Nassau County Department of Health
Nassau County Child Fatality Review Team*
Three Year Summary Report
Report of Findings and Recommendations
2015-2017

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Nassau County Department of Health

In collaboration with the Nassau County Child Fatality Review Team
November 2018
*The Nassau County Child Fatality Review Team is funded by the New York State Office of Children and Family Services

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: 2015-2017 Team Members

Core Team Members (listed alphabetically)

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.

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 Traffic Safety
Mineola, N.Y.

Nassau Pediatric Society
Garden City, N.Y.

Safe Kids Nassau County
Great Neck, N.Y.

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

NYU Winthrop Hospital
Department of Pharmaceutical Services.
Mineola, N.Y.

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

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Nassau County Department of Health
Nassau County Child Fatality Review Team

Summary Report: Summary of Findings and Recommendations 2015-2017

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 fourth 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 2015 through 2017. However, the actual deaths occurred from 2010 through 2017. The purpose of this report is to summarize our findings and to discuss actions, interventions and recommendations. A total of 28 deaths were reviewed in this time frame. Of the 28 deaths reviewed:

- 4% were due to natural causes (n=1)
- 64% were accidental (n=18)
- 21 % were suicide (n=6)
- 11% were undetermined (n=3)
- 64% were male (n=18); 35% were female (n=10)
- 50% were transport related (n=14)
- 22% were infants. All of the infant deaths occurred during 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.

Introduction

The Nassau County Child Fatality Review Team (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. Since inception, the team has been funded by the NYS Office of Children & Family Services. 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 NCCFRT 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 (see pages 1-2 for member agencies).

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 2017, the team has reviewed a total of 117 cases due to a variety of causes. This report will focus on the 28 deaths reviewed from 1/2015 through 12/2017. Older summary reports are available at: https://www.nassaucountyny.gov/3119/Child-Fatality-review-Team.

Data for this report was collected using both vital statistics and NCCFRT data. Vital statistics data is used to give an overview of deaths in New York State and Nassau County. The NCCFRT data is used to describe findings of the in-depth reviews of the team. In some instances in this report, there are small numbers represented. For these instances, limited details are provided to maintain confidentiality.

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 2016, there were 1,361,500 people and 440,230 households with ~22% of the population under the age of 18 years.[1] 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 2016, Whites accounted for 75% of the population (60% non-hispanic white), African Americans accounted for ~13% and Asians accounted for ~10%. Individuals of Hispanic origin (of any race) accounted for ~17% 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 (2012-2016) in Nassau County was $102,044 placing it among the top ranking counties in the US. In NYS, the median household income was $60,741 and in the US it was $55,322. Although there are pockets of

[1] Available at: www.census.gov/popfinder; accessed 1/10/2018.

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 2012-2014[2] was 5.5 (per 1,000 live birth) which exceeds the Nassau County rate of 4.8 per 1,000 live births, and the NYS (excluding NYC) rate of 5.3 per 1,000 live births.

[2] https://www.nassaucountyny.gov/DocumentCenter/View/17688; Page 24; Accessed 10/26/2018

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.

Child Death in the United States:

In children, the leading cause of death varies by age. In the United States in 2015[3], for those:

- **Under 1 year of age:** congenital anomalies, short gestation, SIDS are listed as the top 3 causes of death. SIDS rose from the fourth leading cause of death back to the third as in earlier years.
- **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.
- **15-24 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, unintentional poisoning and drowning.

Child Death in New York State & Nassau County:

In **New York State**[4] (including NYC) in 2015:

- The estimated total population 0-19 years was 4,732,415.
- Approximately 51% were male and 49% were female.
- There were 1,875 *deaths* in children 0-19 years of age. Specifically:
  - 58% (n=1,079) were < 1 year of age; 15% were 1-9 years old; 28% were 10-19 years old
  - 58% were male; 42% were female
  - 56% were White; 28% were Black; 12% were Other
  - 18% were Hispanic
  - 20 deaths were attributed to SIDS
  - 248 deaths were due to congenital anomalies (77% were <1 at time of death)
  - 248 deaths were due to accidents (61% male; 39% female; 13% were <1yo; 12% were 1-4yo; 10% were 5-9 yo; 12% were 10-14 yo; 53% were 15-19yo)
  - 67 deaths due to suicide: (75% male; 25% female; all were between the age of 10-19 years; 81% White; 12% Black; 13% Hispanic)
  - 99 deaths due to homicide/legal intervention (81% male; 19% female; 25% White; 68% Black; 10% Hispanic)

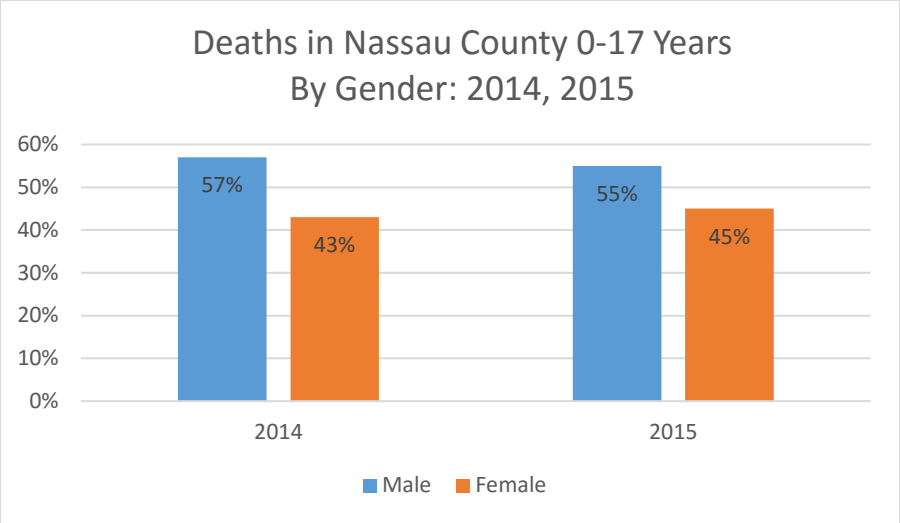
[3] Available at: https://www.cdc.gov/injury/wisqars/LeadingCauses.html. Accesses 1/10/2018

