoke in utero or after birth.



Examples of Local Recommendations

Local CFR boards made more than 20 recommendations to reduce the risk of SIDS. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen. Many recommendations were for the continued repetition of the Back to Sleep message, especially targeting minority families, grandparents and caregivers. Many boards recommended a broader message to include back to sleep in a safe sleep environment. More consistent diagnosis and death scene investigation were recommended to increase understanding of SIDS and other infant deaths.

Examples of Local Initiatives

- Many CFR boards report using existing programs such as WIC, Welcome Home, Ohio Infant Mortality Reduction Initiative projects and Help Me Grow to distribute a coordinated, repeated message regarding SIDS risk reduction and to target hard-to-reach, at-risk populations.
- The Butler County CFR Board has encouraged hospitals and health care providers to specifically educate new parents about the risks of bedsharing.
- The Trumbull County CFR Board organized a presentation by the coroner's investigator to the Help Me Grow staff to increase understanding of the risk factors related to SIDS.

Other Sleep-related Deaths

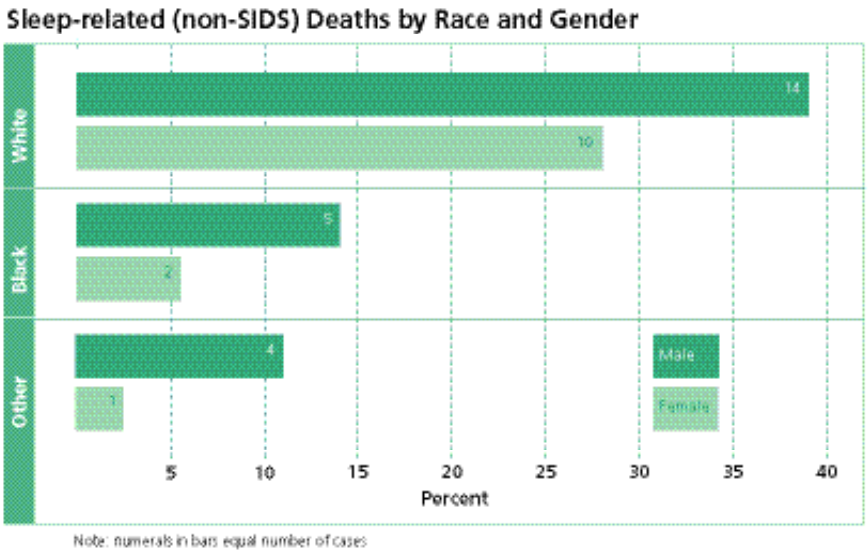
Background

Since the beginning of the Ohio Child Fatality Review (CFR) program in 2001, local boards have been faced with a significant number of deaths of infants while sleeping. Some of these deaths are diagnosed as SIDS, while others are diagnosed as accidental suffocation, positional asphyxia, overlay or undetermined. In order to better understand the contributing factors for these deaths and then to develop prevention strategies, these infant sleep-related deaths are analyzed separately.

