Nassau County Child Fatality Review Team
Summary Report
Report of Findings and Recommendations
2013-2014

September 2016

Acknowledgements

This report is a result of the efforts and commitment of former and current Child Fatality Review Team members. Through data gathering and analysis we hope to frame the public health issues at hand that can then be used to make recommendations for public health interventions to prevent future child deaths.

Nassau County Child Fatality Review Team: Team Members[1]

Core Team Members (listed alphabetically)

Child Protection Center - North Shore-LIJ Health System
New Hyde Park, N.Y.

Nassau County Department of Health
Mineola, N.Y.

Nassau County Department of Social Services
Uniondale, N.Y.

Nassau County District Attorney's Office
Mineola, N.Y.

Nassau County Office of the Medical Examiner
East Meadow, N.Y.

Nassau County Police Department
Mineola, N.Y.

Nassau County Regional EMS Council
East Meadow, N.Y.

New York State Office of Children and Family Services
Hauppauge, N.Y.

New York State Police - Troop L Headquarters
East Farmingdale, N.Y.

NuHealth-Nassau Health Care Cooperation
East Meadow, N.Y.

Office of the Nassau County Attorney
Mineola, N.Y.

[1] Agencies listed are the current 2015 agency members

Auxiliary Team Members (listed alphabetically)

Child Abuse Prevention Services
Roslyn, N.Y.

Cohen Children's Medical Center - Pediatric Critical Care Medicine
New Hyde Park, N.Y.

Family Court of the State of New York
Westbury, N.Y.

Nassau BOCES
Garden City, N.Y.

Nassau County Department of Human Services, Office of Mental Health, Chemical Dependency and Developmental Disabilities Services
Uniondale, N.Y.

Nassau County Fire Commission
Westbury, N.Y.

Nassau County Perinatal Services Network
Mineola, N.Y.

Nassau County Traffic Safety
Mineola, N.Y.

Nassau Pediatric Society
Garden City, N.Y.

Safe Kids Nassau County
Great Neck, N.Y.

Sudden Infant and Child Death Resource Center
Stony Brook, N.Y.

The Safe Center-Long Island
Bethpage, N.Y.

Winthrop University Hospital
Department of Neonatology & Department of Pharmaceutical Services.
Mineola, N.Y.

Zucker Hillside Hospital
Department of Psychiatry
Glen Oaks, N.Y.

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Nassau County Child Fatality Review Team

Summary Report: Summary of Findings and Recommendations

2013-2014

Executive Summary

This summary report presents information obtained from the review of individual child deaths by the Nassau County Child Fatality Review Team (NCCFRT). This is the third such report for Nassau County. This report reflects the work of many dedicated professionals throughout Nassau County who participate on the NCCFRT. A child is not supposed to die. The unexplained or unexpected death of a child causes profound loss to parents, family and the community when it does occur. Child fatality review allows us to better understand how and why children in Nassau County die. Once this is understood, we can target prevention efforts to prevent future similar deaths.

The deaths reviewed occurred in children from birth through the age of 17 years. The death reviews summarized here were conducted from 2013 through 2014. However, the actual deaths occurred from 2009 through 2014. The purpose of this report is to summarize our findings and to discuss actions, interventions and recommendations. A total of 31 deaths were reviewed in this time frame. Of the 31 deaths reviewed:

- 32% were due to natural causes (n=10)
- 42% were accidental (n=13)
- 3% were homicide (n=1)
- 10 % were suicide (n=3)
- 13% were undetermined (n=4)
- 44% were male (n=14); 56% were female (n=17)
- 26% were transport related
- 6% were due to choking
- 39% were infants. Of these infant deaths, 92% were related to sleep.

The intent of this report is to inform the public and any agency involved with the well-being and protection of children on how and why children in Nassau County die. This report will also inform the public on the activities of the Nassau County Child Fatality Review Team. We hope that this report leads to a better understanding of how we can continue to ensure that Nassau County is a safe place for our children.

I. Introduction

A. Nassau County:

Nassau County, New York is situated on Long Island and is a 285.4 square mile urban suburb adjacent to New York City on the West and Suffolk County on the east. The county includes three towns, two cities and 64 incorporated villages, as well as 56 school districts and various special districts that provide fire protection, water supply and other services. Land uses within the county are predominantly single-family residential, commercial and industrial.

The population of Nassau is becoming far more ethnically, racially and economically diverse. In 2010, there were 1,339,534 people and 468,346 households with 23% of the population under the age of 18 years.[2] It is the 27th most populated county in the nation. The size of the county's population has essentially remained at the same level since 1960. In 2010, whites accounted for ~76% of the population, blacks accounted for ~13.0% and Asians accounted for ~9%. Individuals of Hispanic origin (of any race) accounted for ~16% of the population. Twenty-eight percent of Nassau's population speaks a primary language other than English in the home. Approximately 90% of the adult population in Nassau County has graduated High School or the equivalent.

According to U.S. Census Data, the median household income (2009-2013) in Nassau County was $97,690 placing it among the top ranking counties in the US. In NYS, the median household income was $58,003 and in the US it was $53,056. Although there are pockets of great prosperity in Nassau County, areas of poverty abound, and subsequent health disparities are a major concern. For example, the average infant mortality rate in the Select Communities in Nassau County (Elmont, Glen Cove, Inwood, Long Beach, Roosevelt, Hempstead, Freeport, Westbury and Uniondale) from 2008-2010[3] was close to 8 (per 1,000 live birth) which exceeds the Nassau County rate of 4.9 per 1,000 live births, and the NYS (excluding NYC) rate of 5.4 per 1,000 live births.

B. Nassau County Child Fatality Review:

The Nassau County Child Fatality Review Team (NCCFRT) is a multidisciplinary team established pursuant to NY Social Services Law (SSL) § 422-b. The NCCFRT has functioned since December 2008. The team was created to review fatalities of Nassau County residents ages 0-17 years who die in Nassau County and whose death is otherwise unexpected or unexplained ("Child Fatalities"). Cases reviewed include, but are not limited to cases:

1. whose care and custody or custody and guardianship has been transferred to an authorized agency.
2. any child for whom Child Protective Services (CPS) has an open case.

[2] Available at: www.census.gov/popfinder; accessed 10/26/2015.

[3] http://www.nassaucountyny.gov/DocumentCenter/View/8226; accessed 10/26/15

3. any child for whom Social Services has an open preventive services case.
4. any case for which a report has been made to the New York State Central Register of Child Abuse & Maltreatment (SCR).

Child Fatality Review Teams were first developed in the U.S. more than 20 years ago in response to the underreporting of child abuse deaths and the lack of communication between child welfare agencies. The multidisciplinary approach allows for collaboration among agencies and thereby enhances the ability to accurately determine the cause and circumstances of death, making it less likely for maltreatment to be missed. As of October 2015 in NYS, there are 18 OCFS CFRTS, of which 2 function out of the local Department of Health (Broome County and Nassau County).

Since January 2009, the NCCFRT has met regularly to review child fatalities. The team approaches each case in a systematic manner allowing for a complete review of each case identified. Cases are reviewed after completion of any investigations and completion and filing of death certificates. Therefore, not all deaths are able to be reviewed in the same year of occurrence.

Membership in the NCCFRT is defined by SSL §422-b(3). This statute requires the participation of certain agencies and also allows for the appointment of associate members from various fields of practice. Statutorily required team members include Nassau County Child Protective Services, Office of Children and Family Services (OCFS), Nassau County Department of Health, Nassau County Office of the Medical Examiner, Nassau County District Attorney's Office, Office of the Nassau County Attorney, Nassau County Police Department, Emergency Medical Services, New York State Law Enforcement and a pediatrician or comparable medical professional, preferably with expertise in child abuse. The team has added additional members with expertise relevant to child fatality prevention and/or review.

The mission of the NCCFRT is to review child fatalities to better understand the causes of these deaths and to make recommendations based on the team's findings in order to reduce future child fatalities. The NCCFRT meetings by statute are confidential and closed to the public. Further, NCCFRT requires that a confidentiality statement be signed by each member, at the start of each team meeting. The team's protocol and procedure manual is in accordance with New York State Social Service Law §§ 20(5), 422-b, and the rules and regulations of OCFS. As of December 2014, the team has reviewed a total of 89 cases since inception.

We must first understand how and why children die. We then hope to move this knowledge into action. It is through these reviews and subsequent actions, such as the release of Independent Reports, that the NCCFRT hopes to increase the public's knowledge about what is causing our children to die and how to possibly prevent deaths of children in the County. One preventable death is one too many. The team will continue to review unexpected and or unexplained deaths and develop strategic measures to make Nassau County safer for our children.

Due to the fact that the numbers presented here are relatively small, there are some limitations in interpretation. However, the numbers are accurate to the best of our knowledge and will help to demonstrate patterns and trends of death in Nassau County children.

This summary report provides information on general findings and recommendations on deaths that occurred to children under the age of 18 years who were Nassau County residents and for

which the review took place in 2013 or 2014. Between January 1, 2013 and December 31, 2014, the team conducted in-depth reviews of 31 cases whose death occurred between 2007 and 2012. We encourage you to share this two year summary report with others.

II. Child Death in the United States, New York State & Nassau County:

It is important to look at mortality data over time. The NCCFRT does not review every child death in the county. Therefore, the following data should serve as a reference point when examining the data for the cases that the NCCFRT reviewed.

A. Child Death in the United States:

In children, the leading cause of death varies by age. In the United States in 2013[4], for those:

- **Under 1 year of age:** congenital anomalies, short gestation, maternal pregnancy complications are listed as the top 3 causes of death. SIDS dropped to the fourth leading cause.
- **1-4 year olds:** unintentional injury, congenital anomalies and homicide are the top 3 causes of death. The 3 main causes of unintentional injury in this age group are: drowning, motor vehicle traffic and suffocation.
- **5-9 year olds:** unintentional injury, malignant neoplasms and congenital anomalies are the top 3 causes of death. The 3 main causes of unintentional injury in this age group are: motor vehicle traffic, drowning and fire/burn.
- **10-14 year olds:** unintentional injury, malignant neoplasms and suicide are the top 3 causes of death. The 3 main causes of unintentional injury in this age group are: motor vehicle traffic, drowning, and other land transport.
- **15-19 year olds:** unintentional injury, suicide and homicide are the top causes of death. The 3 main causes of unintentional injury in this age are: motor vehicle traffic, poisoning and drowning.