[4] Available at: https://www.health.ny.gov/statistics/vital_statistics . Accessed 1/11/2018

Nassau County 2014-2015:

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 2014 and 2015, a total of 163 **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[5]:

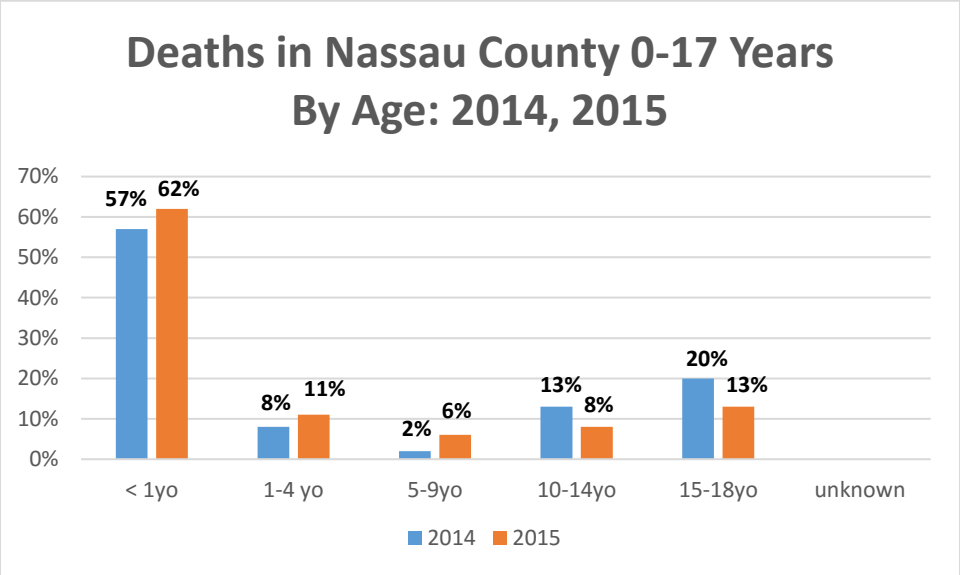
Figure 1: Deaths in Nassau County 0-18 Years by Gender: 2014, 2015



- As shown: there were more male than female deaths in both 2014 & 2015.

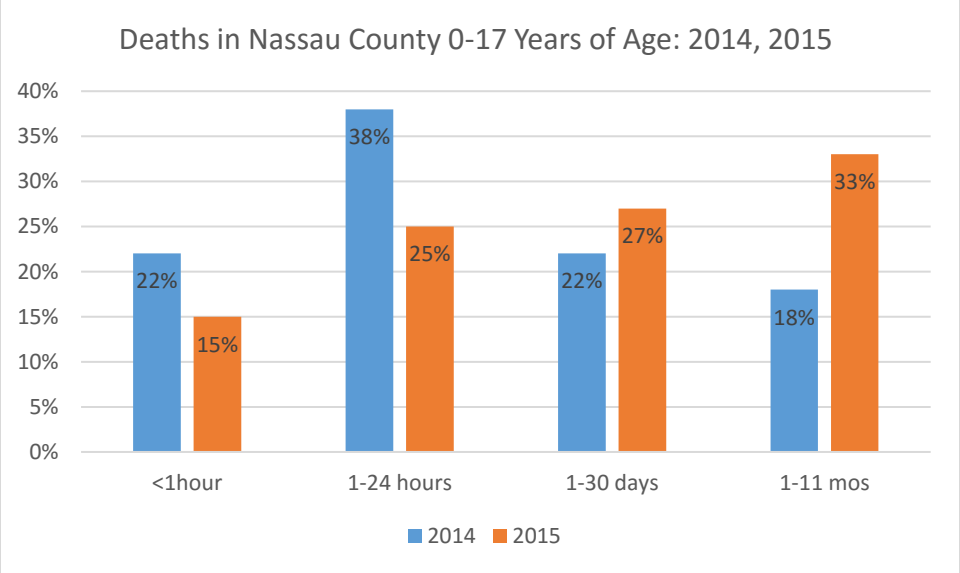
[5] Based on a data request to NYS Vital Statistics 6/2017

Figure 2: Deaths in Nassau County 0-17 Years by Age: 2014, 2015



- As shown, the majority of deaths in both 2014 & 2015 occurred in children under the age of 1 year (see next figure for additional info).

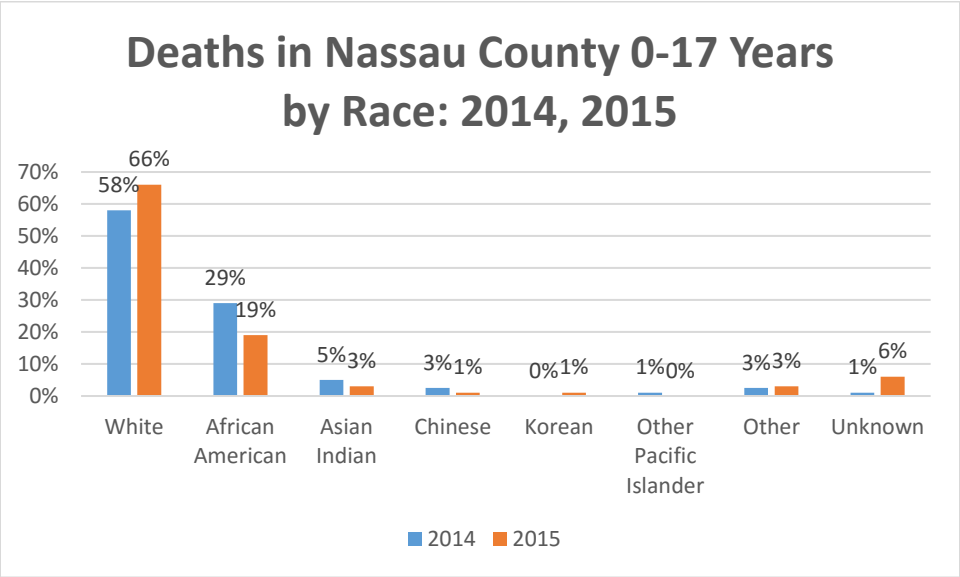
Figure 3: Deaths in Nassau County <1 year of age: 2014, 2015