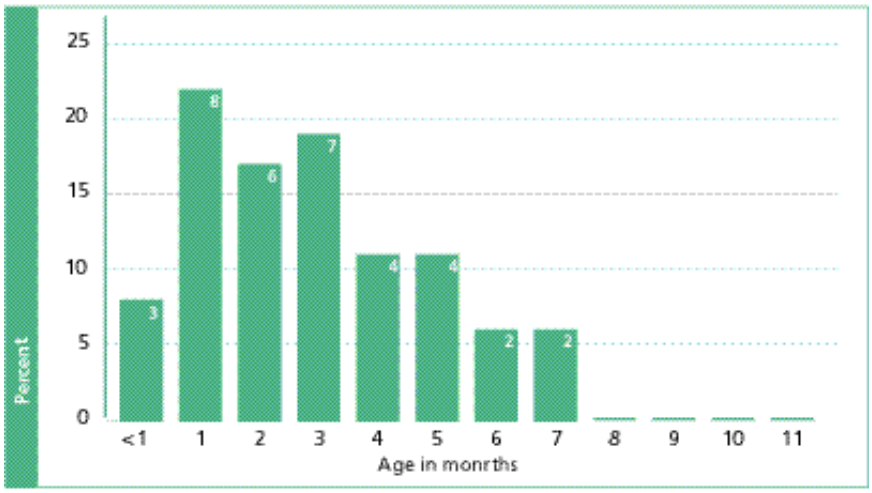
For this analysis, sleep-related infant deaths were defined using the CFR Case Report Tool. Cases were identified by those infant cases of Suffocation where the circumstances were marked, "Other Person Lying on or Rolling on Child;" "Child on or Covered by Object;" or "Wedging." Wedging refers to the child's face or body being trapped in a confined space such as between the mattress and the wall. Cases marked "SIDS" were excluded from the sleep-related category and were analyzed separately.

CFR Findings

Thirty-six cases of sleep-related infant deaths were identified from the reviews of 2003 deaths. (These cases are in addition to the 107 reviews for deaths from SIDS.) Sixty-four percent of the deaths were to boy children and 19 percent were to black infants. Eighty-nine percent of the deaths occurred before six months of age.



Sleep-related (non-SIDS) Deaths by Age at Time of Death

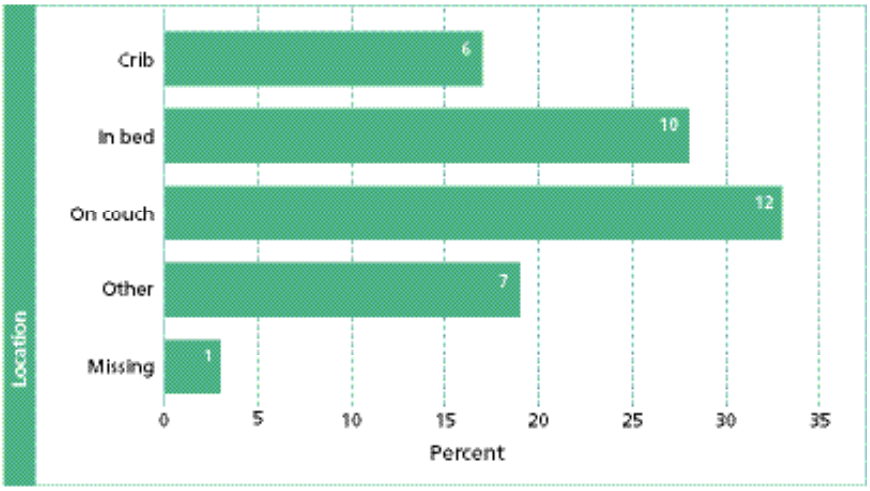


Note: numerals in bars equal number of cases

The CFR data reporting tool includes items surrounding the death that can lead to better understanding of the circumstances of sleep-related deaths so that policy and interventions can be developed to prevent future deaths.

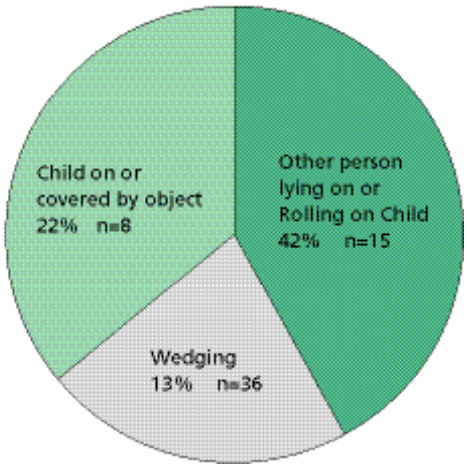
Information about the location of the infant when found; bedsharing status; and circumstances of event was reported with sufficient frequency for analysis. Only 17 percent of sleep-related deaths occurred in cribs, while 61 percent of sleep-related deaths occurred in locations considered unsafe: in other types of beds and on couches. Sixty-one percent of the sleep-related deaths occurred when the child was sleeping on a soft surface. Forty-two percent (15) of the sleep-related deaths occurred when another person laid or rolled onto the child.