B. Child Death in New York State & Nassau County:

In **New York State** (including NYC)[5] in 2013:

- The estimated total population 0-19 years of age was 4,781,831
- Approximately 51% were male and 49% female.
- There were 1,984 deaths in children 0-19 years of age[5]. In particular:
  - 1,144 deaths were < 1 year of age
  - 31 deaths were attributed to SIDS
  - 239 deaths due to congenital anomalies
  - 284 total accidents
    - 125 due to motor vehicle crash
  - 74 deaths due to suicide; (68% Male; 72% White; 16% Black; 18% Hispanic)
  - 36 deaths due to Homicide/legal intervention; (64% male; 42% White; 39% Black; 11% Hispanic)

[4] http://webappa.cdc.gov/cgi-bin/broker.exe accessed 8/13/15

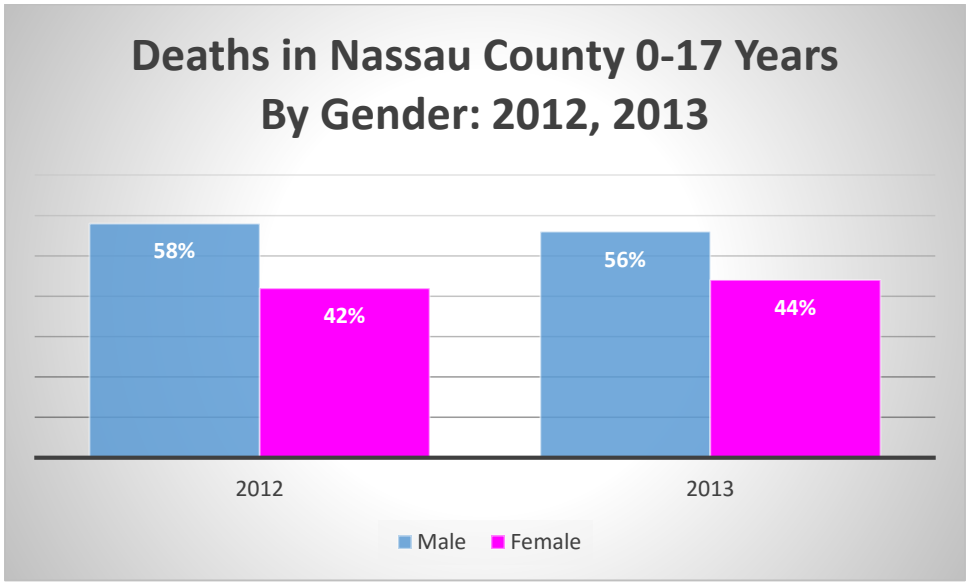
[5] Available at http://www.health.ny.gov/statistics/vital_statistics/ accessed 8/13/15

Based on 2013 **Nassau County** population data[6]:

- 63.9% White
- 11.5% Black
- 8.8% Asian/Pacific Islander
- 15.7% Hispanic

The following data presented is based on data analyzed from a data set obtained from NYS for Nassau County deaths 0-17 years of age. In 2012 and 2013, a total of 135 **Nassau County** children under the age of 18 years died within the county, the most recent years for which data is available. (We are unable to report deaths outside Nassau County due to current data restrictions). The gender, age, race, ethnicity, manner and cause of death distribution of these deaths are as follows[7]:

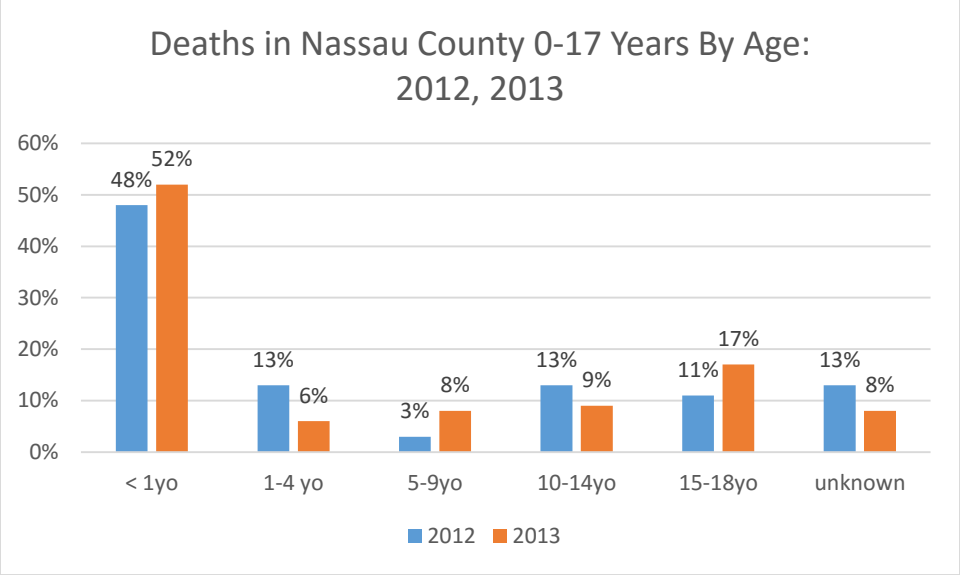
Figure 1: Deaths in Nassau County 0-17 Years by Gender: 2012, 2013



- As shown: there were more male than female deaths in both 2012 & 2013.

[6] Available at http://www.health.ny.gov/statistics/community/minority/county/nassau.htm
[7] Based in Data request to NYS Vital Statisitics 9/2015.

Figure 2: Deaths in Nassau County 0-17 Years by Age: 2012, 2013



- As shown, the majority of deaths in both 2012 and 2013 occurred in children under the age of 1 year (see next figure for further breakdown).

Figure 3: Deaths in Nassau County <1 Year of Age: 2012, 2013

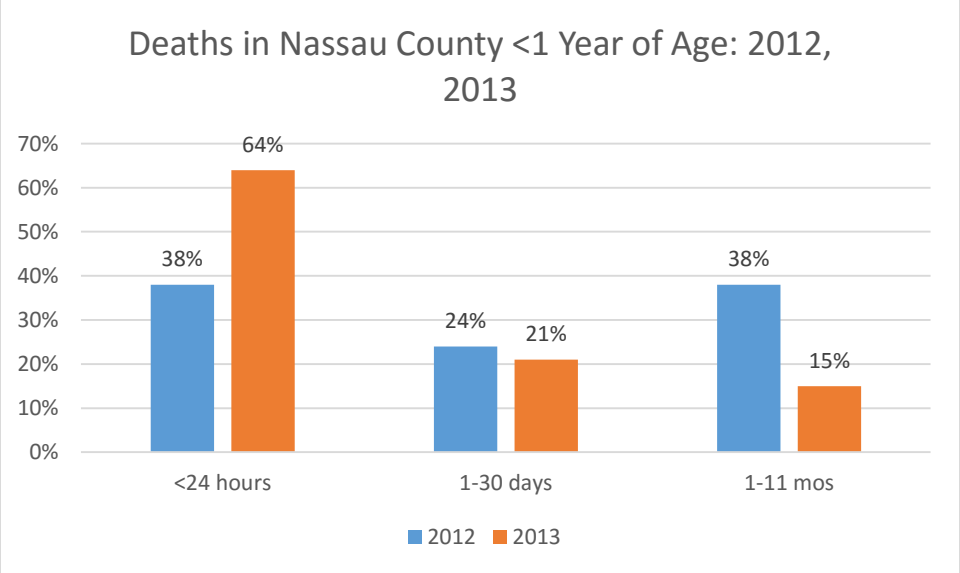
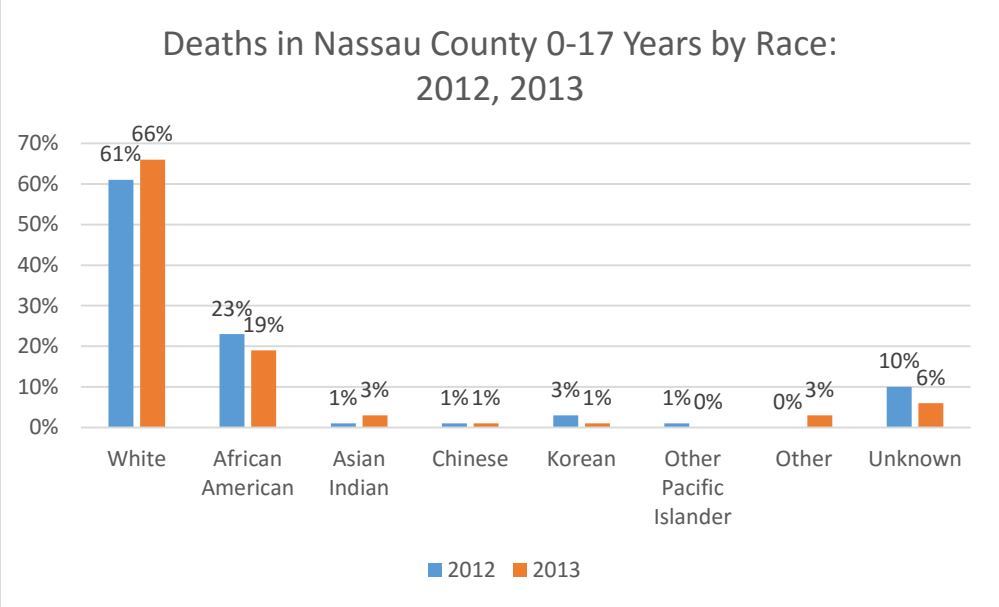


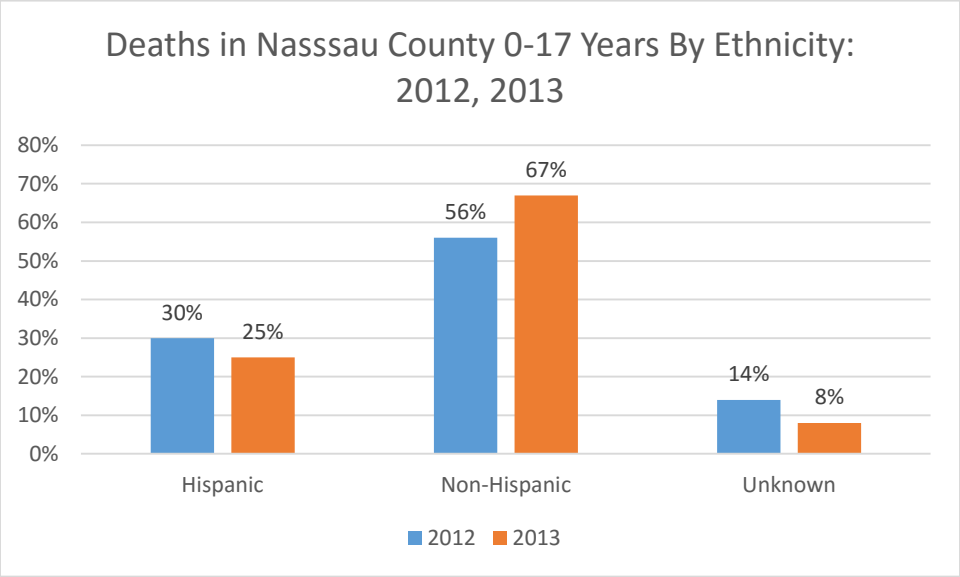
Figure 4: Deaths in Nassau County 0-17 Years by Race: 2012, 2013



- Note: Approximately 64% of Nassau County's population is Non-Hispanic White, 11% African American and 8% Asian/Pacific Islander[8]. Assuming the percentages hold true for 0-17 year olds, then the 23% (2012) & 19% (2013) of deaths (0-17 years) that are African American shows disparity.

[8] Based on 2013 population data. Available at www.health.ny.gov

Figure 5: Deaths in Nassau County 0-17 Years by Ethnicity: 2012, 2013



- Approximately 16% of Nassau County's population identifies as Hispanic[9], and accounts for 30% (2012) & 25% (2013) of the deaths' again revealing a disparity.