Race/Ethnicity distribution based on 2014 **Nassau County** population data[6]:

- 62.9% White
- 11.6% Black
- 9.2% Asian/Pacific islander
- 16.1% Hispanic

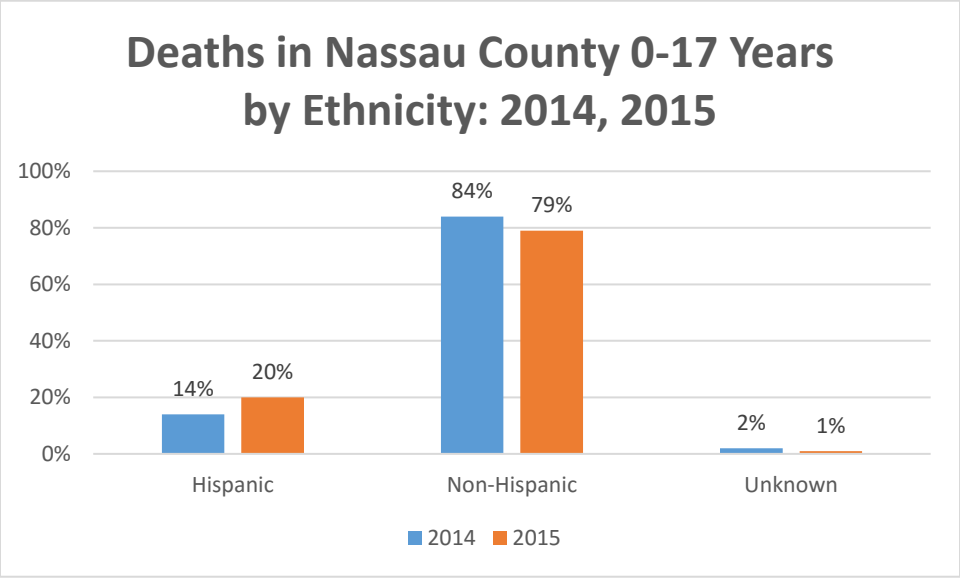
Figure 4: Deaths in Nassau County 0-17 Years by Race: 2014, 2015



- Note: Approximately 60% of Nassau County's population is Non-Hispanic White, 13% African American and 10% Asian/Pacific Islander[7]. Assuming the percentages hold true for 0-17 year olds, then the 29% (2014) & 19% (2015) of deaths (0-17 years) that are African American shows disparity.

[6] Available at https://www.health.ny.gov/statistics/community/minority/county/nassau.htm accessed 1/23/2018
[7] Based on 2016 population data. Available at www.health.ny.gov

Figure 5: Deaths in Nassau County 0-17 Years by Ethnicity: 2014, 2015



- Note: Approximately 16% of Nassau County's population identifies as Hispanic[8]. Assuming the percentages hold true for 0-17 year olds, then the 20% (2015) of deaths (0-17 years) that are Hispanic shows 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 approximately 20% 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 2014, 32% of deaths in Nassau County under the age 18 years were residents of these communities. In 2015, 40% 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[9], Accident, Homicide, Suicide, Undetermined or Pending. Cause of death refers to the injury or disease resulting in the death.

[8] Based on 2016 population data. Available at www.health.ny.gov

[9] A natural death is defined by the Centers for disease Control (CDC) as a death due solely or nearly totally to disease and/or the aging process. Available at: https://www.cdc.gov/nchs/data/misc/hb_me.pdf . Accessed 10/30/2018

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

	2014	2015*
Natural	77%	80%
Accident	13%	5%
Homicide	4%	2%
Suicide	1%	1%
Undetermined	4%	5%
Pending	1%	0%

*6% did not have a manner listed.

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

ICD-10 Code	2014 Number	2015 Number
Infectious and Parasitic diseases	0	3
Malignant Neoplasms	10	5
Diseases of the Blood	0	1
Endocrine, Nutritional & Metabolic Disorders	0	6
Mental & Behavioral Disorders	0	0
Diseases of the Nervous System	0	0
Diseases of the Circulatory System	6	8
Diseases of the Respiratory System	3	6
Diseases of the Digestive System	0	1
Diseases of the Musculoskeletal System & Connective Tissue	0	0
Diseases of the Genitourinary System	0	0
Certain conditions originating in the perinatal period	36	32
Congenital malformations, deformations and chromosomal abnormalities	5	7
Symptoms, signs and abnormal clinical lab findings not classified elsewhere	1	5
External causes of morbidity and mortality	16	10
Total	**77***	**84**

*2 cases did not have ICD-10 code listed

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

Overview of Child Deaths Reviewed by the Nassau County Child Fatality Review Team (2015-2017)

Note: This section describes child deaths that were reviewed by the NCCFRT in 2015-2017.

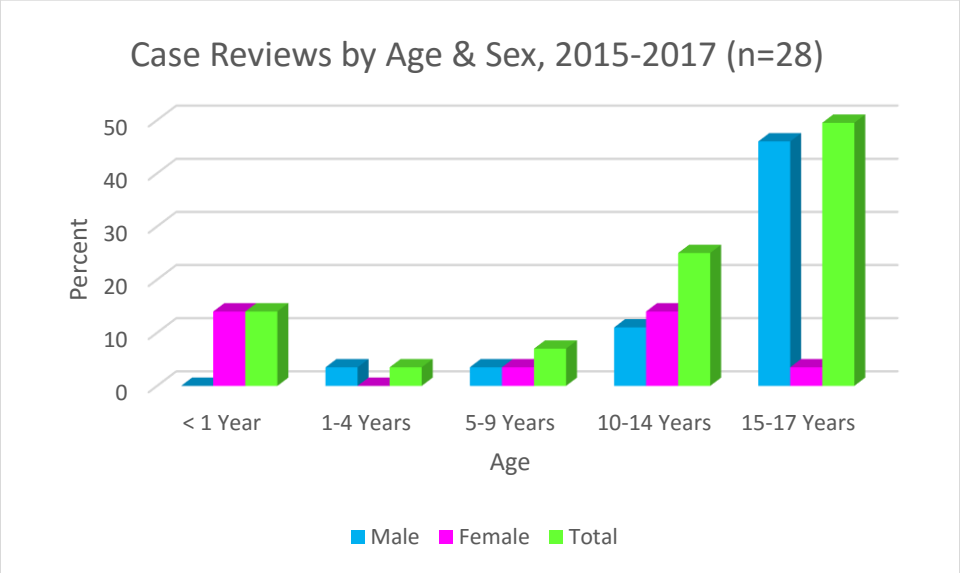
Demographics of Cases Reviewed

Keeping in mind the data presented above for Nassau County, we will now examine the data for the cases that the NCCFRT reviewed in 2015, 2016 and 2017. Table 3 shows the cases reviewed by year of death. Figure 6 shows the breakdown of the cases reviewed by age and sex for 2015-2017.