Sleep-related Deaths by Location of Infant at Time of Death



Note: numerals in bars equal number of cases

Circumstances of Sleep-related Deaths

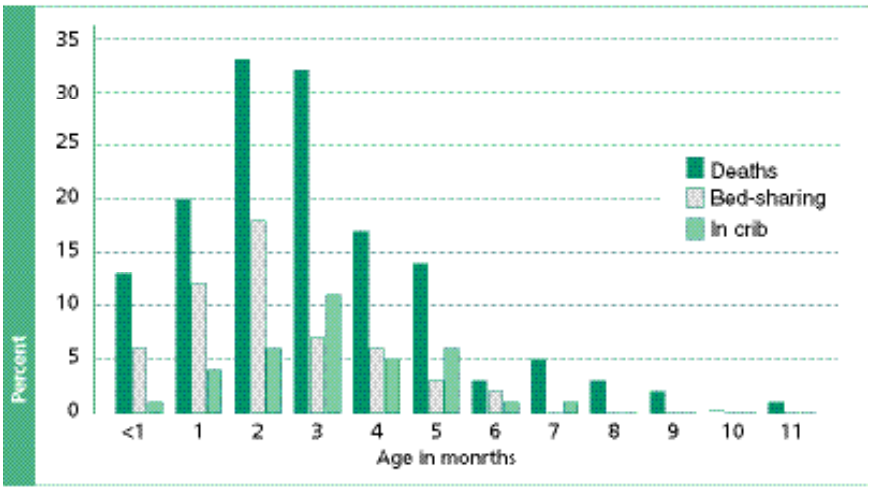


Bedsharing was the most frequently reported factor for sleep-related deaths. Twenty-two (72 percent) of sleep-related deaths occurred to infants who were sleeping with someone else at the time of death. Seventy-nine percent of infants who died of sleep-related deaths before age 4 months were sleeping with someone else at the time of death.

Looking at SIDS and Sleep-related Deaths Together

Common data items from the CFR data reporting tool were combined for cases of SIDS and sleep-related deaths. Of the combined 143 deaths, 38 percent occurred when the infant was sharing a bed with someone else. Only 24 percent of the combined deaths occurred in a crib.

SIDS and Sleep-related Deaths Combined:
Bed Sharing Status and Location in Crib by Age at Time of Death



Note: numerals in bars equal number of cases

Examples of Local Recommendations

Local CFR boards made more than 20 recommendations for the prevention of sleep-related deaths, particularly those attributed to suffocation. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen. As with SIDS, many recommendations were for the continued repetition of the Back to Sleep message, especially targeting minority families, grandparents and caregivers. Many boards recommended a broader message to include back to sleep in a safe sleep environment and advocated a strong warning against bedsharing. More consistent diagnosis and death scene investigation were recommended to increase understanding of sleep-related deaths.

Examples of Local Initiatives

- In addition to the local activities listed in the sections for SIDS and suffocation deaths, many CFR boards such as Allen, Montgomery, Cuyahoga, Hamilton and Franklin counties have created subcommittees to examine sleep-related deaths in more depth. Information learned is shared through communitywide collaborations.
- Some CFR boards have issued letters to service providers, urging that the message of safe sleeping environment be included in all programs for young families. Clermont County used a monthly newspaper article to publicize issues related to child deaths including bedsharing.
- The Lawrence County CFR Board works in collaboration with Help Me Grow to assist parents in obtaining cribs or bassinets.

