Nassau County Child Fatality Review Team
Summary Report: Report of Findings and Recommendations
2009-2010

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"If a disease were killing our children in the proportion that injuries are, people would be outraged and demand that this killer be stopped."
-Former Surgeon General C. Everett Koop, M.D.

Executive Summary

This summary report presents information obtained from the review of individual child deaths. This is the first such report for Nassau County. This report reflects the work of many dedicated professionals throughout Nassau County who participate on the Nassau County Child Fatality Review Team (NCCFRT). Child fatality review allows us to better understand how and why children in Nassau County die. Once we can understand this, 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 were conducted from 2009 through 2010. However, the deaths may have occurred from 2007 through 2010. The purpose of this report is to summarize our findings and to discuss actions, interventions and recommendations. A total of 34 deaths were reviewed in this time frame. Of the 34 deaths reviewed:

- 18% were due to natural causes (n=6)
- 53% were accidental (n=18)
- 3% were homicide (n=1)
- 15% were suicide (n=5)
- 12% were undetermined (n=4)
- More than half (56%) were male
- 29% were transport related
- 12% were due to drowning
- 41% were infants
    - Of these, 71% were related to sleep
- 12% were due to choking

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 helps lead to a better understanding of how we can continue to ensure that Nassau County is the safest place for our children.

Introduction

The Nassau County Child Fatality Review Team (NCCFRT) is a multidisciplinary team established pursuant to NY Social Services Law (SSL) § 422-b that 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"), including cases:

- whose care and custody or custody and guardianship has been transferred to an authorized agency.
- any child for who CPS has an open case.
- any child for whom Social Services has an open preventive services case.
- any case for which a report has been made to the State Central Registry (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. Currently in NYS, there are 16 CFRTS, of which 2 function out of the local Department of Health (Broome County and Nassau County).

Since January 2009, the NCCFRT has met monthly 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 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 with expertise in child abuse. The team has added additional members with expertise relevant to child fatality prevention and/or review (see Appendix A).

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 2010, the team has reviewed 34 cases.

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 cases 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 the County's children.

This summary report provides information on deaths that occurred to children under the age of 18 years who were Nassau County residents and died in Nassau County for which the review took place in 2009 or 2010. Note again, that actual deaths occurred between 2007 and 2010. We encourage you to share this report with others.

Child Death in Nassau County:

Death data for Nassau County residents under the age of 18 is provided below as a frame of reference for the rest of this report. This data includes some of the cases that were reviewed, but not all. It is meant to frame the types of death that occur within the county.
In 2008:

- 89 deaths of Nassau County residents under the age of 18 years (that occurred within the county)
- 60% were male; 40% were female
- Age:
    - <1 year: 63% (n=56)
        - <24 hours: 26% (n=23)
        - 1-30 days: 17% (n=15)
        - 1-11 months: 20% (n=18)
    - 1-4 years: 8% (n=7)
    - 5-9 years: 7% (n=6)
    - 10-14 years: 9% (n=8)
    - 15-17 years: 13% (n=12)

- By manner of death*:
  - 63% Natural
  - 10% Accident
  - 6% Homicide
  - 19% pending investigation (at point of data analysis)
- By cause of death:
  - Infectious and Parasitic diseases: n=1
  - Malignant Neoplasms: n=3
  - Diseases of the Blood: n=1
  - Mental & Behavioral Disorder: n=1
  - Endocrine, Nutritional & Metabolic Disorders: n=4
  - Diseases of the Nervous System: n=4
  - Diseases of the Circulatory System: n=4
  - Diseases of the Respiratory System: n=2
  - Diseases of the Digestive System: n=2
  - Certain conditions originating in the perinatal period: n=35
  - Congenital malformations, deformations and chromosomal abnormalities: n=8
  - Symptoms, signs and abnormal clinical lab findings not classified elsewhere: n=4
  - External causes of morbidity and mortality: n=20

Cases in the last two cause of death categories listed above may qualify for review under current CFRT guidelines, as defined by the teams' Protocols and Procedures manual. Under certain circumstances, deaths in the other categories may qualify for review as well.