Table 3: Cases reviewed in 2015-2017 by year the death occurred

Year of Death	Number of cases reviewed
2010	1
2013	3
2014	8
2015	6
2016	8
2017	2
Total	**28**

Figure 6: NCCFRT Case Reviews by Age and Sex, 2015-2017 (n=28)



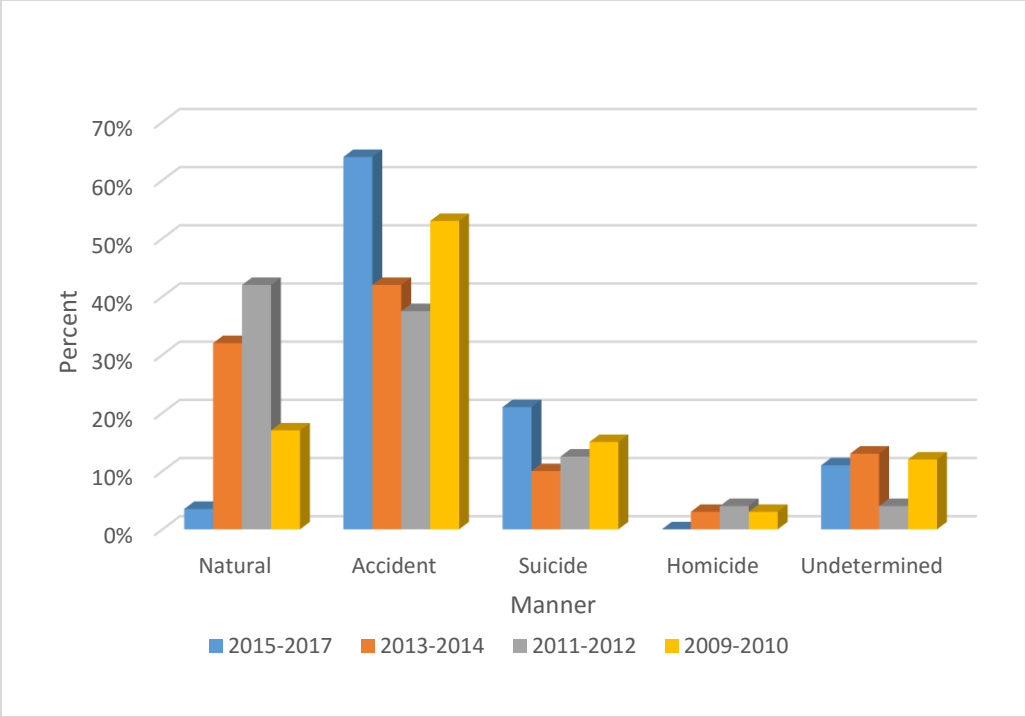
- 64% (n=18) of the deaths reviewed were male and 36% (n=10) were female.
- 14% (n=4) of the cases reviewed were under the age of 1 year, 3.5% (n=1) were between 1-4 years, 7% (n=2) were between 5-9 years, 25% (n=7) were between 10-14 years and 49.5% (n=14) were between 15-17 years. Note: In prior years, ~40% of cases reviewed were under the age of 1 year.
- Not shown: 68% (n=19) of cases reviewed were White, 14% (n=4) were African American, 7% (n=2) were Asian/Indian, 4% (n=1) were Chinese and 7% (n=2) were unknown.
- Not shown: 21% (n=6) were Hispanic, 71% (n=20) were Non-Hispanic and 1% (n=2) were Unknown.
- Not shown: 29% (n=8) of the cases reviewed were form select communities.[10]

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) for 2015-2017 as compared to prior years.

Figure 7: NCCFRT Case Reviews by Manner, 2009-2010, 2011-2012, 2013-2014 and 2015-2017



[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 approximately 20% 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.

- As shown above for 2015-2017, 4% (n=1) of the deaths reviewed were considered natural, 64% (n=18) accidental, 21% (n=6) suicide, 0% homicide[11] and 11% (n=3) undetermined.
- When comparing to cases reviewed in prior years, in 2015-2017 the majority of cases reviewed by the team were considered accidents.

Natural Deaths:

- One death reviewed was considered natural.
- Due to the single review in this category, further data unable to be released.

Accidental Deaths/Unintentional Injury Deaths:

- Of the 18 accidental deaths reviewed: 1 case was under the age of 1 year; 1 case was between 1-4 years; 1 case was between 5-9 years; 6 cases were between 10-14 years; 9 cases were between 15-17 years.
- 61% (n=11) of accidental deaths were male; 39% (n=7) were female.
- 72% (n=13) of the accidental deaths were White; 5% (n=1) were African American; 11% (n=2) were Asian/Indian; 11% (n=2) were not identified.
- 28% (n=5) of the accidental deaths reviewed identified as Hispanic.
- 13 cases were transport related; 3 were due to drug overdose; 1 was due to positional asphyxia; (unable to release additional info due to confidentiality).
    - Of the 12 transport related deaths:
        - 4 were pedestrians
        - 1 was a bicyclist
        - 5 were passengers in a moving vehicle; 2 were drivers.
- Of note, no drowning or choking deaths were reviewed in this time period.

Suicide:

- All 6 of the suicide deaths reviewed were male
- Suicide methods used: asphyxia, gun shot, motor vehicle & jump.
- Age range: 13-17 years
- 100% were White.
- 16% (n=1) identified as Hispanic
- Risk factors identified for suicide were:
    - History of drug and/or alcohol use
    - History of mental illness; prior suicide attempts
    - History of impulsiveness
    - Possible gender identity issues
    - Family issues: divorce
    - Social issues: bullying; partner issues

Undetermined Deaths:

- Three deaths reviewed were considered undetermined by the medical examiner.
- All 3 deaths were female infants between 0-3 months
- 100% were African American; Non-Hispanic.