SUFFOCATION AND STRANGULATION

Background

Deaths in this category include deaths from suffocation, strangulation and choking, as well as confinement in airtight places. The majority of suffocations occur to infants and toddlers while sleeping in unsafe environments. Without complete autopsies and death scene investigations, it is difficult if not impossible to distinguish an unintentional suffocation from SIDS or homicide.

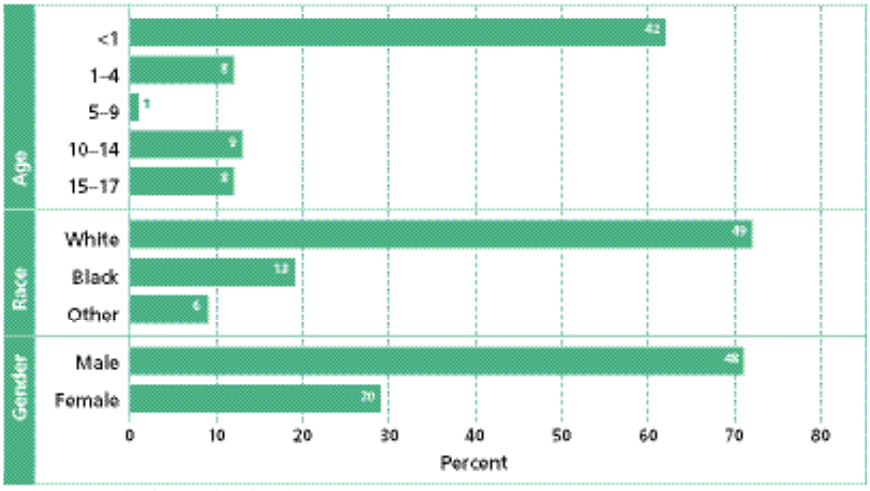
Vital Statistics

Ohio Vital Statistics preliminary data reported 48 deaths from suffocation and strangulation to children in 2003.

CFR Findings

Local child fatality review (CFR) boards reviewed 68 deaths to children from suffocation and strangulation in 2003. These deaths represent 5 percent of all 1,483 deaths reviewed. While 62 percent occurred to children less than 1 year of age, 25 percent are to children 10–17 years old. Thirty-eight percent of the reviews for suicide deaths in 2003 were due to suffocation and strangulation. A greater percentage of suffocation and strangulation deaths occurred among black children (19 percent) relative to their representation in the general population (16 percent). In 28 percent of the deaths reviewed, the child was strangled by an object. In 26 percent of the deaths reviewed, another person laid or rolled on the child.

Suffocation and Strangulation Deaths by Age, Race and Gender

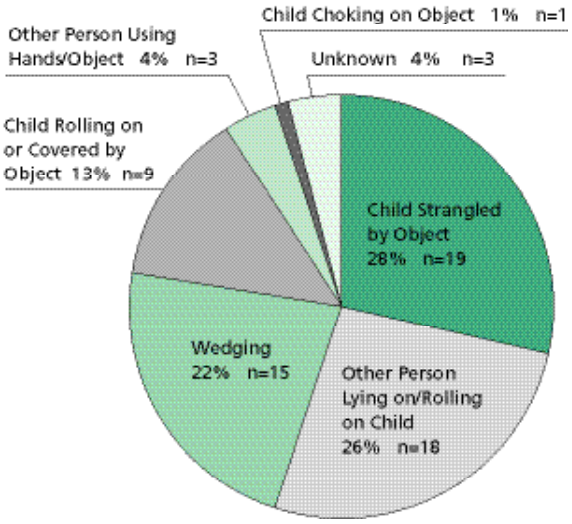


Note: numerals in bars equal number of cases

Examples of Local Recommendations

Local CFR boards made more than 15 recommendations for the prevention of suffocation and strangulation deaths, all of them addressing the sleeping environment. Recommendations for collaboration with health care and other services providers to educate parents and child care providers about safe sleep environments were common. Other recommendations involved increasing the availability of safe cribs to low-income families. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Suffocation and Strangulation by Circumstances



Example of Local Initiatives

- The Gallia County CFR Board has initiated a coordinated effort by the home visiting public health nurses, the perinatal nurses and the pediatricians to give repeated instructions to new parents about creating a safe sleep environment and the dangers of bedsharing.
- The Madison County CFR Board sponsored a display booth at the Madison County Fair to educate the public about suffocation hazards for infants. The staff used a crib, lifelike baby doll and popular styles of crib bedding and toys to demonstrate common risks for suffocation and to model safe sleep practices.