A. Demographics of Cases Reviewed

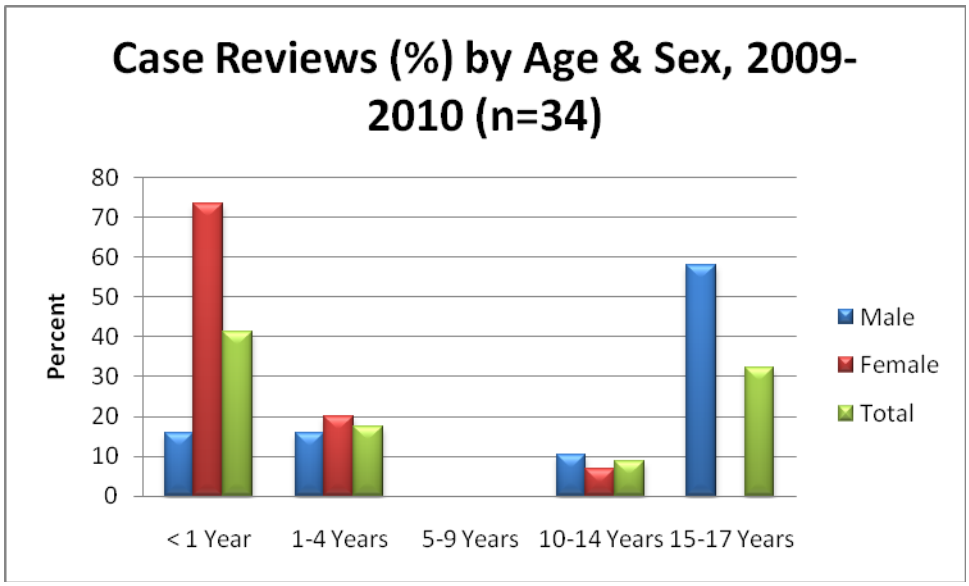
Table 1 shows the cases reviewed by year of death. Figure 1 shows the breakdown of the cases reviewed by age and sex for 2009-2010.

Table 1: Cases reviewed by year of death

Year of Death	Number of cases reviewed
2007	4
2008	14
2009	15
2010	1
Total	**34**

* There are six general categories (Accident, Homicide, Suicide, Natural, Undetermined and Pending) that are found in Item #27 on a NYS Death Certificate.

Figure 1: NCCFRT Case Reviews by Age and Sex, 2009-2010 (n=34)



- 56% (n=19) of the deaths reviewed were male and 44% (n=15) were female.
- As shown in Figure 1, 41% (n=14) of the cases reviewed were under the age of 1 year, 18% (n=6) were between 1-4 years, 9% (n=3) were between 10-14 years and 32% n=11 were between 15-17 years.
- Not shown: 82% (n=28) of cases reviewed were White, 15% (n=5) African American and 3% (n=1) Pacific Islander.
- Not shown: 23% (n=8) of cases reviewed were Hispanic.

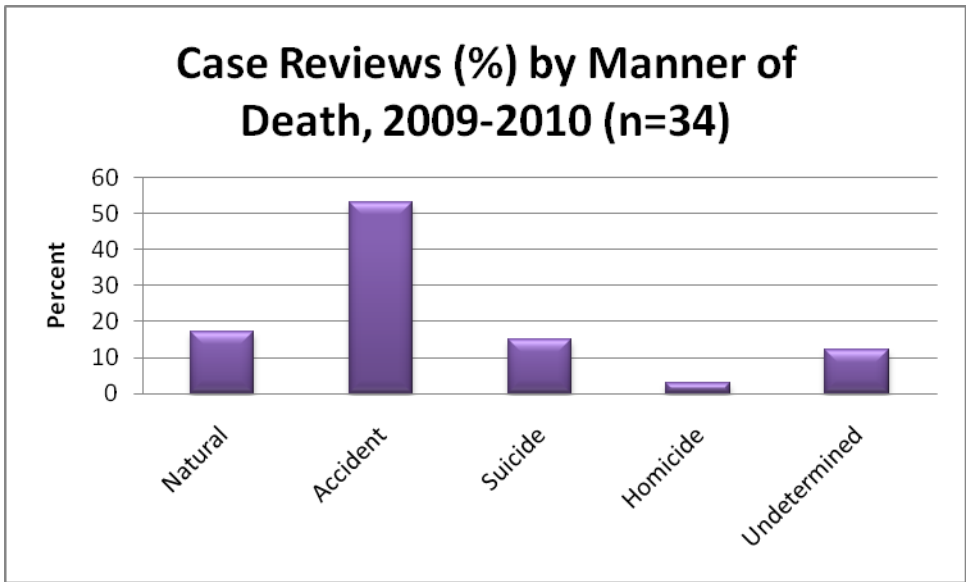
B. Manner and Cause of Death of Cases Reviewed

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.