2. Cause of Death

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

Transport Related Deaths:

[11] Note: Due to the ongoing nature of homicide investigations, the team is unable to review homicide deaths.

- 14 transport related deaths were reviewed.
- 93% (n=13) were considered accidents by manner of death; 7% (n=1) was considered a suicide.
- 71% (n=10) were White; 14% (n=2) Asian/Indian and 17% (n=2) unidentified
- Three (21%) identified as Hispanic.
- 1 death involved a bicyclist; 4 deaths involved pedestrians and 9 deaths involved deceased as driver or passenger.
- Risk factors identified for pedestrian deaths:
  - Inappropriate crossing
  - Drug use
- Risk factors identified for driver/passenger deaths:
  - Excessive speed
  - Unlicensed driving
  - Drug/ETOH use
  - Teen driver/inexperience
  - Inappropriate use of restraints
- Risk factors identified for bicyclist deaths:
  - Lack of helmet use
  - Distracted riding

Infant Death:

- 22% (n=4) of all deaths reviewed occurred to infants (≤1 year of age).
- All 4 deaths were female infants between 0-7 months
- 100% were African American; Non-Hispanic.
- By manner of death: 75% (n=3) were considered undetermined; 15% (n=1) were considered accidents.

  - All four of the infant deaths occurred during sleep. The CFRT voted that 2 of these deaths were preventable and 2 of the deaths were undetermined. Based on CFRT policy, when there is an undetermined finding, the CFRT may not make a recommendation or come to a conclusion about specific factors.

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

      - Adult bed
      - Side sleeping
      - Loose soft bedding such as: comforters, blankets, pillows
      - Prone (belly) or side sleeping
      - Cigarette/smoke exposure

Drug-related:

- Three drug-related deaths were reviewed.
- All 3 were considered accidents by manner of death.

- All were White; 33% (n=1) identified as Hispanic.
- All 3 were between the ages of 15-17 years.
- Risk factors identified include:

    - History of drug abuse
    - History of mental illness
    - Family/social issues

Suicide:

- Discussed in a previous section

Other:

- Information on remaining deaths cannot be released due to small numbers.

Preventability

The NCCFRT definition of a preventable death is based on Arizona's State team definition: a preventable child death has occurred "…if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death."[12] Each case review is presented for NCCFRT vote to determine if the death was either 1) preventable, 2) not preventable or 3) undetermined. The NCCFRT may make recommendations based upon reviews if it is vote that the death was 1) preventable. Of the 28 deaths reviewed in by the NCCRT during this time period, 71% (n=20) were considered to be preventable, as determined by majority vote, 7% (n=5) not preventable and 18% (n=5) preventability could not be determined. Note: for one of the cases the team had equal votes that were spilt between preventable and undetermined and therefore excluded from above.

- The 1 natural death reviewed was considered preventable.
- Of the 18 accidental deaths reviewed, 83% (n=15) were considered preventable; 6% (n=1) were considered not preventable and 11% (n=2) the team could not determine preventability.
- Of the 6 suicide deaths reviewed, 67% (n=4) were considered preventable and 33% (n=2) the team could not determine preventability.
- Of the 3 undetermined deaths, 33% (n=1) were considered preventable and for 66% (n=2) the team could not determine preventability.

[12] Rimsza M.E., Schackner R.A., Bowen K.A., Marshal W., Can Child Deaths Be Prevented? The Arizona Child Fatality Review Program Experience. Pediatrics, 2002; 110:11.

Department of Social Services (DSS) Involvement

- 14% (n=4) of cases reviewed had DSS involvement as indicated below. This is a decrease as compared to the 31.5% of cases reviewed in the 2013-2014 time frame.
    - Of these 4 cases:
        - 75% (n=3) were female; 25% (n=1) were male.
        - 50% (n=2) were White; 50% (n=2) African American
        - 25% (n=1) identified as Hispanic.
        - Age range: 3 weeks to 17 years
        - 50% (n=2) of cases were <1 year of age
        - 50% (n=2) of cases were called into the New York Statewide Central Register of Child Abuse & Maltreatment (SCR) at death
        - 50% (n=2) were indicated/substantiated for inadequate guardianship

Team Findings, Accomplishments & 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. At times, the review process may identify child health and safety issue that could apply to the whole community even if it could not have prevented the case death. 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.

General Accomplishments and Recommendations

Accomplishments

- In-depth regular review meetings held with follow-up of prior cases as necessary.
- 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 continues to be updated as needed. Site available at: http://www.nassaucountyny.gov/3119/Child-Fatality-review-Team
- Professional education:
    - Subject matter experts are invited to present at team meetings based on cases reviewed:
        - Guest speaker from the Nassau County Marine Bureau reviewed and discussed boating safety and regulations.
        - Guest speaker from Long Island Council on Alcoholism and Drug Dependence to discuss drug abuse in teens.
        - Guest speaker from S.T.R.O.N.G. Youth, a youth, family and community development organization specializing in youth and gang violence prevention discussed violence in teens.

        - Guest speaker from Zucker Hillside Hospital discussed suicide risk factors, screening tools and access to care.
        - Guest speaker from the Nassau County Department if Mental Health, Chemical Dependency and Developmental Disabilities discussed their Mental Health First Aid Program.
    - Team coordinator attends the Office of Children's & Family Services Child Fatality Review Team Coordinator meetings which were held in 9/2016 and 6/2017.

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.
- Continue State organized CFRT coordinator meetings 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.

Safe Sleep Environments for Babies and SIDS Reduction

Accomplishments

The NCCFRT has identified the sleep environment to be an important element to consider when trying to understand how and why some infants die. Although neither a recommendation nor conclusion, 100% of the infants reviewed were placed in an unsafe sleep environment according to American Academy of Pediatrics recommendations[13]. Infants should be placed **A**lone, on their **B**ack, in an empty **C**rib that meets current safety standards with a firm mattress and tight fitting sheet (**ABC**'s of Safe Sleep). A hazardous sleep environment places an infant at significant risk of suffocation or asphyxiation. Hazardous sleep environments 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.