FIRE AND BURN

Background

Fires and burns are the third-leading cause of death among children 1-14 years of age in the United States. Most of these deaths occur in house fires, and the majority are due to smoke inhalation rather than burns. Nationally, the factor most frequently responsible for fatal house fires is cigarette smoking. Young children and elderly adults are especially at risk of fire and burn deaths because of their slower response and decreased mobility.

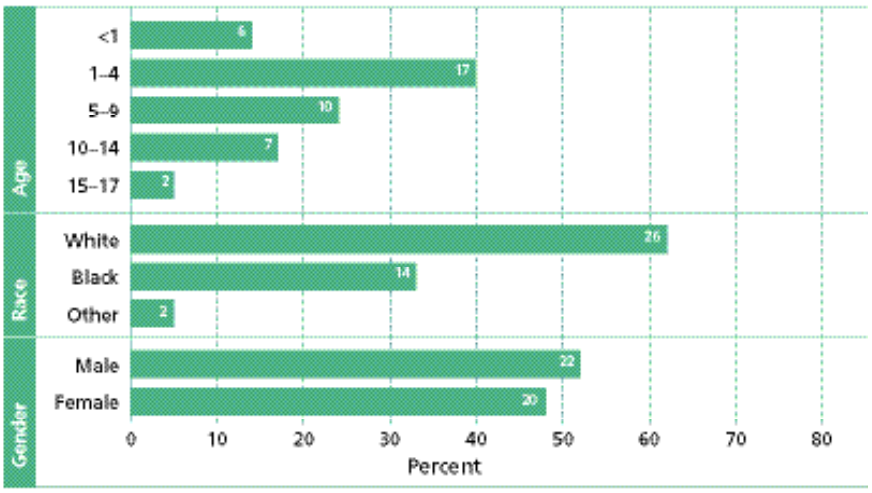
Vital Statistics

Ohio Vital Statistics preliminary data reported 36 deaths from fire and burns to children in 2003.

CFR Findings

Local child fatality review (CFR) boards reviewed 42 deaths from fire and burn to children in 2003. This represents 3 percent of all 1,483 deaths reviewed. Fifty-five percent of the deaths occurred among children less than 5 years of age. A greater percentage of fire and burn deaths occurred among black children (33 percent) relative to their representation in the general population (16 percent). A properly functioning smoke alarm was known to be present in only 7 percent of the deaths reviewed.

Fire and Burn Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Factors Associated with Fire and Burn Death Reviews

Factor	# of Reports	% of Total Fire and Burn Deaths
Inadequate Supervision	15	36%
Alcohol and /or Drugs	15	36%
Smoke Alarm Present	14	33%
Smoke Alarm with Good Battery	3	7%
Smoke Alarm Functioned Properly	3	7%

Note: More than one factor could be identified with each death

Examples of Local Recommendations

Noting that smoke alarms were present and functioning properly in only three of the 42 cases of fire and burn deaths, local CFR boards made more than a dozen recommendations to increase community awareness of the importance of smoke alarms and to increase availability of free smoke alarms. Other recommendations were made to increase community education about home emergency exit plans and more stringent enforcement of fire codes. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Example of Local Initiatives

- Guernsey County CFR Board worked with the fire departments and realtors to distribute free smoke alarms.
- In Cuyahoga County, two specific neighborhoods were targeted for intensive fire safety education and smoke alarm distributions in collaboration with the Greater Cleveland Chapter of the American Red Cross and the Cleveland Fire Department.