Deaths in Nassau County by Residence:

In Nassau County there are 9 select communities based on health disparities. Historically these select communities have a higher burden of adverse health outcomes. These select communities represent 19% of the Nassau County population. The following communities fall into this category: Freeport, Uniondale, Hempstead, Roosevelt, Elmont, Inwood, Long Beach, Glen Cove, Westbury/New Cassel. In 2012, 42% of deaths in Nassau County under the age 18 years were residents of these communities. In 2013, 34% of the deaths were from these select communities.

Deaths in Nassau County by Manner of Death

A death certificate identifies both a manner and cause of death. A manner of death determination on a death certificate places a death into one of the following categories: Natural, Accident, Homicide, Suicide, Undetermined or Pending. Cause of death refers to the injury or disease resulting in the death.

[9] Based on 2010 population data. Available at www.health.ny.gov

Table 1: Deaths in Nassau County 0-17 Years by Manner:

	2012	2013
Natural	68%	80%
Accident	21%	12%
Homicide	1%	5%
Suicide	3%	1.5%
Undetermined	4%	1.5%
Pending	3%	0%

- The majority of deaths in Nassau County 0-17 years are considered natural.

Table 2: Deaths in Nassau County by Cause (ICD-10)

ICD-10 Code	2012 Number	2013 Number
Infectious and Parasitic diseases	1	0
Malignant Neoplasms	6	5
Diseases of the Blood	0	0
Endocrine, Nutritional & Metabolic Disorders	2	2
Mental & Behavioral Disorders	1	0
Diseases of the Nervous System	1	3
Diseases of the Circulatory System	7	3
Diseases of the Respiratory System	4	6
Diseases of the Digestive System	2	0
Diseases of the Musculoskeletal System & Connective Tissue	1	0
Diseases of the Genitourinary System	1	1
Certain conditions originating in the perinatal period	18	25
Congenital malformations, deformations and chromosomal abnormalities	5	3

Symptoms, signs and abnormal clinical lab findings not classified elsewhere	6	3
External causes of morbidity and mortality	16	13
Total	71	64

- The majority of CFRT reviews result from deaths in the last two categories above.

III. Overview of Child Deaths Reviewed by the Nassau County Child Fatality Review Team (2013-2014)

Note: This section describes child deaths that were reviewed in by the NCCFRT in 2013-2014

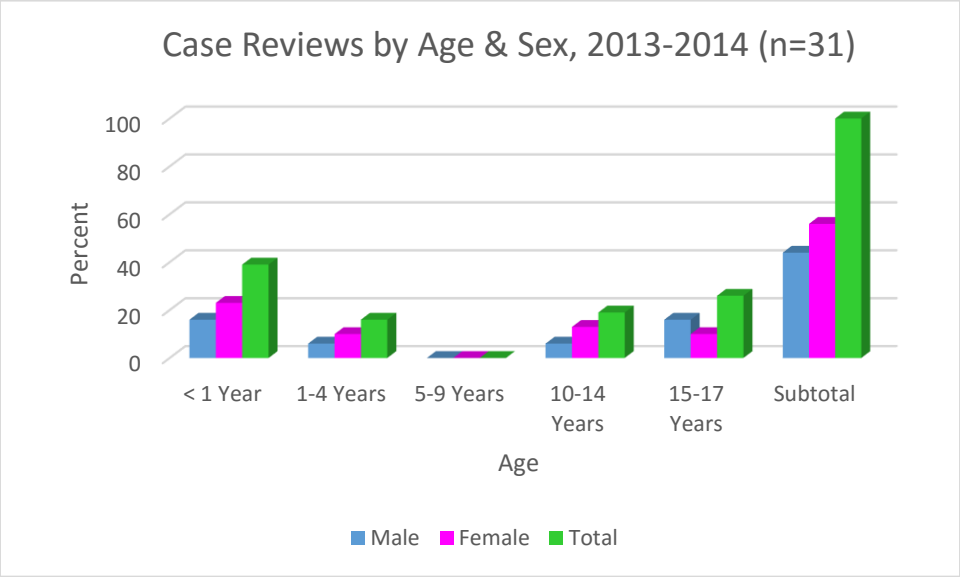
A. Demographics of Cases Reviewed

Keeping in mind the data presented above for Nassau County, we will now examine the data for the cases that the NCCFRT reviewed in 2013 and 2014. Table 3 shows the cases reviewed by year of death. Figure 6 shows the breakdown of the cases reviewed by age and sex for 2013-2014.

Table 3: Cases reviewed in 2013 and 2014 by year of death

Year of Death	Number of cases reviewed
2009	1
2010	3
2011	4
2012	14
2013	5
2014	4
Total	**31**

Figure 6: NCCFRT Case Reviews by Age and Sex, 2013-2014 (n=31)



- 44% (n=14) of the deaths reviewed were male and 56% (n=17) were female.
- As shown in Figure 6, 39% (n=12) of the cases reviewed were under the age of 1 year, 16% (n=5) were between 1-4 years of age, 19% (n=6) were between 10-14 years and 26% (n=8) were between 15-17 years.
- Not shown: 55% (n=17) of cases reviewed were White, 35% (n=11) African American, 6% (n=2) Asian, 3% (n=1) Caribbean and 3% (n=1) were unknown. (Percentage is >100 due to one case identifying with more than 1 race).
- Not shown: 29% (n=9) of cases reviewed were Hispanic.
- Not shown: 52% of the cases reviewed were from the select communities.[10]

B. Preventability

Each case review is presented for CFRT vote to determine if the death was either 1) preventable, 2) not preventable or 3) undetermined. CFRT may make recommendation based upon reviews if it is voted that the death was 1) preventable. The NCCFRT definition of a preventable death is 'if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death'. Of the 31 deaths reviewed by the NCCFRT during this time period, 61% (n=19) were considered to be

[10] In Nassau County there are 9 select communities based on health disparities. Historically these select communities have a higher burden of adverse health outcomes. These select communities represent 19% of the Nassau County population. The following communities fall into this category: Freeport, Uniondale, Hempstead, Roosevelt, Elmont, Inwood, Long Beach, Glen Cove, Westbury/New Cassel.

preventable, as determined by majority vote, 6% (n=2) not preventable and 32% (n=10) preventability could not be determined.

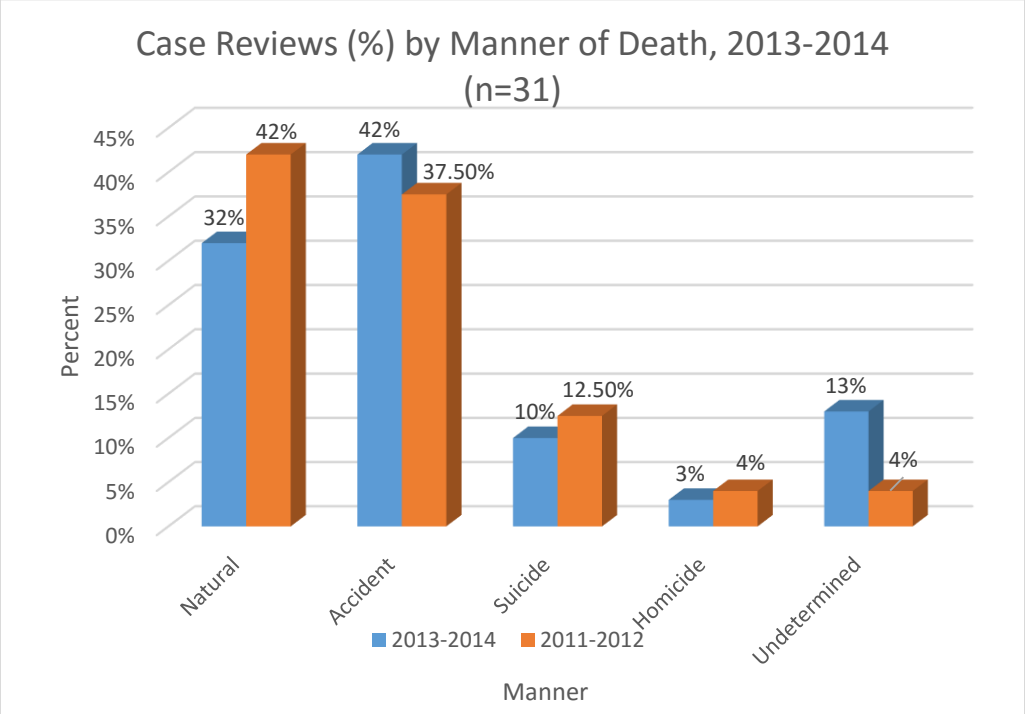
- Of the 10 natural deaths reviewed, 10% (n=1) were considered preventable; 20% (n=2) were considered not preventable; 70% (n=7) preventability could not be determined.
- Of the 13 accidental deaths reviewed, 100% were considered preventable.
- Of the 3 suicide deaths reviewed, 67% (n=2) were considered preventable and 33% (n=1) not preventable
- The 1 homicide death reviewed was considered preventable.
- Of the 4 undetermined deaths, 50% (n=2) were considered preventable and for 50% (n=2) the team could not determine preventability.

C. Manner and Cause of Death of Cases Reviewed

1. Manner of Death

Figure 7 shows the breakdown of cases reviewed by manner of death (as determined by the death certificate) from 2013-2014 as compared to 2011-2012.

Figure 7: NCCFRT Case Reviews by Manner, 2013-2014 and 2011-2012



- As shown above for 2013-2014, 32% (n=10) of the deaths reviewed were considered to be natural, 42% (n=13) accidental, 10% (n=3) suicide, 3% (n=1) homicide and 13% (n=4) undetermined.

- When comparing 2013-2014 case reviews to 2012-2012 case reviews: more deaths considered accidental were reviewed. For both time frames, natural and accidental deaths are the majority of cases reviewed.

Natural Deaths:

- Of the 10 natural deaths reviewed:
  - 6 were under the age of 1 year;
    - 2 of these were documented as SIDS on the death certificate.
    - All 6 infants were found unresponsive during a sleep period.
  - The remaining 3 deaths in this category ranged from 2-16 years.
- 60% (n=6) of the natural deaths were male; 40% (n=4) were female.
- 40% (n=4) of the natural deaths were White; 50% (n=5) were African American; 10% (n=1) Caribbean.
- 30% (n=3) were Hispanic.

Accidental Deaths/Unintentional Injury Deaths:

- Of the 13 accidental deaths reviewed: 1 case was under the age of 1 year; 3 cases were between 1-4 years; 4 cases were 10-14 years; 5 cases were 15-17 years.

- 2 were due to choking on food items, 1 traumatic (not transport related), 8 were transport related, 1 was due to airway obstruction in an infant sleeping in adult bed and 1 was due to a drug overdose.
- 46% (n=6) of accidental deaths were male; 54% (n=7) were female.
- 77% (n=10) of the accidental deaths were White; 15% (n=2) were African American; 8% (n=1) not identified.
- 46% (n=6) of the accidental deaths reviewed identified as Hispanic.
- Of the 8 transportation related deaths: 4 were in a motor vehicle, 3 were pedestrian related and 1 was a bicyclist
- Of note, of the 13 accidental deaths, there were no drowning deaths reviewed in this time period.

