The mission of the Mahoning County Child Fatality Review Board is to decrease the incidence of preventable fetal and child deaths by:

- Promoting 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 an 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 the following conditions:

- A death which has been investigated by the coroner, which includes any death unattended by a physician and a death due to an injury, either intentional or unintentional
- 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 2009 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

Dedication

This report reflects the work of many dedicated professionals in the community who have committed themselves to gaining a better understanding of how and why children die. Their work is driven by a desire to protect and improve the lives of young children. Each child’s death represents a tragic loss for the family, as well as the community. We dedicate this report to the memory of these children and to their families. (Ohio Child Fatality Review, 10th Annual Report, 2010)
2009 deaths

The Board reviewed 16 of the 38 Mahoning County resident child deaths that occurred in 2009. Prematurity was responsible for the greatest number of child deaths (14). Eleven others died due to birth defects, 3 children died in a sleep environment, and 3 died due to motor vehicle crashes. One child in Mahoning County died from each of the following: homicide, suicide, a drug overdose, cancer, SIDS, and an infectious disease. A table summarizing all 38 child deaths in 2009 can be found on page 5 of this report. We will focus on three of these deaths in this report.

In July 2009, a four-year old child was riding as a passenger in a van in Youngstown. Her body was thrown from the vehicle when it struck a telephone pole. The child was unrestrained in the front seat. A car seat was present but not used.

In 2009, Ohio strengthened its booster seat laws. A booster seat is designed to work in combination with a shoulder/lap belt. Use of a booster seat rather than a seat belt by itself reduces the risk of injury by 59 percent, according to the Ohio Department of Health. Parents and caregivers must secure kids less than 8 years-old and under 57 inches tall in a booster seat. In terms of safety belt use among teens, according to the 2010 Observation Seatbelt Survey by the Ohio Traffic Safety Office, seat belt use for vehicle occupants ages 15-25 is at 77%, lagging behind the state’s overall seat belt use rate of 83.8%. This age group has the lowest seat belt use of all age groups. Educational and enforcement initiatives need to be ongoing to improve safety for these young passengers and new drivers.

Motor Vehicle Safety Tips
- Fasten your seat belt and use the appropriate child restraint/booster seat, every trip, every time
- Obey the speed limit and other rules of the road
- Don’t drink and drive, ever
- Don’t drive distracted, this includes using your cell phone, texting, and eating

In January 2009, a 5-week old infant in Boardman was found unresponsive after being placed on her side in bed next to her mother. Her cause of death was ruled as asphyxia due to co-sleeping. A crib was present in the home but not used.

The Child Fatality Review Board continues to urges health care and social service providers to continue to reinforce the “back to sleep” and “ABC” (babies should sleep “Alone, on their Backs, in a Crib) messages with new parents. Despite efforts by the community to help families provide a safe sleep environment, sleep-related deaths like these still continue. Promoting a safe sleep environment has been the Board’s most often cited recommendation.

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
In October 2009, a 10 year-old Youngstown youth was playing outside with relatives when he collapsed after complaining of abdominal pain. He was found to have a heart defect which was previously asymptomatic and therefore went untreated.

One of every 33 babies is born with a birth defect. A birth defect can affect almost any part of the body. The well-being of the child depends mostly on which organ or body part is involved and how much it is affected. Many birth defects affect the heart. Heart defects make up about one-third to one-fourth of all birth defects. Some heart defects can be serious and a few are very severe. Knowing your family history can provide important information about your health risks and can help your doctor in identifying a heart defect early.

Preventing Birth Defects

There are things that a woman can do before and during pregnancy to increase her chance of having a healthy baby:

- Take 400 mcg of folic acid every day, starting at least one month before getting pregnant
- Don’t drink alcohol, smoke, or use “street” drugs
- Talk to a health care provider about taking any medications, including prescription and over-the-counter medications and dietary or herbal supplements
- Learn how to prevent infections during pregnancy
- If possible, be sure any medical conditions are under control, before becoming pregnant. Some conditions that increase the risk for birth defects include diabetes and obesity
- If you are pregnant or planning to get pregnant, see your healthcare provider

Trends in child deaths

To understand child fatalities in Mahoning County, it is important to examine trends over time. The following graph demonstrates that while there has been some variability over time in the numbers, we have seen a notable decrease of child deaths since the high of 69 child deaths in 1993. Since 2006, the graph is showing a slight upward trend.
On the final page of this report you will find a table summarizing all child deaths from 2005 to 2009 by cause of death. Of note:

- Sixty percent (110) of the deaths were of infants less than 1 year of age
- The top 5 causes of deaths to child under the age of 18 are:
  - Prematurity (37%)
  - Birth Defects (16%)
  - Homicide (12%)
  - SIDS and Sleep-Related Deaths (7%)
  - Motor Vehicle Crashes and Cancer (6% each).

Previous Child Fatality Review Board recommendations, 2000-2008

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:

- Involving law enforcement agencies in the child death review process (2001)

Acknowledgements

We wish to thank the L.E. Black, Phillips & Holden Funeral Home, Higgins-Reardon Funeral Home, Howard-Rhoden Memorial Home, F.D. Mason Memorial Funeral Home, Sterling McCullough Williams Funeral Home, Lane Funeral Home, Joseph Rossi & Sons Funeral Home, Wasko Funeral Home, and other members of the Mahoning, Trumbull and Columbiana County Funeral Directors Association for providing the Review Board with copies of child death certificates.

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Staff Coordinator, Mahoning County Child Fatality Review Board

Jan Baharis
Family Service Agency - Daybreak
Volunteer Coordinator, Mahoning County Child Fatality Review Board

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

April, 2011

Mahoning County Child Fatality Review Board reports from 2000 through 2009 may be found on the Mahoning County District Board of Health website at http://www.mahoninghealth.org/Reports/AnnualReports.aspx.
Child Deaths in Mahoning County 2009

**Ages**
- 38 child deaths in 2009
- 25 (65.8%) deaths were infants (birth-1 year)
  - 16 infant deaths (42.1%) were neonates (birth-28 days)
  - 9 infant deaths (23.7%) were post-neonates
- 3 death (7.9%) was preschool-age (1-4 years)
- 1 deaths (2.6%) was 5-9 years
- 3 deaths (7.9%) were 10-14 years
- 6 deaths (15.8%) were teens (15-17 years)

**Deaths by Age Group and Cause - 2009**

<table>
<thead>
<tr>
<th>Cause</th>
<th>0-1 Month</th>
<th>1-12 Months</th>
<th>1-4 Years</th>
<th>5-9 Years</th>
<th>10-14 Years</th>
<th>15-17 Years</th>
<th>Total</th>
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**Residence**
- 21 in Youngstown (55.3%)
- 3 in Boardman (7.9%)
- 3 in Austintown (7.9%)
- 3 in Struthers (7.9%)
- 2 in Campbell (5.3%)
- 2 in Poland (5.3%)
- 2 in Sebring (5.3%)
- 1 in each Berlin Center and Alliance

**Race**
- 15 were white (39.5%); 21 were black (55.3%); 2 were “other” (5.3%)

**Sex**
- 20 were boys (52.6%); 18 were girls (47.4%)
## Deaths by Age Group and Cause – 2005 to 2009

<table>
<thead>
<tr>
<th>Cause</th>
<th>0-1 Months</th>
<th>1-12 Months</th>
<th>1-4 Years</th>
<th>5-9 Years</th>
<th>10-14 Years</th>
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*Source: Mahoning County District Board of Health*