FIREARMS AND WEAPONS

Background

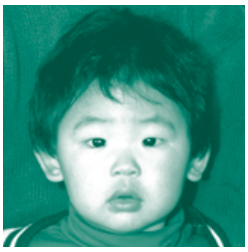
Firearm deaths can be either intentional or unintentional. Unintentional deaths may occur when children play with guns or when guns fire while being cleaned, for example. Intentional deaths include homicides and suicides. Nationally, more than half of deaths for all ages attributable to homicide and suicide are caused by firearms. There are more than 200 million privately owned guns in the United States. Approximately 40 percent of U.S. households have some type of firearm and 25 percent have handguns. Nearly 3.3 million children in the United States live in homes where guns are available, loaded and unlocked.

Vital Statistics

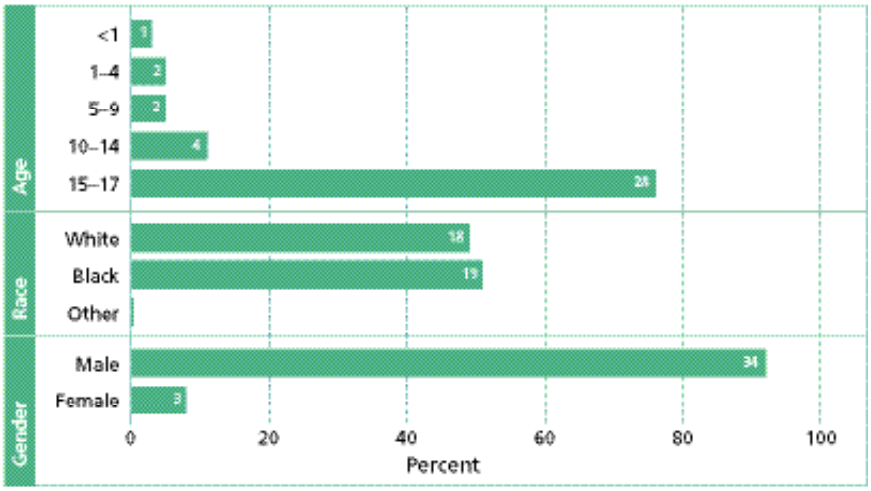
Ohio Vital Statistics preliminary data reported 22 deaths from firearms and weapons to children in 2003.

CFR Findings

Local child fatality review (CFR) boards reviewed 37 deaths to children from firearms and weapons in 2003. This represents 3 percent of all 1,483 deaths reviewed. Seventy-six percent were children 15-17 years of age. Twenty-seven percent of the firearms and weapons deaths were suicides. Firearms and weapons deaths were disproportionately higher among boys (92 percent) and among black children (51 percent) relative to their representation in the general population (51 percent for boys and 16 percent for black children). Handguns were involved in 65 percent of the deaths reviewed. In 62 percent of the deaths reviewed, intent to harm was the use of the weapon at the time.



Firearms and Weapons Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Examples of Local Recommendations

Local CFR boards made more than 10 recommendations for the prevention of deaths due to firearms and weapons. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen. Recommendations included:

- Improve education of adults to prevent the access of children to guns and ammunition and to promote the use of gun locks;
- Gun safety education for families;
- Institute peer mediation and anger management programs for youth;
- Promote and support programs such as Block Watch to encourage the public to report suspicious activities.

Example of Local Initiatives

The Mahoning County CFR Board wrote to the Youngstown City Council to encourage the council to regulate the sale and possession of weapons. The board also urged law enforcement authorities to continue the Gun Reduction Interdiction Plan (GRIP) to reduce unlawful firearms possession.

DROWNING AND SUBMERSION

Background

Drowning represents the second-leading cause of injury-related death among children aged 1 through 14 years in the United States. It is also the leading cause of unintentional injury death to children between the ages of 1 and 4. Regardless of the age of the child, most drowning deaths happen when there is a lapse in adult supervision.