Suicide:

- All 3 of the suicide deaths reviewed were female.
- Suicide methods used: asphyxia/hanging.
- Age range: 13-17 years.
- 67% (n=2) were Asian; 33% (n=1) was African American.
- None identified as Hispanic.
- Risk factors identified for suicide were:
  - Family issues/stressors: divorce, recent immigration
  - History of mental illness: depression
  - Questionable sexual identity issues

Homicide:

- One death reviewed was considered a homicide.
- Due to the single review, further data unable to be released.
- Other homicide deaths not reviewed because of ongoing legal proceedings.

Undetermined Deaths

- Four deaths reviewed were considered undetermined by medical examiner.
- All 4 of the deaths involved an unsafe sleep environment of an infant.
- 50% were male
- All 4 were 0-2 months of age
- 50% (n=2) were African American; 25% (n=1) was White; 25% (n=1) identified as multi-racial)
- 25% (n=1) identified as Hispanic.

2. Cause of Death

In some instances, further detail is not provided to protect confidentiality.

Transport Related Deaths:

- 8 transport related deaths were reviewed.
- All were considered accidents by manner of death
- 75% (n=6) were White; 12.5% (n=1) African American and 12.5% (n=1) unidentified
- Four (50%) identified as Hispanic.
- 1 death involved a bicyclist; 3 deaths involved pedestrians and 4 deaths involved deceased as driver or passenger.
- Risk factors identified for pedestrian deaths:
    - Inappropriate crossing
    - Dark or hooded clothing
    - Crossing while distracted
- Risk factors identified for driver/passenger deaths:
    - ---Excessive speed
    - Lack of seatbelt use
    - Driver distraction
    - Front seat passenger
    - Teen driver/inexperience
- Risk factors identified for bicyclist death
    - Inappropriate crossing
    - Lack of helmet use
    - ? drug use

Infant Deaths:

- Each reviewed case is presented for CFRT vote to determine if the death was either 1) preventable, 2) not preventable or 3) undetermined. CFRT may make a recommendation based upon reviews if it is voted that a death was 1) preventable
- 39% (n=12) of all deaths reviewed occurred to infants (≤1 year of age).
- 33% (n=4) were White; 50% (n=6) were African American; 8% (n=1) multi-racial; 8% (n=1) Caribbean
- 33% (n=4) were Hispanic.
- 58% (n=7) were female; 42% (n=5) were male.
- By manner of death: 58% (n=7) were considered natural; 8% (n=1) were considered accidents; 33% (n=4) was undetermined.
- 92% (n=11) of the infant deaths occurred during sleep. The CFRT voted that 3 of these deaths were 1) preventable and the remaining 8 of these deaths were 3) undetermined. Based on CFRT policy, when there is an undetermined finding, the CFRT may not make a recommendations or come to a conclusion about specific factors.

    - All of these infant were placed in environments that included one or more of the following:

        - Adult bed; Couch
        - Loose soft bedding such as: comforters, blankets, pillows
        - Prone (belly) or side sleeping
        - Bouncy seat

Cardiac-Related Deaths

- 2 cases were reviewed whose deaths were due to cardiac failure.
- Both deaths were considered natural.
- Unable to release further details due to small numbers.

Choking:

- 6% (n=2) of the deaths reviewed were due to choking on food
- No non-food choking deaths were reviewed
- 50% (n=1) were White; 50% (n=1) were African American
- 50% (n=1) identified Hispanic origin
- 100% (n=2) were female
- Age range: 2-4 years
- Both children choked on a food item not typically recommended for infants and toddlers.

Drug-related:

- One drug related death was reviewed during this this period;
- Unable to release further details

Suicide:

- Discussed in previous section

Other:

- Information on the remaining deaths (n=3) cannot be released due to small numbers.

D. Department of Social Services (DSS) Involvement

- 31% (n=8) of cases reviewed had DSS involvement as indicated below. This is a decrease as compared to the 62.5% of cases reviewed in the 2011-2012 time frame.
- Of these 8 cases:
  - 37.5% (n=3) were female; 62.5% (n=5) were male.
  - 37.5% (n=3) were White; 50% (n=4) African American; 12.5% (n=1) Asian/Indian.
  - 25% (n=2) identified as Hispanic.
- Age range: 3 weeks to 17 years
  - 50% (n=4) of cases were <1 year of age.
  - 25% (n=2) of cases were between 1-4 years of age.
  - 12.5% (n=1) of cases were between 10-14 years.
  - 12.5% (n=1) of cases were between 15-17 years.
- 75% (n=6) of cases were called into the New York Statewide Central Register of Child Abuse & Maltreatment (SCR) at death
  - 25% (n=2) were indicated/substantiated for one or a combination of the following: Lack of Supervision, Inadequate Guardianship, Fatality
- 12.5% (n=1) had CPS involvement at some point prior to death;
  - 100% (n=1) indicated/substantiated
- 12.5% (n=1) had ongoing Preventive Services at time of death

E. Team Findings, Accomplishments and Recommendations

The NCCFRT reviews each of its cases individually and as comprehensively as possible with the information shared by all of the involved agencies. Though while we realize that it is impossible to prevent all deaths, by looking at risk factors, and identifying trends, we can promote child safety and prevent some deaths. Some of the significant themes that have emerged over the years that we have been reviewing cases are listed below, along with some accomplishments and recommendations of the NCCFRT. Please note that the recommendations discussed below are a result of our specific reviews. It is not meant to be a comprehensive listing of recommendations for injury prevention.

I. General Accomplishments and Recommendations

Accomplishments

- In-depth regular review meetings held with follow-up of prior cases as necessary. In 2014, the number of team meeting was reduced from 12/year to 6/year because of OCFS funding cuts.
- Screening of all death certificates received by the Nassau County Department Health for review eligibility.
- Maintain de-identified database of cases reviewed via the National Center for the Review & Prevention of Child Death's database.
- Improved communication between participating agencies has occurred due to case reviews
- Improved collaboration between participating agencies has occurred due to case reviews
- NCCFRT homepage within the NCDOH website was re-created (& improved) in December 2014 due to changes at the County IT level. Site available at: ***http://www.nassaucountyny.gov/3119/Child-Fatality-review-Team***
- Professional education:
    - Attendance at the 2013 regional state coordinator CFRT meeting
    - Subject matter experts invited to present on team meetings based on cases reviewed:
        - Director of Injury Prevention and Control at Winthrop University Hospital spoke on teen driving.
        - Guest speaker from the Department of Epidemiology at Columbia University's College of Physicians and Surgeons and the Mailman School of Public Health spoke with team on pedestrian injury.
        - Chair of Pediatrics and Pediatric Cardiology at St. Francis Hospital discussed cardiac arrest in teens.

Recommendations

- State create a state level CFRT component to current legislation with direction from DOH to engender a public health focus to child fatality review.
- State organized CFRT coordinators meeting to allow for networking, mock reviews and shared experiences.
- Guidelines to review cases across county lines to allow for a wider range of case reviews.

II. Safe Sleep Environments for Babies and SIDS Reduction:

Although neither a recommendation nor conclusion, 92% of the infants reviewed were placed in an unsafe sleep environment according to American Academy of Pediatrics recommendations[11].

[11] SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. Available at: http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284. Accessed 4/15/2016.

A hazardous sleep environment places an infant at significant risk of suffocation or asphyxiation. Hazardous sleep environment include: (but are not limited to): bumper pads, sleep positioners, pillows, cushions, blankets, comforters, stuffed animals, pets, bed-sharing, belly sleeping, sleep in product not meant for sleeping (i.e. couches, chairs, boppy pillows, car seats). Risk factors identified by review include:

- Soft bedding: blankets & pillows
- Bed-sharing (with parent +/- sibling)
- Maternal smoking history
- Male gender
- Prematurity
- Prone Sleeping
- Side sleeping
- Sleeping on couch/sofa

There are various reasons a caregiver may give for sharing a sleep surface with an infant. The NCCFRT is aware that there are both opponents and proponents of bed-sharing and that cultural factors may play a role in decision making. BUT, the NCCFRT firmly believes, based on case reviews, that the safest way for an infant to sleep is alone, on back, in a safety-approved crib with a tight fitting sheet (i.e. crib, bassinet) placed near caregiver.

Accomplishments

- The NCDOH on behalf of the NCCFRT became a chapter of the National Cribs for Kids program. Activities include:
  - Trademark license agreement signed with the National Program in coordination with County Attorney's office.
  - Memorandum of Understanding drafted by County Attorney office to use with local partners.
  - Protocols and procedures developed for local/community based partners.
  - Grant money received from Ronald McDonald house Charities and Macy's to support purchase of cribs for the program.
  - Activities planned for 2015: recruit local partners; train local partners; continue to complete grant applications to support the program.
  - Cribs for Kids brochure developed and printed. (see appendix)
- Maintain bilingual safe sleep information in DSS waiting areas and on DOH website.
- Letters are now being sent to the birth hospital of any case reviewed where unsafe sleep circumstances were identified (without identifying case information). The letter encourages the use of the American Academy of Pediatrics guidelines.
- A checklist was created in consultation with the Sudden Infant & Child Death Resource Center, to be used specifically by the team during infant death reviews to reinforce with the team and investigators the information needed to make a decision regarding preventability of infant deaths while sleeping which will in turn help prevention initiatives.
- Four team members applied for and were selected to participate in the National Leadership Academy for the Public's Health (NLAPH) inaugural cohort of 20 teams. The goal of the program is to improve specific, measurable public health problems, while developing leadership skills. During 2013-2014, team members developed a safe sleep questionnaire for birthing hospitals.
- Health Department newborn mailings continue to include information on safe sleep for infants. The information was updated based on the revised brochure from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, National

Institutes of Health, U.S. Department of Health and Human Services (DHHS). (See appendix)
- Use of the Centers for Disease Control Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form by the Nassau County Police Department.

Recommendations

- All caregivers follow the AAP guidelines-see Appendix for caregiver handout.
- Improved documentation of death scene investigation. Collecting more complete information at the death scene, including doll-reenactment to identify the exact position of the infant when found, may help provide a better understanding of how and why infants die.[12]
- Continue work with the local Cribs for Kids, Nassau County chapter.
- Community leaders and policy makers should support safe sleep campaigns.
- Education and awareness of all professionals working with parents/caretakers of newborns of infant safe sleep guidelines.
- Enact Legislation: requiring hospitals to uniformly educate new parents on how to prevent infant sleep related deaths.
- Produce and disseminate resource materials.
- Increase consumer education: a product being sold does not necessarily mean that it is safe to use. Two examples include:
    - Bumper pads-widely sold in baby stores: The following is the current AAP recommendation: Because there is no evidence that bumper pads or similar products that attach to crib slats or sides prevent injury in young infants and because there is the potential for suffocation, entrapment, and strangulation, these products are not recommended.[13]
    - Wedges, sleep positioners and other products advertised to protect against SIDS are also widely sold. The following is the current AAP recommendation: Avoid commercial devices marketed to reduce the risk of SIDS—These devices include wedges, positioners, special mattresses, and special sleep surfaces. There is no evidence that these devices reduce the risk of SIDS or suffocation or that they are safe.[14]

III. Choking Prevention

Accomplishments

- The Team identified a need for bilingual choking prevention information targeting food items. A working relationship with the Graphic Arts Department at Nassau Community College was developed and a project to create a bilingual choking prevention poster was

[12] 2008/2009 Office of Children and Family Services Report on Child Fatalities. Available at: https://www.ocfs.state.ny.us/main/reports/2008-09%20OCFS%20Fatality%20Report%20-%20Final.pdf

[13] Task Force on Sudden Infant Death Syndrome. Policy Statement: SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. *Pediatrics,* 2011;128(5)1030-1039.