[13] 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.

- The NCDOH on behalf of the NCCFRT became a chapter of the National Cribs for Kids program in October 2013 and started distributing cribs in February 2015. Activities during 2015-2017 include:
    - Applying for grants to support the purchase of the cribs. Though many grant applications have been completed, funding was successfully received from: Northrup Grumman, Richard & Mary Morrison Foundation.
    - Donations were also received from: the Nassau Pediatric Society, New York State Safe Kids (led by Northwell Health and supported in part by the Kiwanis Pediatric Trauma Foundation of Northwell) and the Nassau County PBA.
    - Cribs for Kids Policy & Procedure manual finalized.
    - Training curriculum (for community-based partner agencies) developed.
    - Community partner agencies recruited & trained include: WIC, Office of Children with Special Needs, Visiting Nurse Services of New York, Family & Children's Association, North Shore Child Guidance/Good Beginning's for Babies, EOC & the Federally Qualified Health Centers Care Coordination Program.
    - A National Association of County and City Health Officials (NACCHO) model practice was submitted and awarded for: A Safe Place to Sleep: Developing a National/Local Partnership in July 2016.
    - Cribs for Kids webpage updated as needed. Available at: https://www.nassaucountyny.gov/3533/Cribs-for-Kids
    - A total of 64 cribs were delivered to families in need from 2015-2017.
- Safe Sleep Zones created at the following birthing hospitals: South Nassau Communities Hospital, Mercy Hospital & Nassau University Medical Center. The 'Safe Sleep Zone' includes a display of a full-sized crib and educational information and is used as a teaching tool by the staff on the maternity unit.
- Maintain bilingual safe sleep information in DSS waiting areas and on DOH website.
- Letters continue to be 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.
- Health Department newborn mailings continue to include information on safe sleep for infants. The brochure was revised in 12/2016 (see appendix).
- Continue use of the Centers for Disease Control Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form by the Nassau County Police Department.

Recommendations

- Continue work with other birthing hospitals to set up model Safe Sleep Zones; Currently working with Northwell Hospital.
- 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.[14]
- 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.
- Produce and disseminate resource materials.

[14] 2008/2009 Office of Children and Family Services Report on Child Fatalities. Available at: https://ocfs.ny.gov/main/reports/2008-09%20OCFS%20Fatality%20Report%20-%20Final.pdf

- 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.[15]
    - 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.[16]

Transport-Related Death Prevention

Accomplishments

- Halloween Safety press release in coordination with County Executive Office and Safe Kids:
    - 10/2015 available at: https://www.nassaucountyny.gov/CivicAlerts.aspx?AID=2578
    - 10/2016 available at: https://www.nassaucountyny.gov/CivicAlerts.aspx?AID=4649
    - 10/2017 available at: https://www.nassaucountyny.gov/CivicAlerts.aspx?AID=5812

Recommendations

- 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.
- Appropriate use of care seats, boosters and seat belts as indicated for child weight and height to prevent injury

[15] 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.
[16] 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.

Suicide Prevention

Accomplishments

- A letter was sent to ~900 Nassau County Pediatricians on suicide prevention 8/2015. (See appendix)

Recommendations

- Teen suicide has been identified as an area of concern and team discussions are ongoing to determine future steps.
- Parents and caregivers should know the signs that indicate a child is at risk for suicide. Links to resources can be found here: http://www.preventsuicideny.org/

Choking Prevention

Accomplishments

- ❖ Choking prevention materials are mailed to all 1 year olds in Nassau County with the One year old birthday mailing.

Drowning Prevention

Accomplishments

- Bathtub drowning prevention information continues to be sent in the DOH newborn mailing (see appendix)

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.

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 fourth such report that the NCCFRT has produced. It is meant to provide general findings of the 28 cases reviewed from 2015-2017 and involved child deaths that occurred from 2010-2017. 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. Funding from the NYS Office of Children and Family Services helps support activities of the NCCFRT. However, 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. The value of in-depth child death fatality reviews can be seen both at the local and State level.

Appendix: Printed Materials

Safe Sleep Brochure
Suicide prevention letter to pediatricians from 8/2015
Bathtub drowning prevention

Follow the ABC's of Safe Sleep

★ Alone ★ Back ★ Crib

About 90 babies die each year in New York State from sleep-related causes. Right from the start, help your baby sleep safely every time sleep begins.

ALONE

- Put baby on their back to sleep – even if the baby was born early (premature).
- Your baby should not sleep with adults or other children.
- Share your room, not your bed. Room-sharing lets you keep a close watch over your baby while preventing accidents that might happen when baby is sleeping in an adult bed.
- Nothing should be in the crib except baby; no pillows, bumper pads, blankets or toys.

BACK

- Put baby to sleep on their back, not on their tummy or side.
- Do put your baby on their tummy every day when baby is awake and being watched. "Tummy time" helps baby develop strong shoulder and neck muscles.

CRIB

- Use a safety-approved* crib/bassinet/playard with a firm mattress and a fitted sheet.
- If baby falls asleep on a bed, couch, armchair, or in a sling, swing or other carrier, put baby in a crib to finish sleeping.

***For crib safety, go to the Consumer Product Safety Commission: cpsc.gov/en/Safety-Education/Safety-Education-Centers/Cribs/**

TIPS

- Use a one-piece sleeper. Don't use blankets.
- Be sure baby is not too warm.
- Breastfeed your baby.
- Try using a pacifier for sleep but don't force baby to take it.
- Get your baby immunized.
- If your baby is in a front or back baby carrier, be sure that baby's face is always visible.
- Never use a car seat, baby swing, carriage or other carrier without properly fastening all the straps. Babies have been caught in partially fastened straps and died.
- Make sure no one smokes in your home or around your baby.
- Don't use alcohol or drugs.
- Don't rely on home baby monitors.
- Make sure **everyone** caring for your baby follows theses tips!

NEW YORK STATE **Department of Health** health.ny.gov/safesleep | **Office of Children and Family Services**

Siga las ABC's del sueño seguro

★ Solo ★ Sobre su espalda ★ Cuna

Aproximadamente 90 bebés mueren cada año en el estado de Nueva York por causas relacionadas con el sueño. Desde el principio, ayude a su bebé a dormir de manera segura cuando llegue la hora de descansar.

