Nassau County Child Fatality Review Team
Summary Report
Report of Findings and Recommendations
2011-2012

September 2013

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Nassau County Child Fatality Review Team

Summary Report: Report of Findings and Recommendations

2011-2012

"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 second 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 summarized here were conducted from 2011 through 2012. However, the actual deaths occurred from 2007 through 2012. The purpose of this report is to summarize our findings and to discuss actions, interventions and recommendations. A total of 24 deaths were reviewed in this time frame. Of the 24 deaths reviewed:

- 42% were due to natural causes (n=10)
- 37.5% were accidental (n=9)
- 4% were homicide (n=1)
- 12.5% were suicide (n=3)
- 4% were undetermined (n=1)
- 46% were male (n=11); 54% were female (n=13)
- 25% were transport related
- 8% were due to drowning
- 38% were infants. Of these, 67% were related to sleep
- 12.5% were cardiac related

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 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:

- whose care and custody or custody and guardianship has been transferred to an authorized agency.
- any child for who Child Protective Services (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. As of July 2013 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 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 (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 2012, the team has reviewed a total of 58 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 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 the County's 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 2011 or 2012. Between January 1, 2011 and December 31, 2012, the team conducted in-depth reviews of 24 cases whose death occurred between 2007 and 2012. We encourage you to share this two year summary report with others.

Child Death in the United States:

In children, the leading cause of death varies by age. In the United States[1], for those:

- **Under 1 year of age:** congenital anomalies prematurity and SIDS are the top 3 causes of death
- **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 fire/burn.
- **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 suffocation.
- **15-19 year olds:** unintentional injury, homicide and suicide are the top causes of death. The 3 main causes of unintentional injury in this age are: motor vehicle traffic, poisoning and drowning.

[1] Available at www.cdc.gov

Child Death in New York State & Nassau County:

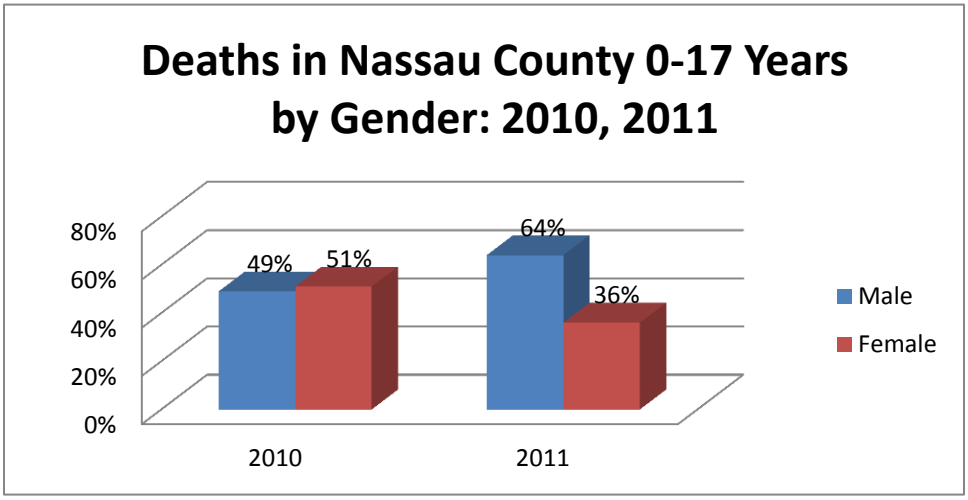
As the NCCFRT does not review all County deaths, the following information should serve as a frame of reference for child death in NYS and Nassau County. In **New York State** (excluding NYC)[2] in 2011:

- The estimated total population 0-19 years of age was 2,856,324.
- Approximately 51% were male and 49% female.
- There were 1,843 deaths in children 0-19 years of age. In particular:
    - 40 deaths were attributed to SIDS
    - 155 deaths due to congenital anomalies
    - 405 deaths due to certain conditions originating in the perinatal period
    - 189 deaths due to accidents
    - 90 deaths due to motor vehicle crashes
    - 67 deaths due to suicide
    - 53 deaths due to Homicide/legal intervention
- Based on 2010 **Nassau County** population data[3]:
    - 66.2% White
    - 11.0% Black
    - 8.1% Asian/Pacific Islander
    - 14.6% Hispanic

In 2010 and 2011, a total of 120 **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[4]:

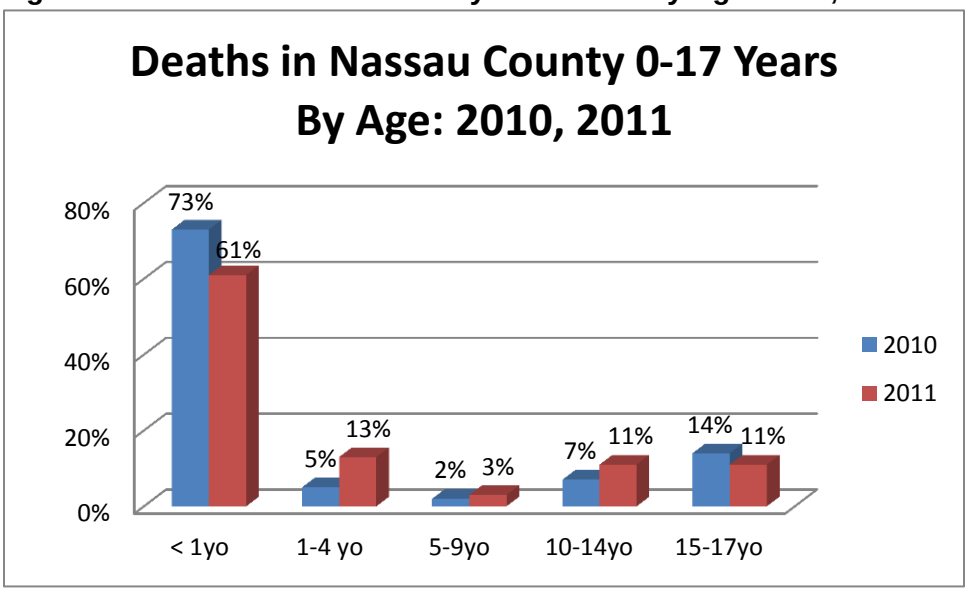
[2] Available at http://www.health.ny.gov/statistics/vital_statistics/
[3] Available at http://www.health.ny.gov/statistics/community/minority/county/nassau.htm
[4] Based in Data request to NYS Vital Statisitics 5/2013.

Figure 1: Deaths in Nassau County 0-17 Years by Gender: 2010, 2011



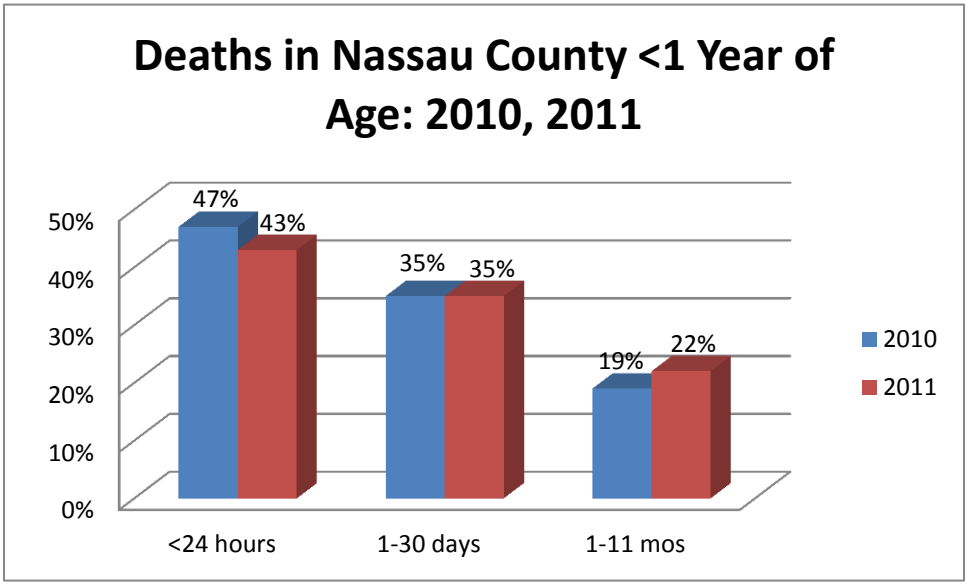
- As shown: in 2010, there was approximately equal number of male and female deaths. In 2011, there were more male than female deaths.