[14] Task Force on Sudden Infant Death Syndrome. Policy Statement: SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. *Pediatrics,* 2011;128(5)1030-1039.

assigned to students. Four posters were selected for final competition and then brought to community residents who voted on the poster that best conveyed the message about food choking (see appendix). The winning poster became the focus of the Team's choking prevention campaign in Nassau. The artist received a citation from the County Executive.

- A choking Information Release was released (Choking on Food—A Risk for All Children, march 2013), posted on our website and mailed to Nassau County Pediatricians, Neonatologists, and Family Practitioners along with the bilingual posters and a bilingual choking prevention brochure (see appendix).
- The NYS Injury Prevention newsletter highlighted the NCCFRT choking prevention initiative in August 2013.
- Choking prevention materials distributed to: Nassau County libraries, Mayor of Hempstead, Department of Social Services, Early Intervention, WIC, Winthrop Welcome Center, Winthrop University Hospital pediatric clinics, Nassau County Probation, SNAP program, NUMC Health Center sites, Nassau Pediatric Society, Child Care Council for distribution to Day Care Centers and Nursery Schools.
- Choking prevention information incorporated into the Department of Health one year old birthday mailing.

IV. Drowning Prevention

Accomplishments

- Team members participated on the Long Island Drowning Prevention Task Force.
- Health Department newborn mailings continue to include information on drowning.
- Drowning Independent Report (see appendix) released and posted on Health Department website in conjunction with drowning prevention press release by County Executive office (June 6, 2013; see appendix)
- Pool safety placards distributed to Town of Hempstead (for distribution with pool permit applications)

Recommendations

- Community leaders and policy makers should support improvement of pool fencing laws.
- Professionals (i.e. newborn nursery personnel, physicians, nurses) should educate parents and children on water safety and facilitate CPR training.

V. Transport Related Death Prevention

Accomplishments

- Halloween Safety press release in coordination with County Executive Office and Safe Kids 10/2013 & 10/2014 (see appendix).

Recommendations

- Photojournalism project for High School affected by pedestrian deaths in coordination with Safe Kids and Traffic Safety.
- Parents should be aware of correct graduated license regulations.
- Community leaders and policy makers should advocate for improved graduated licensing requirements.
- Professionals (i.e. physicians, nurses) should educate parents and teens about motor vehicle safety and teen driving.

VI. Suicide Prevention

Recommendations

- Review available options for/resources for pediatricians; Draft letter to update pediatricians.
- Parents and caregivers should know the signs that indicate a child is at risk for suicide. An extensive list can be found at: http://www.preventsuicideny.org/Warning_Signs.html

F. Conclusions

The child fatality review process is a unique and valuable opportunity to learn about the manner, causes and circumstances of Nassau County child deaths in order to prevent future child death. This summary report is the third such report that the NCCFRT has produced. It is meant to provide general findings of the 31 cases reviewed from 2013-2014 and involved child deaths that occurred from 2009-2014. General and de-identified case specific findings and recommendations have been included.

The team continues to review cases, follow-up on current recommendations and pursue additional recommendations to decrease child fatality in Nassau County. The team hopes to continue to issue such reports periodically that will serve as a resource to the community as well as local and state leaders. Decreasing funding levels for the NCCFRT over the past few years is a major concern to the team. The NCCFRT hopes to see funding continue, and possibly improve, as the value of the interventions begins to emerge.

Appendix: Printed Materials

- Cribs for Kids Brochure
- Safe Sleep Brochure
- Choking Prevention Poster
- Choking Prevention Independent Report
- Choking Prevention Brochure
- Drowning Independent Report
- County Executive Drowning Press Release
- County Executive Halloween Safety Press Release

ABC's of Safe Sleep

A **Alone:** Keep baby's sleep area close but separate from where others sleep. Baby should not sleep with others in a bed, on a couch or in a chair.

B **Back:** Baby should be placed to sleep in his/her back in a safety-approved crib on a firm mattress with a fitted sheet for naps and nighttime.

C **Crib:** There should be no loose bedding, comforters, quilts, sheepskins, bumpers, stuffed animals,

How can you help?

- **Become a Partner Agency**:

Any agency that works with pregnant or parenting families can partner

- **Consider Fundraising Activities to benefit Cribs for Kids**

- **Donate**:

For each $100 donation, this program is able to provide a Crib for Kids Graco Pack n' Play, Halo sleep sack, 1 crib sheet, home delivery and safe sleep education by a partner agency to a family in need.

Please consider making a donation of any amount to help Nassau County babies sleep safely. Checks can be written to "**Cribs for Kids— Nassau County, NY Chapter**" and mailed to: **Cribs for Kids**

Suite 250, Riverfront Place

810 River Avenue

Pittsburgh, PA, 15212

(516) 227-9501

For additional information, contact us at: cribsforkids@nassaucountyny.gov

EDWARD P. MANGANO

NASSAU COUNTY EXECUTIVE

LAWRENCE E. EISENSTEIN, M.D., F.A.C.P.

COMMISSIONER of HEALTH

Nassau County

Cribs for Kids®

Helping every baby sleep safer

Because Every Baby Needs A Safe Place To Sleep

Why is “safe sleep” so important for an infant?

* The leading cause of death in babies 1-12 months of age is due to sleep related causes such as accidental suffocation and SIDS
* Every year, 4,500 babies die suddenly and unexpectedly in their sleep from accidental suffocation, strangulation, and Sudden Infant Death Syndrome.

Sharing a bed, with an adult or another child, increases an infant's risk of death from sudden infant death syndrome, or SIDS or other sleep-related causes. To reduce infants' risk of sleep-related deaths, the American Academy of Pediatrics (AAP) recommends that infants sleep in the same room, but not in the same bed, as caregivers. Cribs, portable cribs bassinets, or playards (playpens) that meet safety standards can be placed next to the caregiver's bed. Infants should not be placed to sleep on an adult bed at any time.*

*http://pediatrics.aappublications.org/content/

Why create a Nassau County Cribs for Kids chapter?

The Nassau County Child Fatality Review Team has reviewed 27 cases since 2007 where infants were placed in unsafe sleep environments which could not be eliminated as a risk factor in the death.

Partnering with community agencies

As a result of the Nassau County Child Fatality Review Team findings, the Nassau County Department of Health (NCDOH) has become a chapter of the National Cribs For Kids program. The NCDOH is committed to training partners that serve families. These partners will identify families that need a crib, coordinate delivery of the crib and educate the families on infant safe sleep.

Providing education and a crib to at risk families

- Nassau County residents with infants up to 9 months of age that display a need based on any of the following:
  - Receiving a public health benefit
  - Members of household unemployed
  - Any other special need as identified by partnering agencies

Safe Sleep For Your Baby

SAFE TO SLEEP®

- Always place your baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.
- Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet, to reduce the risk of SIDS and other sleep-related causes of infant death.
- Room sharing–keeping baby's sleep area in the same room where you sleep–reduces the risk of SIDS and other sleep-related causes of infant death.
- Keep soft objects, toys, crib bumpers, and loose bedding out of your baby's sleep area to reduce the risk of SIDS and other sleep-related causes of infant death.
- To reduce the risk of SIDS, women should:
  - Get regular health care during pregnancy, and
  - Not smoke, drink alcohol, or use illegal drugs during pregnancy or after the baby is born.
- To reduce the risk of SIDS, do not smoke during pregnancy, and do not smoke or allow smoking around your baby.
- Breastfeed your baby to reduce the risk of SIDS.
- Give your baby a dry pacifier that is not attached to a string for naps and at night to reduce the risk of SIDS.
- Do not let your baby get too hot during sleep.
- Follow health care provider guidance on your baby's vaccines and regular health checkups.

* For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or http://www.cpsc.gov.

- Avoid products that claim to reduce the risk of SIDS and other sleep-related causes of infant death.
- Do not use home heart or breathing monitors to reduce the risk of SIDS.
- Give your baby plenty of Tummy Time when he or she is awake and when someone is watching.

Adapted from materials from the Safe to Sleep® campaign led by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, National Institutes of Health, U.S. Department of Health and Human Services (DHHS).
For more information on SIDS or on the Safe to Sleep® campaign:
Phone: 1-800-505-CRIB (2742) or **Website:** http://safetosleep.nichd.nih.gov

NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development

NIH Pub. No. 12-5759

Nassau County Department of Health
200 County Seat Drive
Mineola, NY 11501

Sueño seguro para su bebé

SEGURO AL DORMIR®

- Tanto en las siestas como en la noche, siempre ponga a su bebé a dormir boca arriba para reducir el riesgo del síndrome de muerte súbita del bebé.
- Use una superficie firme para poner a dormir a su bebé, como un colchón en una cuna que cumpla las normas de seguridad aprobadas*, y cubra en colchón con una sábana ajustable para reducir el riesgo del síndrome de muerte súbita del bebé y de otras causas de muerte relacionadas con el sueño.
- Compartir la habitación (Room Sharing), es decir, tener el área donde duerme el bebé en la misma habitación donde duermen los padres, reduce el riesgo del síndrome de muerte súbita del bebé y de otras causas de muerte relacionadas con el sueño.
- Para reducir el riesgo de este síndrome, las mujeres:
  - Deben obtener cuidados de salud regulares durante el embarazo y
  - No deben fumar, tomar alcohol o consumir drogas ilegales durante el embarazo o después de que nazca el bebé.
- Para reducir el riesgo del síndrome de muerte súbita del bebé, no fume durante el embarazo y después no fume ni permita que otros fumen alrededor de su bebé.
- Dele el pecho a su bebé para reducir el riesgo del síndrome de muerte súbita del bebé.
- Para reducir el riesgo de este síndrome, en la hora de la siesta o en la noche puede darle a su bebé un chupete o chupón seco que no tenga un cordón alrededor.
- No deje que su bebé tenga demasiado calor al dormir.
- Siga los consejos de un proveedor de servicios de la salud para las vacunas y las visitas de rutina de su bebé.
- Evite los productos que aseguran reducir el riesgo del síndrome de muerte súbita del bebé y de otras causas de muerte relacionadas con el sueño.
- Para reducir el riesgo de este síndrome, no use aparatos caseros para monitorear el corazón o la respiración.
- Ponga a su bebé boca abajo sobre su barriguita cuando esté despierto y alguien lo esté vigilando.

*Para obtener más información sobre las normas de seguridad de las cunas, llame gratis a la Comisión de Seguridad de Productos del Consumidor al 1-800-638-2772 (en español o en inglés) o visite su página electrónica en http://www.cpsc.gov.