1. Manner of Death

Figure 2 shows the breakdown of cases reviewed by manner of death.

Figure 2: NCCFRT Case Reviews by Manner, 2009-2010 (n= 34)



- As shown above: 17% (n=6) of the deaths reviewed were considered to be natural, 53% (n=18) accidental, 15% (n=5) suicide, 3% (n=1) homicide and 12% (n=4) were undetermined.

Natural Deaths:

- Of the 6 natural deaths reviewed, 5 were considered SIDS and 1 was considered a sudden infant death with a coincidental medical finding.
- All natural deaths reviewed were under 1 year of age.

Accidental Deaths:

- 72% (n=13) of the accidental deaths were male; 28% (n=5) were female
- 94% (n=17) of the accidental deaths were white; 6% (n=1) was African American
- 33% (n=6) Hispanic
- 5 were <1year
- 5 were 1-5years
- 2 were 10-14 years
- 6 were 15-17 years
- Of the 18 accidental deaths reviewed, 2 were due to asphyxia, 2 due to drowning, 8 were transportation related, 4 were due to choking, and 2 were due to medical causes
- Of the 8 transportation related deaths: 2 were bicyclists hit by motor vehicles, 4 were in a motor vehicle, 1 was pedestrian related, 1 was train related.
- 2 deaths involved soft bedding and infants
- 2 deaths were considered medical and were associated with maternal

drug abuse.

Suicide Deaths:

- Five suicide deaths were reviewed.
- 80% (n=4) were male; 20% were female (n=1).
- Suicide methods used: 1 hanging; 1 gunshot; 1 fire/burns; 2 trains
- 1 victim was 10-14 years; 4 victims were 15-17 years.
- 80% (n=4) victims were White; 20% (n=1) were Asian
- 20% (n=1) identified as Hispanic
- Risk factors identified:
  - Mental illness: 3
  - Recent relationship loss or conflict: 2
  - Academic problems : 1
  - History of drug use: 2
  - Positive toxicology for drugs and or alcohol at death: 3
  - Criminal and or juvenile delinquency record: 1
  - Prior suicide attempts: 2
  - History of mental health treatment: 2

Homicide:

- One death reviewed was considered a homicide
- Due to the single review, further data unable to be released

Undetermined Deaths:

- 4 of the deaths reviewed were considered undetermined for Manner of Death.
- When looking at these cases by cause of death:
  - One case was considered a Sudden Unexplained Infant Death (SUID)
  - One case involved a medical cause with associated soft bedding
  - One case was a hypothermia/drowning
  - One was Undetermined

2. Cause of Death

Transport Related Deaths:

- All 10 transport related deaths were male
- 8 were considered accidents and 2 were considered suicides
- 90% were White; 10% were African American;
- 30% were Hispanic
- 3 deaths involved trains
- 2 deaths were to bicyclists
  - Both bicyclists were not wearing helmets
- 4 deaths involved teen driving
  - 3 cases involved violation of graduated licensing regulations

- 3 cases involved incorrect use or no use of seat belts
- 1 death occurred to a pedestrian
- 2 cases involved use of alcohol

Drowning Deaths:

- Out of the 4 drowning deaths reviewed, 2 were considered accident, 1 homicide and 1 undetermined
- 2 occurred in a tub to infants < 1 year; 1 occurred in a pool to a 1-4 year old; 1 occurred in an open body of water to a teen
- 3 of the deaths were female; 1 male
- 2 drowning death involved lack of supervision
- 1 supervisor was impaired by alcohol/drugs

Infant Deaths:

- 41%(n=14) of all the deaths reviewed occurred to infants (<1 year of age)
- 71% (n=10) were White; 29% (n=4) were African American
- 79% (n=11) were female; 21%(n=3) were male
- Of the infant deaths:
  - 71% (n=10) of these deaths were caused by SIDS or another sleep related condition.
    - Age range spanned from 9 days to 5 months.
    - Occurred during warm and cold seasons.
    - 60% (n=6) were White; 40% (n=4) African American
    - 90% (n=9) were female; 10% (n=1) were male,
    - 20% (n=2) identified Hispanic origin.
    - All 10 cases revealed at least one of the following risk factors: bed sharing, prone sleep position, positional supports and/or soft bedding.