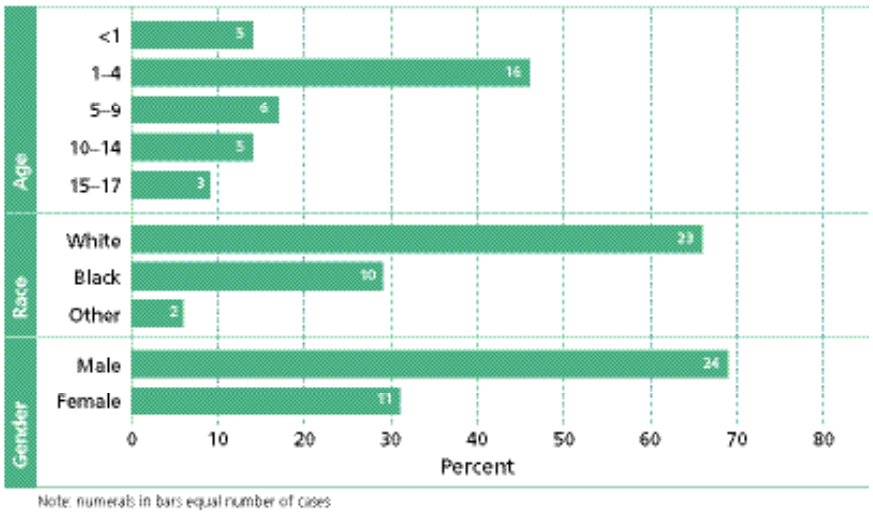
Vital Statistics

Ohio Vital Statistics preliminary data reported 35 deaths from drowning and submersion to children in 2003.

CFR Findings

Local child fatality review (CFR) boards reviewed 35 deaths to children from drowning and submersion in 2003. The deaths represent 2 percent of all 1,483 deaths reviewed. Sixty percent of the children were less than 5 years old. Twenty-nine percent of all drowning and submersion deaths occurred in bathtubs. A greater percentage of drowning and submersion deaths occurred among boys (69 percent) and among black children (29 percent) relative to their representation in the general population (51 percent for boys and 16 percent for black children).

Drowning and Submersion Deaths by Age, Race and Gender



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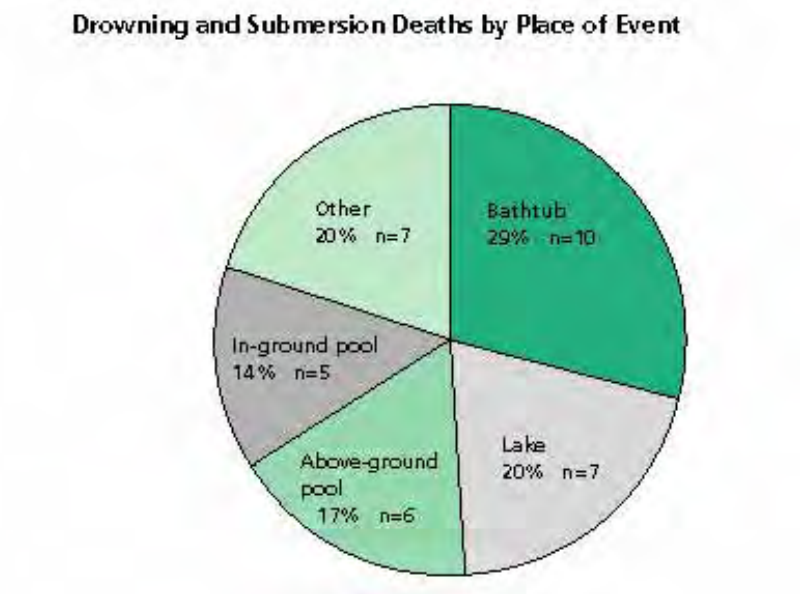


Examples of Local Recommendations

Local CFR boards made 12 recommendations for the prevention of drowning deaths. All of the recommendations involved increasing public awareness of swimming safety and improving the supervision of young children around water. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Examples of Local Initiatives

Several local CFR boards have collaborated with service providers such as birth hospitals, home visiting nurses, licensed child care providers and schools to reinforce the important messages of swimming safety and close supervision of young children at all times.