Solo

- Recueste al bebé sobre su espalda para dormir, incluso si el bebé nació antes de tiempo (prematuro).
- Su bebé no debe dormir con los adultos ni con otros niños.
- Comparta su habitación, no su cama. Compartir la habitación le permite vigilar de cerca a su bebé a la vez que evita que puedan ocurrir accidentes si el bebé duerme en una cama para adultos.
- No coloque nada en la cuna excepto a su bebé; ni almohadas,ni cojines protectores, ni cobertores o juguetes.

Sobre su espalda

- Recueste al bebé sobre su espalda para dormir, no boca abajo ni de costado.
- Recueste boca abajo al bebé todos los días, cuando esté despierto ylo esté supervisando. "Ponerlo boca abajo" ayuda al bebé a fortalecer los músculos del hombro y del cuello.

Cuna

- Utilice una cuna/moisés/corralito de seguridad aprobado* con colchón firme y una sábana a medida.
- Si el bebé se queda dormido en una cama, sofá, sillón o en un columpio u otro portabebé, traslade al bebé a una cuna para que siga durmiendo.

Para obtener más información sobre la seguridad de las cunas, diríjase a la Comisión de Seguridad de productos para el consumidor (Consumer Product Safety Commission): **cpsc.gov/en/Safety-Education/Safety-Education-Centers/Cribs/

Sugerencias

- Utilice un pijama de una sola pieza. No utilice cobertores.
- Asegúrese de que el bebé no esté muy caliente.
- Amamante a su bebé.
- Intente utilizar un chupón pero no fuerce al bebé a aceptarlo.
- Vacune a su bebé.
- Si su bebé está en un portabebé delantero o trasero, asegúrese de que su rostro siempre esté visible.
- Nunca use un asiento para bebé, columpio para bebé, carruaje u otro portabebé sin ajustar correctamente todas las correas. Ha ocurrido que los bebés quedan atrapados entre las correas parcialmente ajustadas y han muerto.
- Asegúrese de que nadie fume en su casa o cerca de su bebé.
- No consuma alcohol ni drogas.
- No confíe plenamente en los monitores para bebé.
- ¡Asegúrese de que **todas las personas** que cuidan a su bebé sigan estas sugerencias!

NEW YORK STATE

Department of Health
health.ny.gov/safesleep

Office of Children & Family Services

Nassau County
Child Fatality Review Team

Dr. Julie Weiser, MD, MPH
Coordinator, Chair

Maria Lauria, LMSW,
Co-chair

August 2015

Dear Colleague,

The Nassau County Child Fatality Review Team would like to share with you information on teen suicide as you are in a unique position to prevent suicide deaths among your patients. Suicide is considered a preventable cause of death, yet it remains a severe public health challenge. Nationally, suicide is the third leading cause of death in 15-24 year olds (following unintentional injury and homicide).

Data from the Youth Risk Behavior Study in 2013[1] of 9-12 graders in New York shows that:

- ~24% of students feel sad or hopeless almost every day for 2 or more weeks in a row so that they stop doing some usual activities
- ~14% of students seriously considered suicide in previous 12 months
- ~7% of students attempted suicide at least once in previous 12 months

The Nassau County Child Fatality Review Team (NCCFRT) is a multidisciplinary team that has functioned as a NYS approved child fatality review team as provided in Social Services Law (SSL) §422-b working under the supervision of the Office of Children and Family Services (OCFS) since December 2008. The team was created to review fatalities of Nassau County residents age 0-17 years who die in Nassau County and whose death is otherwise unexpected or unexplained 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 has reviewed 11 suicide cases that occurred to Nassau County residents between 2008 and 2014. The victims were between the ages of 12 and 17 years of age. Sixty-four percent were female. Ninety percent were White, 8% were African American. Ninety percent were non-Hispanic.

- 6 victims died by asphyxia hanging; other methods included self-inflicted gunshot, fire/burns, train
- 5 of the victims had a known history of mental illness at some point
- 3 victims had a history of mental health treatment at some point
- 3 had a positive toxicology for alcohol or drugs at death
- 5 had prior suicide attempts
- 7 had family issues or other relationship loss or conflict at time of death (incl. verbal abuse, divorce, financial issues, recent immigration)

Research has shown that up to 83% of suicides had contact with their primary care provider within a year prior to death and up to 66% within the prior month.[2,3] Psychiatric disorders, including depression are under-recognized and undertreated in the primary care setting.[4] Accurate identification of those at risk is required for suicide prevention to be effective. A major factor contributing toward poor help seeking behavior is a perceived stigma associated with mental illness. The AAP, in conjunction with Bright Futures, publishes recommendations for preventive pediatric health care[5]. The 2014 guidelines

The Nassau County Child Fatality Review Team is funded by the New York State Office of Children and Family Services
200 County Seat Drive • Mineola, NY 11501 • Phone: (516) 227-9501 •Fax: (516) 227-9644•
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were updated to include an alcohol and drug assessment and depression screening annually starting at 11 years of age. Based on the depression screening recommendation we are reaching out to you to inform you of some available resources:

- The Nassau County Behavioral Health Helpline, (516) 227-TALK (8255), is available 24 hours a day, 7 days a week to assist professionals and parents with accessing community resources, as well as provide information and referrals.
- CAP-PC NY, funded by the New York State Office of Mental Health, provides real time access to child and adolescent psychiatrists for phone consultation and CME training in recognizing, assessing and managing mild moderate mental health issues in children and adolescents. CAP-PC NY can assist with linkage and referral to specialty mental health services. Although they do not provide crisis services or evaluations for emergencies, they can refer urgent cases to appropriate medical services. More information about their services can be found at www.cappcny.org. The website also has guidelines for adolescent depression in primary care (GLAD-PC toolkit).
- Suicide Prevention Resource Center (SPRC): www.sprc.org
- American Academy of Pediatrics Mental Health Initiatives available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/default.aspx

The NCCFRT encourages practitioners to seek ways to implement primary prevention activities. The AAP Task Force on Mental Health notes that the many unmet needs of children and adolescents and their families warrant enhanced primary care efforts to identify children with occult mental health problems and families in need of mental health or social assistance.[6] Screening should be done in concert with the behavioral health system that can provide effective care to those identified. Although no prevention strategy is fail-safe for every patient early identification and treatment increases the likelihood an adolescent can become a more productive, healthy adult.