Choking Deaths:

- 12% (n=4) of the deaths reviewed were due to choking on food
- No non-food choking deaths were reviewed
- 100% (n=4) were White;
- 75% (n=3) identified Hispanic origin
- 50% (n=2) were female; 50% (n=2) were male
- Age range: 2-4 years
- All 4 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.

C. Department of Social Service Involvement

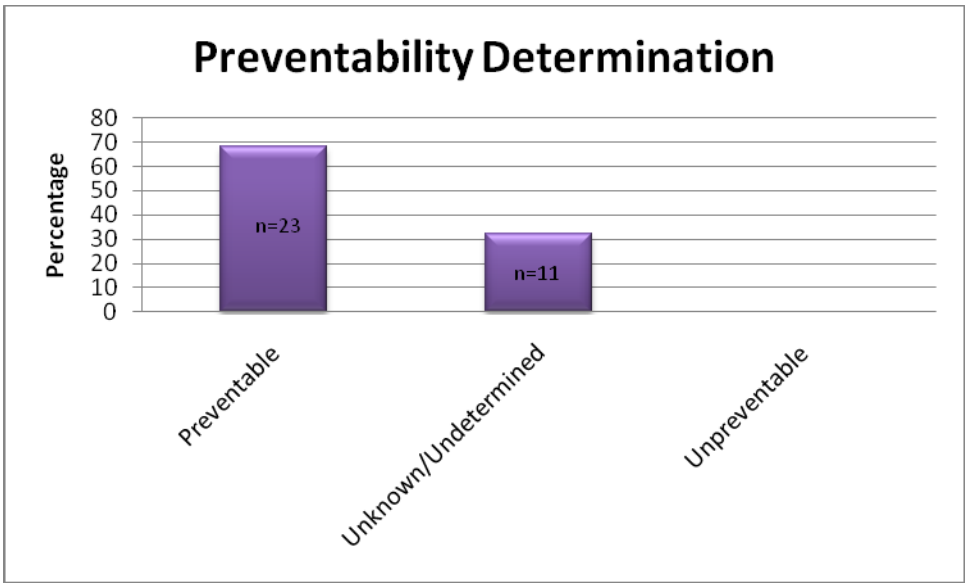
- 26% (n=9) of cases reviewed had involvement with DSS at some point during their lives.
- Of these 9 cases:

- 56% (n=5) were female; 44% (n=4) were male
- 11% (n=1) identified as Hispanic
- Age range: 1 day to 16 years
  - 44% (n=4) cases were <1 year of age
  - 22% (n=2) cases were between 1 and 4 years
  - 11% (n=1) cases was between 10 and 14 years of age
  - 22% (n=2) cases were between 15 and 17 years of age.
- 78% (n=7) were called in to the State Child Registry (SCR) at death
  - 57% (n=4) of the SCR cases were indicated
- 11% (n=1) case was receiving Preventive Services at time of death
- 11% (n=1) case was a PINS (person in Need of Supervision) case prior to death.

D. Preventability:

One of the goals of the NCCFRT is to determine if a death was 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 34 deaths reviewed by the NCCFRT during this time period, 68% (n=23) were considered to be preventable, as determined by majority vote.

- Of the 6 natural deaths reviewed, 67% (n=4) were considered preventable.
- Of the 18 accidental deaths reviewed, 94% (n=17) were considered preventable.
- Of the 5 suicide deaths reviewed, 20% (n=1) were considered preventable and 80% (n=4) the team could not determine preventability.
- The 1 homicide death reviewed was considered preventable.
- All 4 undetermined deaths reviewed were considered preventable.



E. TEAM ACCOMPLISHMENTS AND RECOMMENDATIONS

The child fatality review process helps to facilitate a thoughtful and sensitive discussion by the team on the circumstances involved in the child's death and how to prevent a future similar death. From the risk factors identified at reviews, the NCCFRT develops recommendations to reduce future preventable deaths. 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 monthly review meetings held with follow-up of prior cases as necessary.
  - Initial and ongoing trainings with a national expert from the National Center for Child Death Review.
- *Recommendations*
  - State should create a state level CFRT component to current legislation with direction from DOH to engender a public health focus to child fatality review.
  - State level 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

- *Accomplishments*

- Implementation and use of the Centers for Disease Control and Prevention (CDC) Sudden Unexplained Infant Death Investigation (SUIDI) forms by Police Department and Medical Examiner's office.
- Doll Reenactment training for the NCCFRT.
- In conjunction with the National Institute of Child Health and Human Development, developed an English and Spanish information sheet that is mailed to the parents of all newborns in the county monthly.
- Safe Sleep information sent to Nassau County Pediatricians and Nassau County day care providers in 2009.
- Independent report on safe sleep released to media and public 9/2010.
- Safe sleep independent report mailed to Nassau County pediatricians 10/2010.

o *Recommendations*
- Doll reenactment training for medical examiner /forensic investigators.
- Professionals (i.e. newborn nursery personnel, physicians, nurses) should teach parents and child care personnel safe sleep practices and SIDS reduction strategies.
- Community leader and policy makers should support safe sleep campaigns.