Adaptado de campaña "Seguro al dormir®" de materiales de la el Instituto Nacional de Salud Infantil y Desarrollo Humano Eunice Kennedy Shriver, Institutos Nacionales de la Salud, Departmento de Salud y Servicios Humanos de los EE.UU. Para obtener más información acerca del síndrome de muerte súbita del bebé, comuníquese con la campaña "Seguro al dormir®":
Teléfono: 1-800-505-2742 o **Página electrónica:** http://safetosleep.www.nichd.nih.gov

NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development

Nassau County Department of Health
200 County Seat Drive
Mineola, NY 11501

NIH Pub. No. 12-5759(S)

Be Careful of Dangerous Foods and Toys!

The Nassau County Child Fatality Review Team is a New York State Office of Children and Family Services grant funded program administered by the Nassau County Department of Health.
For more information please go to: www.safekids.org

Poster design by Mary Gunther through Nassau Community College Graphic Arts Dept.

NASSAU COUNTY EXECUTIVE

ED MANGANO

www.nassaucountyny.gov

Follow Ed Mangano on Facebook, Twitter and www.nassaucountyny.gov. and/or download the NassauNow App for iPhone and Android.

Tener Cuidado con Juguetes y Comidas Peligrosas!

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Nassau County Child Fatality Review Team
Informational Release
Volume 13; Issue 1

CHOKING ON FOOD: A RISK IN ALL CHILDREN

For Immediate Release:
March 2013

The Nassau County Child Fatality Review Team (NCCFRT), in accordance with its Protocols and Procedures Manual, is distributing its second Informational Release with approval from the New York State Office of Children and Family Services. The NCCFRT is a multidisciplinary team that has functioned since December 2008 as a NYS approved child fatality review team as provided in Social Services Law (SSL) §422-b. The team was created to review fatalities of Nassau County residents age 0-17 years whose death is otherwise unexpected or unexplained.

Membership in the CFRT is defined by SSL §422-b. This statute requires the participation of certain local governmental agencies and private individuals. §422-b also allows for the appointment of permissive members from various fields of practice. Mandatory team members include Nassau County Child Protective Services, Office of Children and Family Services (OCFS), Nassau County Department of Health, Nassau County Office of the Medical Examiner, Nassau County District Attorney's Office, Office of the Nassau County Attorney, Nassau County Police Department, Emergency Medical Services, New York State Law Enforcement and a pediatrician, or comparable medical professional, preferably with expertise in child abuse. The team has added additional members with expertise relevant to child fatality prevention and/or review.

The mission of the NCCFRT is to review child deaths to better understand the causes of these deaths and to make recommendations based on the team's findings in order to reduce future child fatalities. The NCCFRT meetings are confidential and closed to the public. A confidentiality statement is signed by each member, at the start of each team meeting. The team follows a protocol and procedure manual which is in accordance with New York State Social Service Law §§ 20(5) and 422-b, along with OCFS guidelines. As of December 2012, the team has reviewed a total of 59 cases due to a variety of causes. This report is *not* intended to function as an annual report, but rather as an Informational Release addressing certain NCCFRT cases. In this issue, the Informational Release will focus on those cases whose death was related to choking.

Choking in Children

Since January 2009, the team reviewed four cases, occurring since 2008, where the cause of death was listed as asphyxia or aspiration related to a food item. There were no non-food choking deaths reviewed. The age range of the deceased children spanned from two to four years. All four children choked on a food item not typically recommended for infants and toddlers. These items included a grape, a piece of meat, a carrot and a piece of exotic/tropical fruit with a large seed. Though three of the cases occurred in children of Hispanic origin, it is recognized that food choking poses a universal risk for children.

Choking, due to the blockage of the airway, deprives a person of oxygen, which can result in death, permanent brain damage or other injury.[1] For children under the age of 5 years, choking is the fourth leading cause of unintentional death.[2] Food, toys and household items can be choking hazards.[2] According to the 2012 American Academy of Pediatrics (AAP) policy statement on choking prevention, one child dies every 5 days due to choking on food, with more than 10,000 children presenting to emergency rooms each year due to choking injuries.[3] According to the 2010 NYS Department of Health 'Health Advisory', there was an average of 45 deaths annually in New York,

between 2006-2008, due to choking in children 0-19 years.[4] This may be due, in part, because young children have the tendency to place objects in the mouth. The primary causes of choking-related deaths in children are food, coins and toys.[3]

The focus of this report is on food related choking. The most common foods associated with choking in children are hot dogs, hard candy, nuts, seeds, whole grapes, raw carrots, apples, popcorn, chunks of peanut butter, marshmallows, chewing gum and sausages.[3] Other food items frequently cited as choking risks include: raisins, cheese cubes,[5] meat chunks, fish with bones, chips, pretzel nuggets, caramels, jelly beans, raw vegetables, fruit, fruit with skin, dried fruits, ice cubes.[2] In addition to food, household items may also be high risks for choking, including latex balloons, coins, small balls, toys with small parts, pen/marker caps, button batteries, screws, medicine syringes, bean bag stuffing, rings, earrings, crayons, erasers, staples, pins.[2]

Young children are particularly at risk of choking on food due the anatomy of the airway and the underdeveloped ability to chew and swallow.[3] The airway of a child is smaller in diameter than that of an adult, and a child's ability to dislodge a piece of food by coughing may be less effective than an adult's ability to cough out a similarly sized item of food.

According to the AAP, the issue of choking on food is relatively under-addressed in the United States in respect to children.[3] The U.S. Consumer Products Safety Commission (CPSC) has a system in place, which includes surveillance, legislation and regulations that regulate toys and consumer products to protect against choking and injury.[3] The CPSC requires labeling of toys that pose a risk to children, but there are no such counterpart regulations for food. While some food manufacturers do place warning labels on high risk products, it is not a requirement. Such warnings are voluntary.

AAP recommendations to prevent choking include[3]:

- Mandatory system to label food with appropriate warnings according to choking risk by the Food and Drug Administration (FDA) with collaboration with United States Department of Agriculture (USDA). (USDSA controls meat, poultry and certain egg products.)
- Surveillance and investigation by the FDA of food-related choking incidents with reporting to the public by FDA in coordination with the CPSC of existing and emerging food hazards.
- Recall of food products with unacceptable choking hazards with collaboration with USDA for meat products.
- A widely publicized food choking campaign with a focus on children by the FDA in cooperation with the USDA, CPSC and AAP.
- Intensified choking prevention counseling by pediatricians, dentists and other infant and child health care providers.
- Design of new foods and redesign of existing foods to avoid the characteristics that increase choking risk (shape, size, texture).
- Cardiopulmonary resuscitation (CPR) and choking first aid training for those who care for children such as parents, teachers and childcare providers.

Public Health Law §2500-I, passed in 2007, addresses childhood choking and gives authority to the New York State Department of Health (NYS DOH) to[3]:

1. Establish criteria for choking risks based on age for different foods.
2. Conduct public awareness and education programs.
3. Review available choking data

Note, however, that implementation of these programs is contingent upon appropriation from the legislature. To date, no such appropriations have been made. In spite of the lack of funding, the State DOH, using other grant funds, has implemented certain informational programs regarding children and food safety. These additional recommendations from the NYS DOH include[2]:

- Always supervise a small child when eating.

- Do not rush meals or snacks.
- Shape, size and texture of food matters!
    - Remove seeds and pits
    - Cut food into small pieces
    - Cook vegetables to soften texture
    - Cut hotdogs lengthwise and widthwise.
- Offer liquids between mouthfuls (but not simultaneously).
- Model good eating behaviors.
- Only use small amounts of peanut butter.
- Educate caregivers on choking hazards.
- Be familiar with CPR and the Heimlich maneuver.
- Be very careful with toys and foods that are considered to be high risk.

Additional tips for parents not mentioned above include:[6, 7]

- Keep high risk foods (see above) away from children under the age four years.
- Allow children to eat only while sitting, not while walking, playing or riding in a car.
- Be aware of older children's actions. An older child may give dangerous objects or food items to a younger child.
- Avoid toys with small parts and follow recommendations on toy packages; Consider using a small parts toy tester. A small parts toy tester should NOT be used on food items.
- Check in and under furniture for loose objects.
- Never allow young children (or infants) to play with coins.
- Be aware that balloons are considered to be a choking risk in children up to the age of *eight years*.
- Thoroughly clean floors and remove all food particles after eating.
- Make sure all your child's caregivers, including grandparents and babysitters are aware of all the risks!

It is clear that there needs to be more done to fill in the gaps in food-related choking prevention measures. It is important to remember that choking deaths are preventable.
To help address this issue the team has/will:

- Released this Informational Release initially to OCFS followed by release to the media and to the general public.
- Will work to disseminate and support the recommendations of the AAP.
- Will continue to review individual choking cases as appropriate.
- Develop an outreach and educational effort for community members and health care providers.

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[1] Centers for Disease Control and Prevention. Nonfatal Choking-Related Episodes Among Children: United States, 2001. *MMWR Morbidity Mortality Weekly Report* 2002;51(42);945-948.
[2] Available at: http://www.nyhealth.gov/prevention/injury_prevention/choking_prevention_for_children.htm. Accessed 8/19/2010.
[3] American Academy of Pediatrics Committee on Injury, Violence and Poison Prevention. Policy Statement Prevention of Choking Among Children. *Pediatrics*. 2010; 125; 601-607.
[4] York State Department of Health , Health Advisory, September 1, 2010.
[5] Companies Urged to Label Food Choking Hazards. Available at http://www.cspinet.org/new/200307171.html Accessed 7/1/2010.
[6] Choking Prevention; Available at http://injuryresearch.net/resources/1/FactSheets/ChokingPreventionFS.pdf
[7] Available at: http://www.aap.org/publiced/br_choking.htm. Accessed 8/19/2010.

WATCH OUT FOR THE FOLLOWING FOODS AND OBJECTS WITH CHILDREN UNDER AGE 6

FOOD * Raw Vegetables such as celery, carrots, and peas; whole olives; and cherry tomatoes * Nuts, sunflower seeds, pumpkin seeds, etc. * Hard candy, lollipops, and cough drops * Taffy or chewing gum * Soft candies with a firm texture such as gel or gummi candies * Marshmallows * Caramels and jellybeans * Popcorn * Raw, unpeeled fruit slices such as apples and pears; whole grapes, cherries with pits, and dried fruits such as raisins or apricots * Chunks of foods, especially meat or poultry, hot dogs or sausages served whole or cut in "coins," * cheese cubes * Spoonfuls of Peanut Butter * Snack Chips * Pretzel nuggets * Fish with bones * Ice cubes *

NON FOOD ITEMS * Coins, button-cell batteries * Buttons (loose as well as those attached to clothing) * Deflated or broken balloons * Pencils, crayons and erasers: pen and marker caps * Rings, Earrings * Nails, screws, staples, safety pins, tacks, etc. * Small toys, such as tiny figures, balls or marbles, or toys with small parts * Holiday decorations, including tinsel or ornaments that are toy like and lights * Small stones * Damaged or loose nipples on pacifiers or bottles * Medicine Syringes * Bean Bag stuffing

The Nassau County Child Fatality Review Team is a New York State Office of Children and Family Services grant funded program administered by the Nassau County Department of Health.