If you are interested in additional behavioral health services or resource information please feel free to contact the Nassau County Office of Mental Health, Chemical Dependency and Developmental Disabilities Services at 516-227-7038.

Thank you in advance for your time and effort.

Julie Weiser, MD, MPH
Coordinator, NCCFRT

[1] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance-United States, 2013. Surveillance Summaries, June 13. MMWR 2014; 63(No.4).
[2] Ahmedani et al.: Health Care Contacts in the Year Before Suicide Death, J Gen intern Med, 2014: Jun;39(6):870-7.
[3] Mann et al.: Suicide Prevention Strategies: A Systematic Review, JAMA. 2005;294(16):2064-2074.
[4] Mann et al.: Suicide Prevention Strategies: A Systematic Review, JAMA. 2005;294(16):2064-2074.
[5] Available at: http://www.aap.org/en-us/professional-resources/practice-support/periodicity/periodicity%20schedule_FINAL.pdf
[6] American Academy of Pediatrics, Task Force on Mental Health. Enhancing Pediatric mental health care: strategies for preparing a primary care practice. *Pediatrics*. 2010;125(3 suppl):S69-S74

200 County Seat Drive • Mineola, NY 11501 • Phone: (516) 227-9501 •Fax: (516) 227-9644•
EMAIL: jweiser@nassaucountyny.gov

Protect Your Child Against Bathtub Drownings!

A child can drown in the time it takes to answer the phone.

Parents and caregivers of babies need to be aware of the potential hazards in their environment, hazards caused through the misuse of products and products poorly designed by manufacturers.

Often bath rings are mistaken for 'safety rings'. **This could not be further from the truth!**

Putting a child into an infant bathtub seat or ring can be a risky business. Bathtub seats or rings often give parents or caregivers a false sense of security, increasing the chance they will leave a baby unattended. Suction cups often fail to hold, and will not adhere to textured or slip resistant bath surfaces.

Numerous infants have drowned in bathtub seats when they were left unsupervised by an adult.

This year an estimated 100 drownings will occur in bathtubs. Half of these drownings will be infants under 12 months of age.

Studies clearly show that in almost every drowning instance the infant was left unsupervised.

Safety Tips

1. **Never rely on bath rings or seats to keep baby safe!**
2. **Never leave a child alone in the bathtub or near any toilet, or container of water.**
3. **Never rely on a sibling to supervise an infant.**
4. **Only fill the tub with enough water to cover the infant's legs. Beware: a child can drown in as little as one inch of water!**
5. **Learn CPR for infants. Accidents around water DO occur. Be prepared!**
6. **Remember: It only takes 3 minutes or less for a baby to drown!**
7. **Drowning is a silent killer, your child will not cry out.**

Bath seats and rings do not keep your baby safe!

DROWNING PREVENTION FOUNDATION (707) 747-0191

Adapted from the Drowning Prevention Foundation with permission. For more information about water safety for infants and toddlers contact the Drowning Prevention Foundation at: (707)747-0191 or www.drowningpreventionfoundation.us

NASSAU COUNTY · STATE OF NEW YORK ·

Nassau County Department of Health
200 County Seat Drive
Mineola, N.Y. 11501

¡Proteja a su niño contra ahogamientos en la bañera!

Un niño puede ahogarse en el tiempo quetoma el contester el teléfono.

Los padres y los proveedores de cuidado infantil necesitan estar concientes de los peligros potenciales en su entorno, peligros causados por el mal uso de los productos y por productos defectuosos diseñados por sus fabricantes.

Casi siempre los anillos para la bañera son confundidos con "anillos de seguridad" **¡Eso está tan lejos de la realidad!**

El colocar un niño dentro de un asiento o anillo para bañera de infante podría ser un riesgo. Los asientos o anillos para bañeras casi siempre dan a los padres o a los proveedores de cuidado infantile un sentimiento de seguridad falso, aumentando el riesgo de dejar a un niño sin vigilancia. Las ventosas casi siempre fallan al sostener el peso y no se adhieren a superficies con textura del baño o a superficies resistentes a resbalones.

La mayoría de casos de ahogamientos de infantes han sucedido cuando éstos han sido colocados en asientos para bañeras y se han dejado solos sin ser supervisados por un adulto. Este año un estimado de 100 ahogamientos ocurrirán en bañeras. La mitad de éstos ahogamientos serán infantes menores de 12 meses de edad.

Los estudios demuestran claramente que en casi todos los casos de ahogamientos el infante fue dejado sin ninguna supervision.

Consejos para la Seguridad

1. **Nunca confíe en anillos o en asientos para bañeras para mantener a un infante seguro.**
2. **Nunca deje a su niño solo en la bañera, cerca de un baño o de un recipiente con agua.**
3. **Nunca dependa de otro niño (hermano/a) para que supervise a un infante.**
4. **Llene la bañera solamente con el agua suficiente para cubrir las piernas del niño. ¡Tenga presente que un niño puede ahogarse en tan solo una pulgada de agua!**
5. **Aprenda CPR para infantes. Los accidentes alrededor de agua OCURREN. ¡Esté preparado!**
6. **Recuerde: ¡Solamente toma 3 minutos o menos para que un niño se ahogue!**
7. **El ahogamiento es un asesino silencioso, su niño no gritará.**

¡LOS ASIENTOS Y LOS ANILLOS PARA LAS BAÑERAS NO MANTIENEN SEGURO A SU BEBÉ!

FUNDACIÓN PARA LA PREVENCIÓN DE AHOGAMIENTOS (707) 747-0191

Adaptado de Fundación Para La Prevención De Ahogamientes con permiso. Para más información sobre la seguridad en el agua para los infantes y para los niños pequeños y para obtener información en como usted puede ayudar, por favor comuníquese con Fundación Para La Prevención De Ahogamientes al (707)747-0191 o www.drowningpreventionfoundation.us

Nassau County Department of Health
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