III. Choking Prevention

o *Accomplishments:*
- See below. The NCCFRT will be addressing this topic further in 2011.

o *Recommendations:*
- Independent report on choking prevention to be released to media and public in 2011.
- Team members will meet with Village of Hempstead officials to discuss a targeted approach for the Hispanic community in 2011.
- Develop a choking prevention poster for dissemination, in English and Spanish, with a focus on food risks in 2011.

IV. Drowning Prevention

o *Accomplishments*
- In conjunction with the Drowning Prevention Foundation, developed an English and Spanish bath tub safety brochure which is mailed to the parents of newborns born in Nassau County monthly.

- Participate on Long Island Drowning Prevention Task Force and assisting in developing of a pool safety brochure for parents/caretakers (ongoing).
- Working with towns to develop method to disperse pool safety recommendation to those applying for residential pool permits (ongoing).

o *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

o *Accomplishments:*
- DOH issued a press release in 10/2009 in conjunction with Halloween with an emphasis on pedestrian safety.
- Team has reviewed teen driving regulations.
- Team to address teen driving further after additional cases reviewed.

o *Recommendations:*
- Children should always wear helmets while riding bicycles, regardless of age.
- Parents should be aware of helmet use and be aware of correct graduated license regulations.
- Community leaders and policy makers should advocate for improved helmet laws and improved graduated licensing requirements.
- Professionals (i.e. physicians, nurses) should educate parents and children on helmet use, motor vehicle safety and teen driving.

VI. Suicide Prevention

o Initiatives:
- Team will make a recommendation to schools in 2011 on suicide prevention.

Appendix A

Nassau County Child Fatality Review Team
Team Members[†]

Core Team Agencies (listed alphabetically):

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

Nassau County Department of Health
Uniondale, 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 Police
Troop L Headquarters
East Farmingdale, N.Y.

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

Office of Children and Family Services
Central Islip, N.Y.

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

[†] Agencies listed are the current 2011 team agency members

Auxiliary members (listed alphabetically):

Child Abuse Prevention Services
Roslyn, N.Y.

Coalition Against Child Abuse & Neglect
Bethpage, N.Y.

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

Cohen Children's Medical Center
Trauma Department
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 Mental Health, Chemical Dependency and Developmental Disabilities
Uniondale, N.Y.

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

Nassau County Fire Commission
Westbury, N.Y.

Nassau County Medical Society
Garden City, N.Y.

Nassau County Perinatal Services Network
Uniondale, N.Y.

Nassau County Traffic Safety
Mineola, N.Y.

Nassau County Youth Board
Uniondale, N.Y.

Nassau Pediatric Society

Garden City, N.Y.

New York State Center for SIDS
Stony Brook, N.Y.

Safe Kids Nassau County
Great Neck, N.Y.

Winthrop University Hospital
Department of Neonatology
Mineola, N.Y.

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

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

Acknowledgements

- All members (past and present) of the NCCFRT for their participation, support and willingness to explore difficult issues and develop prevention strategies.

Appendix B: Printed materials

1. **Safe Sleep Brochure**
2. **Bath Tub Safety Brochure**

Safe Sleep for Your Baby

Reduce the Risk for Sudden Infant Death Syndrome (SIDS)

1. **Always place your baby on his or her back to sleep, for naps and at night.** The back sleep position is the safest, and every sleep time counts.

2. **Place your baby on a firm sleep surface, such as on a safety-approved* crib mattress, covered by a fitted sheet.** Never place your baby to sleep on pillows, quilts, sheepskins, or other soft surfaces.

3. **Keep soft objects, toys, and loose bedding out of your baby's sleep area.** Don't use pillows, blankets, quilts, sheepskins, or pillow-like crib bumpers in your baby's sleep area, and keep all objects away from your baby's face.

4. **Do not allow smoking around your baby.** Don't smoke before or after the birth of your baby, and don't let others smoke around your baby.