For more information on choking prevention, go to: www.safekids.org

Cover design by Mary Gunther through Nassau Community Graphic Arts Department

NASSAU COUNTY EXECUTIVE
ED MANGANO
www.nassaucountyny.gov

Follow Ed Mangano on Facebook, Twitter and www.nassaucountyny.gov. and/or download the NassauNow App for iPhone and Android.

2/2013

Be Careful of Dangerous Foods and Toys!

Tener Cuidado con Juguetes y Comidas Peligrosas!

Prevent Childhood Choking

IT'S UP TO YOU

KIDS UNDER 3 ARE MOST AT RISK: Babies and children under age 3 put lots of things in their mouths. Choking (or airway obstruction) occurs when a small object or piece of food blocks the airway.

CLEAN UP AND PUT AWAY-EVERYDAY: Homes and childcare facilities must be continually "childproofed" for safety. Small and sharp objects should be kept out of a child's reach.

THE RIGHT TOY AT THE RIGHT AGE: Choose age appropriate toys (follow age guidelines on toy packages). Inspect all toys regularly for breakage or loose parts. Consider purchasing a small parts tester at your local toy or baby store.

THE RIGHT FOOD AT THE RIGHT AGE: When it comes to food, keep it safe, cut it small and keep kids seated. Selecting and preparing appropriate foods for young children can help prevent airway obstruction. CHILDREN SHOULD EAT ONLY WHEN SITTING DOWN, and be encouraged to take small bites and eat slowly.

STAY CLOSE WITH A WATCHFUL EYE: When a child is eating or playing, ALWAYS stay close and watch for signs of choking. Adult supervision is key to prevent choking.

LEARN CPR AND HEIMLICH MANEUVER

Como Evitar Que Los

Depende De Usted

LOS NIÑOS MENORES DE 3 AÑOS, PRESENTAN MAYOR RIESGO: Los bebés y los niños menores de 3 años se colocan muchas cosas en la boca. El atragantamiento (o la obstrucción de las vías respiratorias) se produce cuando un objeto pequeño o trozo de comida bloquea el paso del aire.

LIMPIAR Y GUARDAR—TODOS LOS DÍAS: El hogar y las guarderías deben ser sitios seguros para los niños, y, deben revisarse diariamente. Los objetos pequeños y/o cortantes deben guardarse fuera del alcance de los niños.

EL JUGUETE APROPIADO PARA LA EDAD APROPIADA: Siempre elija juguetes que sean apropiados para la edad (lea las pautas que figuran en los empaques de los juguetes). Inspeccione todos los juguetes periódicamente y verifique que no estén rotos o que les falten piezas. Adquiera un probador de piezas pequeñas en la tienda de juguetes o de artículos para bebés. Los objectos que puedan introducirse en el probador se consideran riesgosos y pueden hacer que los niños menores de 3 años se atraganten.

LA COMIDA APROPIADA PARA LA EDAD APROPIADA: Cuando se trate de la comida, siempre trate de que los alimentos sean seguros, que los trozos sean pequeños y que los niños permanezcan sentados mientras coman. Seleccionar y preparar alimentos que sean apropiados para niños pequeños puede ayudar a evitar posibles obstrucciones de las vias respiratorias. Los niños sólo deben comer cuando estén sentados, y se les debe indicar que tomen trozos pequeños y mastiquen lentamente.

SIEMPRE ESTAR CERCA DEL NIÑO Y ATENTO: Se recomienda estar SIEMPRE cerca de los niños cuando estén jugando o comiendo y atentos a que no se atraganten. La supervisión de los adultos es fundamental para prevenir atraganten. La supervisión de los adultos es fundamental para prevenir cualquier situatión peligrosa.

TENGA CUIDADO CON LOS SIGUIENTES ALIMENTOS Y OBJETOS CON TIENE NIÑOS MENORES DE 6 AÑOS

ALIMENTOS* Verduras crudas como apio, zanahorias y chicharos; aceitunas enteras y tomatoes cherry * Nueces, semillas de girasol, semillas de calabaza, etc.* Dulces duros, paletas y pastillas, carmelos suanes con textura firme, como por ejemplo, marsmelos, carmelos o dulces suaves, caramelos de manj * Palomitas de maiz * Rebanadas de fruta cruda sin pelar, como por ejemplo, manzanas y peras, uvas enteras, cerezas con la pepa, y frutas secas como uva pasa o duraznos secos * Trozos grandes de alimentos, especialmente carne y aves, perros calientes o salchichas servidos enteros o cortados en rodajas; cubos de queso * Cucharadas de mantequilla de mani * Chips de papa como botanas

OTROS OBJETOS * Monedas, baterías pequeñas * Botones (sueltos y los que están cosidos a las prendas de vestir) * Globos destinflados o pinchados * Lápices, crayones y gomas de borrar, tapas de bolígrafos y de marcadores * Anillos, arêtes * Clavos, tornillos, broches, alfileres de seguridad, tachuelas, etc.* Juguetes pequeños, como por ejemplo, soldaditos, pelotas o canicas, o brien juguetes que incluyan piezas pequeñas * Adornos de Navidad, como por ejemplo, oropel y adornos que parezcan juguetes, y lucas Piedras pequeñas * Tetillas de biberón que estén sueltas o dañadas, chupetes rotos

Nassau County Child Fatality Review Team
Informational Release
Volume 13; Issue 2

CHILDHOOD DROWNING PREVENTION

For Immediate Release:
May 5, 2013

The Nassau County Child Fatality Review Team (NCCFRT), in accordance with its Protocols and Procedures Manual, is distributing its third Informational Release with approval from the New York State Office of Children and Family Services (OCFS). The NCCFRT is a multidisciplinary team that has functioned since December 2008 as a NYS approved child fatality review team as provided in Social Services Law (SSL) §422-b. The team was created to review fatalities of Nassau County residents age 0-17 years whose death is unexpected or unexplained.

Membership in the CFRT is defined by SSL §422-b. This statute requires the participation of certain local governmental agencies and private individuals. SSL § 422-b also allows for the appointment of permissive members from various fields of practice. Mandatory team members include Nassau County Child Protective Services, Office of Children and Family Services (OCFS), Nassau County Department of Health, Nassau County Office of the Medical Examiner, Nassau County District Attorney's Office, Office of the Nassau County Attorney, Nassau County Police Department, Emergency Medical Services, New York State Law Enforcement and a pediatrician, or comparable medical professional, preferably with expertise in child abuse. The team has added additional members with expertise relevant to child fatality prevention and/or review.

The mission of the NCCFRT is to review child deaths to better understand the causes of these deaths and to make recommendations based on the team's findings in order to reduce future child fatalities. The NCCFRT meetings are confidential and closed to the public. A confidentiality statement is signed by each member, at the start of each team meeting. The team follows a protocol and procedure manual, in accordance with New York State Social Services Law §§ 20(5) and 422-b, along with OCFS guidelines. The Team has the authority to prepare Informational Releases to address various safety issues. As of May 2013, the team has reviewed a total of 66 cases due to a variety of causes. This report is *not* intended to function as an annual report, but rather as an Informational Release addressing certain NCCFRT cases. In this issue, the Informational Release will focus on those cases whose death was related to drowning.

Drowning in Children

Since January 2009, the team reviewed six cases, occurring since 2007, where the cause of death was listed as drowning or asphyxia due to drowning. The age range of the deceased children spanned from 11 months to 17 years of age. Two of the children drowned in bathtubs, three in private pools and one in an open body of water. Two of the children were male, four were female. According to death certificate information, four of the drownings were considered accidental, one was considered a homicide and one remained undetermined. Risk factors identified in the reviews conducted included: inadequate/distracted supervision, filled bathtub, toys in water (tub), alcohol use by adult supervisors, broken gates/missing locks and adult supervisors unable to swim.

Drowning is the leading cause of injury death in United States children 1-4 years[1] and was the second leading cause of unintentional injury death in United States children ages 1-19 years from 2000-2006.[2] For every child death related to drowning, there are four children that require emergency room care for a nonfatal submersion injury.[3] These nonfatal drownings can cause brain damage leading to long-term disabilities. Age groups considered to be at the highest risk for drowning are toddlers and

male adolescents.[2] Racial disparities are greater after 5 years of age.[2] Drowning can happen in as little as 1 inch of water and is usually quick and silent.[4] After two minutes under water a child will loose consciousness and irreversible brain damage occurs within 4-6 minutes.[4]

Recently, the American Academy of Pediatrics (AAP) has relaxed its policy[2] regarding the age at which children should learn water survival skills. In the past, the AAP stated that children under the age of four years were not developmentally ready for swim lessons due to a lack of data, concerns that it would give a false sense of security and lead to inadequate supervision and that it might reduce a child's fear of water. The new guidelines recognize a study by the Eunice Kennedy Shriver National Institute of Child Health and Human Development that concluded that swimming lessons in those ages 1-4 years do not increase the risk of drowning and *may* provide a reduction in drowning risk. In the new guidelines the AAP stresses that swim lessons will not always prevent drowning and that they must be considered with other levels of protection, such as pool barriers and supervision. In addition, the Consumer Product Safety Commission (CPSC)[2] has identified large, inexpensive, inflatable or portable pools that are 18-48 inches deep as a risk factor for drowning. Such pools often fall outside of the local building codes for pool barriers and parents do not consider the need for fencing. In addition, soft sides on some of these pools allow a child to easily lean over and fall headfirst into the pool.

What can you do?

A multifaceted approach should be used to prevent childhood drowning. Drowning Prevention Strategies from the AAP and Safe Kids include:

1. SUPERVISION: Never leave child unattended (or in the care of another child) while in the bathtub, pool, wading pool, spa or any standing water. NOT EVEN FOR A MOMENT. Empty pails and buckets. Do not leave young child unattended in bathroom to prevent drowning in toilet.
    a. Designate a 'water watcher' – a supervisor whose sole responsibility is to constantly observe children in or near the water.
    b. An adult supervising young children in pool or open body of water should be in the water in arm's length.
    c. Adult supervision of older children should be constant and without distraction such as the telephone, reading, socializing or drinking.
    d. Adult supervisor should know how to swim, perform a rescue, start CPR and call for help.
    e. An infant bath seat/ring is not a substitute for adult supervision. The bath seat can tip over or slip.
    f. Consider using toilet seat locks (for infants and toddlers)
2. Barriers: 4-sided fencing, completely isolating the pool from the house and the yard, if properly used, can reduce drowning in young children by more than 50%.[2] In addition:
    a. Move chairs and tables to prevent them from being used as a climbing aide.
    b. Remove floats, balls and toys from the pool area.
    c. Currently, NYS regulations do not require 4-sided **isolation** fencing for residential pools.[5] Isolation fencing is defined as fencing that completely isolates the pool from the house and yard.[2] However, individual localities may have additional regulations and should be checked prior to pool installation. NYS regulations requires pool fencing to be at least 4 feet high, allows for a building wall to be part of the barrier if other conditions are met, gates must be self closing and self latching and securely locked, and pool alarms are required for pools installed after 12/14/06.[5] See http://www.dos.ny.gov/DCEA/pdf/PoolsumUC0708.pdf for full regulations.
    d. Pool owners should also consider pool alarms and rigid pool covers
3. Install proper drain covers and filter pump equipment to prevent body entrapment and hair entanglement.