Other Causes of Death

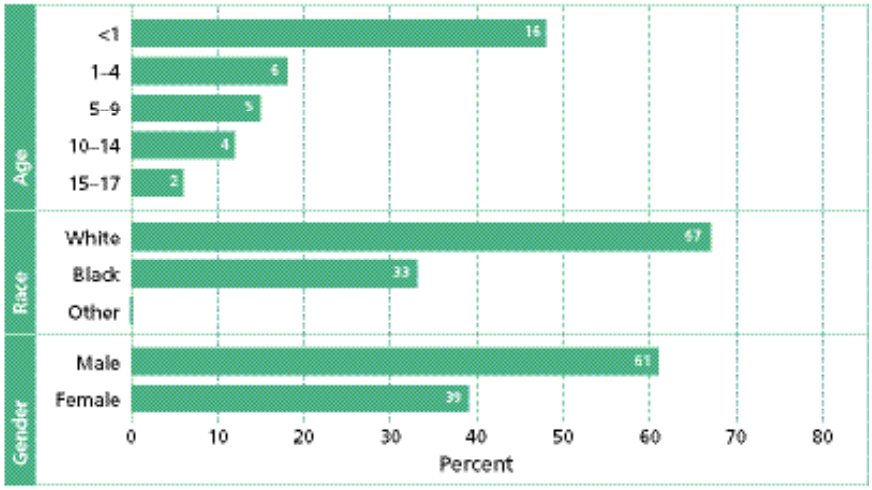
Falls, Poisoning, Electrocution

Local child fatality review (CFR) boards reviewed 19 deaths from other causes to children in 2003: poisoning (12 deaths); falls (three deaths); and electrocution (four deaths). This represents 1 percent of all 1,483 deaths reviewed.

Any Other or Unknown Cause of Death

Local CFR boards reviewed 33 deaths to children in 2003 from any other or unknown causes. This represents 2 percent of all 1,483 deaths reviewed. Forty-eight percent of these deaths occurred among children younger than 1 year.

Any Other or Unknown Causes of Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Examples of Local Recommendations

Local CFR board recommendations regarding the prevention of deaths from falls, poisoning and electrocutions focused on repeating the message of adult supervision for young children and responsibility of parents for home safety. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Example of Local Initiatives

In response to deaths reviewed by the Hardin County CFR Board, the health commissioner contacted Future Farmers of America advisers to encourage more education regarding farm safety.

Local Recommendations and Initiatives for General Prevention

As in past years, the most frustrating cases for child fatality review (CFR) boards to review are the child deaths that could have been prevented with increased adult supervision, increased parental responsibility and the exercise of common sense. The review of the circumstances of many of the child deaths supports the National SAFE KIDS Campaign study, which found that while 98 percent of parents agree it is important for them to be role models for safe behavior for their children, the percentage of parents who report actually practicing safe behaviors is significantly lower. Through the sharing of perspectives during the CFR discussions, members have learned that the often-repeated health and safety messages need to be presented in new ways to reach new generations of parents and children. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Examples of Local Initiatives

- A group of Guernsey County service agencies sponsors an annual baby safety shower. Topics were selected based on the recommendations of the Guernsey County CFR Board, and included fire safety, poisoning, smoking, summer safety, shaken baby syndrome and food safety.
- Medina County uses an interactive Web page to distribute important safety and prevention messages.
- Many local CFR boards share their findings with other health care providers, child advocates, prevention programs and social service agencies to enlist community-wide help in spreading information to families and caregivers.

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