5. **Keep your baby's sleep area close to, but separate from, where you and others sleep.** Your baby should not sleep in a bed or on a couch or armchair with adults or other children, but he or she can sleep in the same room as you. If you bring your baby into bed with you to breastfeed, put him or her back in a separate sleep area, such as a bassinet, crib, cradle, or a bedside cosleeper (infant bed that attaches to an adult bed) when finished.

6. **Think about using a clean, dry pacifier when placing the infant down to sleep,** but don't force the baby to take it. (If you are breastfeeding your baby, wait until your child is 1 month old or is used to breastfeeding before using a pacifier.)

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

7. **Do not let your baby overheat during sleep.** Dress your baby in light sleep clothing, and keep the room at a temperature that is comfortable for an adult.

8. **Avoid products that claim to reduce the risk of SIDS** because most have not been tested for effectiveness or safety.

9. **Do not use home monitors to reduce the risk of SIDS.** If you have questions about using monitors for other conditions talk to your health care provider.

10. **Reduce the chance that flat spots will develop on your baby's head:** provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

Adapted from *Back to Sleep* campaign materials 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.
1-800-505-CRIB (2742) or http://www.nichd.nih.gov/SIDS

Nassau County Department of Health
106 Charles Lindbergh Blvd.
Uniondale, NY 11553

Ponga a su bebé a dormir sin peligro

Las diez maneras más importantes para que su bebé duerma sin peligro:

1. **Tanto para las siestas como por la noche, siempre ponga a su bebé a dormir boca arriba.** Esta posición es la más segura, en cualquier momento en que el bebé duerma.

2. **Acueste al bebé en una superficie firme como un colchón para cuna con seguridad aprobada*, y cubra el colchón con una sábana ajustable.** Nunca ponga a dormir al bebé sobre almohadas, colchas, pieles u otras superficies suaves.

3. **Mantenga todos los objetos suaves, juguetes o ropa de cama suelta fuera del área donde duerme su bebé.** No use almohadas, colchas, mantas, pieles o protectores de cuna acolchonados en el área donde duerme su bebé, y mantenga todo objeto alejado de su cara.

4. **No permita que fumen cerca de su bebé.** No fume ni antes ni después del nacimiento de su bebé, y no permita que otros fumen cerca de su bebé.

5. **Mantenga el sitio donde duerme su bebé cerca, pero separado, de donde duerman usted u otras personas.** Su bebé no debe dormir en una cama, sofá o sillón con adultos u otros niños, pero sí puede dormir en la misma habitación que usted. Si usted lleva a su bebé a su cama para darle el pecho, asegúrese de que una vez que haya terminado, lo regrese a un lugar separado para dormir, tal como a un moisés, cuna, cuna-mecedora, o a una cama para bebé ("bedside cosleeper") de las que se pueden unir a las camas de los adultos.

6. **Considere darle un chupete limpio y seco a su bebé cuando lo ponga a dormir,** pero no lo obligue a tomarlo. (Si usted está dándole el pecho a su bebé, espere a que cumpla 1 mes de nacido antes de darle el chupete).

7. **No deje que su bebé tenga demasiado calor al dormir.** Abrigue al bebé con ropa de dormir ligera y mantenga la habitación a una temperatura que sea cómoda para un adulto.

8. **Evite usar productos que aseguran reducir el riesgo del síndrome de muerte súbita del bebé,** porque no se ha comprobado la seguridad y eficacia de la mayoría de ellos.

9. **No use monitores caseros para reducir el riesgo de este síndrome.** Si tiene preguntas acerca del uso de monitores para otros problemas médicos, hable primero con su proveedor de servicios de la salud.

10. **Disminuya la posibilidad de que se desarrollen áreas planas en la cabeza de su bebé.** Cuando el bebé esté despierto y alguien lo esté vigilando, déjelo pasar un tiempo boca abajo. Cambie la posición en la que su bebé descansa en la cuna de una semana a otra, y evite que su bebé permanezca mucho tiempo en asientos para el carro, coches, cargadores o brincadores infantiles.

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

Adaptado de Campaña Dormir Boca Arriba 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.
1-800-505-CRIB (2742) or http://www.nichd.nih.gov/SIDS

Nassau County Department of Health
106 Charles Lindbergh Blvd.
Uniondale, NY 11553

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
106 Charles Lindbergh Blvd.
Uniondale, N.Y. 11553

¡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

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