4. Swim lessons:
    a. AAP supports lessons for most children over 4 years.
    b. Current evidence does not support swim lessons for 1-4 year olds, but there is no longer an AAP advisory against it.
5. Learn CPR and keep a telephone and US Coast Guard approved equipment at poolside.
    a. Air-filled swim aids (i.e. inflatable arm bands) should not be used in place of a life jackets/personal floatation device.
    b. Any child on a boat or participating in water sports should wear a personal flotation device (PFD). U.S. Coast Guard PFD requirements can be found at http://www.uscgboating.org/safety/life_jacket_wear_wearing_your_life_jacket.aspx NYS PFD requirements can be found at http://www.nysparks.com/recreation/boating/documents/NYSBoatersGuide.pdf
6. When swimming in an open body of water—only select sites with lifeguards.
7. Recognize risk during cold seasons—do not walk, skate or ride on weak or thin ice.
8. Children with seizure disorders should be supervised closely in bathtub and while swimming by an adult.
9. Avoid alcohol use when swimming or supervising children around water.
10. Remove toys from in and around pool when not in use. Drain and remove toys from bathtub when not in use.
11. Instruct babysitters and any child care providers about water safety.

The NCCFRT plans to:

- Increase public education regarding water safety.
- Support mandated 4-sided isolation pool fencing for all new and existing residential pools.
- Support efforts towards systematic reporting of immersion events to allow for consistent data collection which is critical for the development of drowning prevention strategies.

For more information on water safety, visit:

- http://www.cdc.gov/safechild/Drowning/index.html
- http://www.poolsafely.gov/
- http://www.safekids.org/water-safety
- http://www.drowningpreventionfoundation.org/safety.asp
- http://www.healthychildren.org/English/health-issues/injuries-emergencies/Pages/Drowning.aspx
- http://www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.html
- http://www.health.ny.gov/publications/3112/

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[1] Available at http://www.cdc.gov/homeandrecreationalsafety/water-safety/waterinjuries-factsheet.html Accessed 5/30/2013.

[2] American Academy of Pediatrics Committee on Injury, Violence, and Poison Prevention. Policy Statement—Prevention of Drowning. *Pediatrics*. Published online May 24, 2010; 1-8.

[3] Available at http://www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.html. Accessed 12/6/2011.

[4] Clear Danger: A National Study of Childhood Drowning and Related Attitudes and Behaviors; April 2004. Available at http://corpslakes.usace.army.mil/employees/watersafety/pdfs/2004%20National%20Study%20of%20Childhood%20Drowning%20&%20Related%20Attitudes.pdf

[5] NYS Fire Prevention And Building Codes available at: http://www.dos.ny.gov/DCEA/pdf/PoolsumUC0708.pdf

NASSAU COUNTY

June 6, 2013

County Executive Mangano and Health Commissioner Eisenstein Offer Water Safety Tips

Mineola, NY - With the start of the summer swimming season, Nassau County Executive Edward P. Mangano and Health Commissioner Dr. Lawrence Eisenstein today released the following water safety tips to help residents and visitors stay safe this summer. Drowning is a leading cause of injury-related deaths in children of all age groups, with nearly 33 children ages birth to 19 years dying each year in New York State. Children aged one through four years are especially at risk, with 12 deaths coming from this age group alone. Near drowning incidents in NYS often result in lifelong medical conditions.

"As we enjoy the warm days ahead, I wish all of our residents and visitors a healthy, fun-filled summer," said Nassau County Executive Ed Mangano. "Please keep safety in mind when enjoying water-related activities."

Nassau County Department of Health offers the following water safety tips:

- **Fence It Off.** Install a four-sided isolation fence which completely isolates the pool from the house and yard. Install a pool alarm and always lock gates and remove ladders when the pool is not in use. Clear the pool and deck area of toys, tables and chairs after use. The presence of these items may encourage children to enter the pool area unsupervised or lean over the pool and potentially fall in.
- **Supervise When in or Around Water.** Designate a 'water watcher' – a supervisor whose sole responsibility is to constantly observe children in or near the water.
- **Use the Buddy System.** Always swim with a buddy and always swim at sites that have lifeguards on duty. Obey all posted signs.
- **Be Alcohol-free.** Do not drink alcohol while swimming or supervising children who are swimming.
- **Learn life-saving skills.** Everyone should know the basics of swimming (floating, moving through the water) and cardiopulmonary resuscitation (CPR).
- **Do not use air-filled or foam toys.** Do not use air-filled or foam toys, such as "water wings", "noodles", or inner-tubes, in place of life jackets (personal flotation devices). These toys are not designed to keep swimmers safe.

In addition to these safety tips, homeowners must consult with their municipality for all local laws, ordinances, codes and regulations pertaining to backyard swimming pools.

For additional information on childhood drowning prevention, visit the Nassau County Department of Health web site at http://www.nassaucountyny.gov/agencies/Health/cfrteam.html

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Health Department

October 7, 2013

Mangano Partners with Safe Kids Nassau County
Be Safe on the Street ...While You Trick-or-Treat

Mineola, NY - Nassau County Executive Edward P. Mangano and the Nassau County Department of Health join Safe Kids Nassau County in promoting pedestrian safety awareness this Halloween. With the days getting shorter, children are likely to be trick-or-treating in the dark when it is harder for drivers to see them and the excitement of the holiday can make everyone less cautious. A Safe Kids 2011 study revealed that only one third of parents talk to their children yearly about Halloween safety. According to National Highway Traffic Safety Administration data, twice as many children are killed in pedestrian/vehicle incidents on Halloween between 4-10 pm as compared to the same hours on other days throughout the year.

"Halloween is an exciting time of the year, and to help ensure a safe and fun-filled day I urge parents to keep safety in mind while enjoying this exciting day," said County Executive Mangano.

"Halloweenfestivities give opportunities for parents, teachers and child caregivers to educateour young children aboutpedestrian and motor vehicle safety tips."said Rosemarie Ennis, Director of Safe Kids New York State.

Tips for Parents

Safe Kids recommends that children under age 12 do not trick-or-treat without adult supervision. If kids are mature enough to go trick-or-treating without supervision, make sure they go in a group and remain on the predetermined route with good lighting. Parents must also remind kids to:

- **Cross streets safely**. Cross at a corner, using traffic signals and crosswalks. Try to make eye contact with drivers before crossing in front of them. Look left, right and left again when crossing, and keep looking as you cross. Walk; don't run, across the street.
- **Walk on well lit sidewalks or paths.** If there are no sidewalks, walk facing traffic as far to the left as possible. Children should walk in familiar areas with minimal street crossings.
- **Be a safe pedestrian around cars**. Watch for cars that are turning or backing up. Never dart out into the street or cross between parked cars.
- **Costumes can be both creative and safe**. Decorate costumes and bags with reflective tape or stickers and, if possible, choose light colors. Masks can obstruct a child's vision, so choose non-toxic face paint and makeup whenever possible instead. Have kids carry glow sticks or flashlights in order to see better, as well as be seen by drivers. (Liquid in glow sticks is hazardous, so parents should remind children not to chew on or break them.)

Tips for Drivers

Drivers need to do their part to keep trick-or-treaters safe from harm. Safe Kids also reminds motorists to be extra careful this Halloween and recommends that drivers:

- **Be especially alert.** Children are excited and may move in unpredictable ways. Remember that popular trick-or-treating hours are during the typical rush-hour period between 5:30-9:30 p.m.
- **Drive more slowly**. Slow down and anticipate heavier than usual pedestrian traffic.
- **Lights on.** Be sure to drive with your full headlights on so you can spot children from greater distances.
- **Reduce distractions.** Reduce distractions in your car such as talking on the phone or eating so you can concentrate on the road and your surroundings.

Although pedestrian safety is a main concern on Halloween, parents also need to keep in mind that there are

other hazards for their children on this holiday. For more tips on how to keep kids safe while walking on Halloween and throughout the year, visit http://www.usa.safekids.org and search Halloween.

About Nassau County Safe Kids:

Safe Kids Nassau County is a coalition of public and private organizations working together to prevent injuries to children. Unintentional injuries are the number one killer of children ages 2 to 14. Local statistics have identified the need to focus on: child passenger safety, pedestrian safety, bicycle safety and fire/burn safety. Safe Kids Nassau County coalition members have a passion to protect children and help them grow up safe and healthy.

The North Shore-LIJ Health System serves as the lead organization for the Nassau County Safe Kids Coalition who's 57 health agencies, organizations and hospitals membership collaboratively service its county's 4 million children.

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County Executive

Mangano Partners With Safe Kids Nassau County To Offer Trick-Or Treat Safety Tips

Nassau County Executive EdwardP. Mangano and Nassau County Department of Health join Safe Kids Nassau County in promoting pedestrian safety awareness this Halloween. With daylight hours getting shorter, children are more likely to be trick-or-treating in the dark when it's more difficult for drivers to see them. According to National Highway Traffic Safety Administration data, twice as many children are killed in pedestrian/vehicle incidents on Halloween between 4:00 p.m. - 10:00 p.m. as compared to the same hours on other days throughout the years.

"Halloween is an exciting time of the year for our children," said County Executive Mangano. "I urge parents to review safety with their children this Halloween, and I wish all an exciting fun-filled day."

"Halloween festivities give opportunities for parents, teachers, and child caregivers to educate our young children about pedestrian and motor vehicle safety tips," said Rosemarie Ennis, Director of Safe Kids New York State.

Nassau County Executive Mangano and Safe Kids Nassau County offer the following Halloween safety tips for parents and drivers:

- **Cross streets safely.** Cross at a corner, using signals and crosswalks. Make eye contact with drivers before crossing. Look left, right and left again when crossing, and keep looking as you cross.
- **Walk on well-lit sidewalks or paths.** If there are no sidewalks, walk facing traffic as far to the left as possible. Children should walk in familiar areas with minimal street crossings.
- **Be a safe pedestrian around cars.** Watch for cars that are turning or backing up. Never dart out into the street or cross between parked cars. Do not use electronic devices while walking.
- **Costumes can be both creative and safe.** Decorate costumes and bags with reflective tape or stickers. Masks can obstruct a child's vision, so choose no-toxic face paint and make-up instead. Children should carry flashlights in order to see and be seen.
- **Be especially alert.** Children are excited and may move in unpredictable ways.Remember that popular trick-or-treating hours are during the typical rush-hour period between 5:30 p.m. - 9:30 p.m.
- **Drive slowly**. Slow down and anticipate heavier than usual pedestrian traffic. Full headlights should be on so that children can be spotted from greater distances.
- **Reduce distractions.** Eliminate driver distractions such as talking on the telephone or eating.

Although pedestrian safety is a main concern on Halloween, parents also need to keep in mind that there are other hazards for their children on this holiday. For more tips on how to keep kids safe while walking on Halloween and throughout the year, visit http://www.usa.safekids.org and search Halloween.

About Nassau County Safe Kids:

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