Figure 2: Deaths in Nassau County 0-17 Years by Age: 2010, 2011



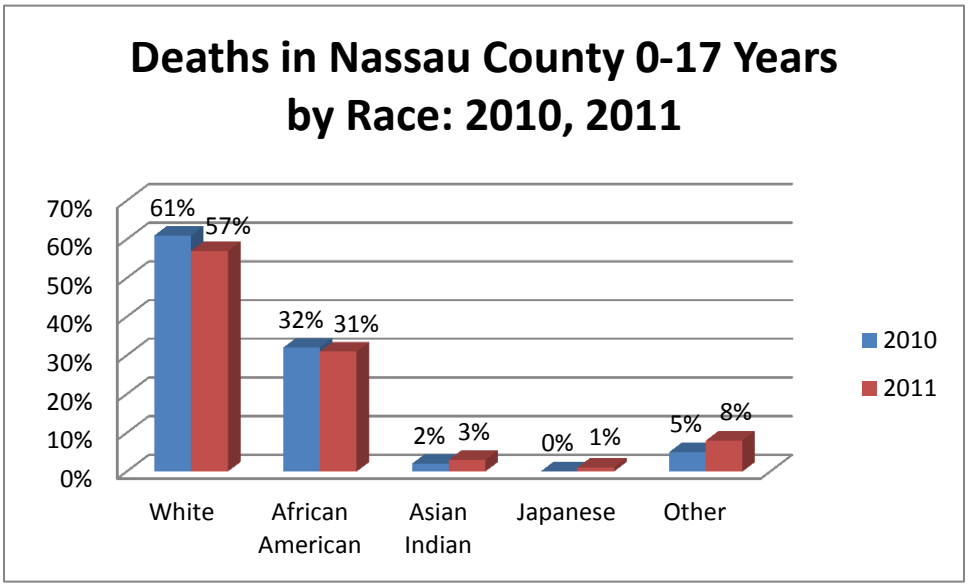
- As shown, the majority of deaths in both 2010 and 2011 occurred in children under the age of 1 year.

Figure 3: Deaths in Nassau County <1 Year of Age: 2010, 2011



- Almost half of the children that die under the age of 1 year, die within the first 24 hours.

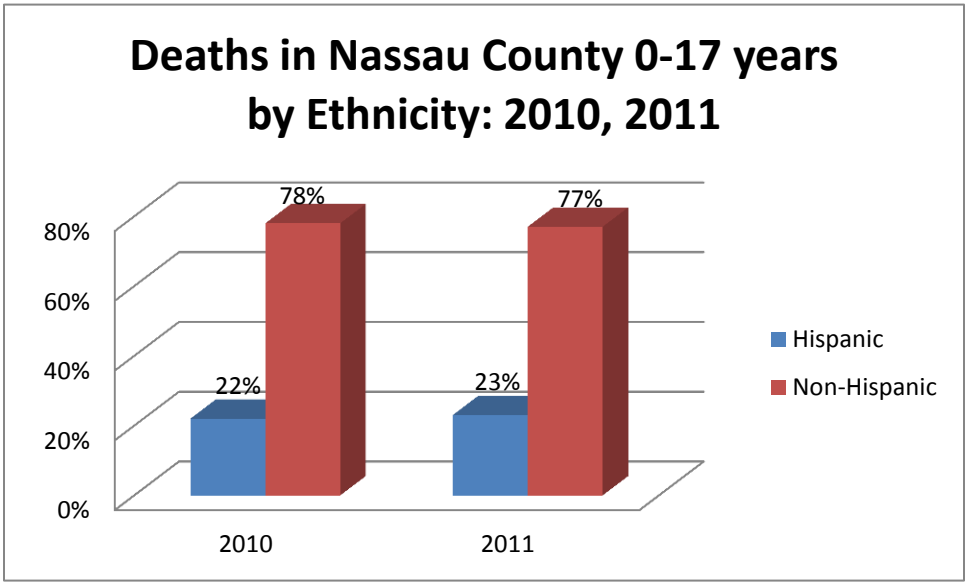
Figure 4: Deaths in Nassau County 0-17 Years by Race: 2010, 2011



- Note: Approximately 66% of Nassau County's population is Non-Hispanic White, 11% African American and 8% Asian/Pacific Islander[5]. Assuming the percentages hold true for 0-17 year olds, then the ~ 30% of deaths (0-17 years) that are African American shows disparity.

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

Figure 5: Deaths in Nassau County 0-17 Years by Ethnicity: 2010, 2011



- Approximately 15% of Nassau County's population identifies as Hispanic[6], and account for slightly more than 20% of the deaths.

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 2010, 42% of deaths in Nassau County under the age 18 years were residents of these communities. In 2011, 51% 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.

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

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

	2010	2011
Natural	75%	75%
Accident	8%	10%
Homicide	2%	0%
Suicide	2%	2%
Pending	14%	10%
Undetermined	0%	3%

- 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	2010 Number	2011 Number
Infectious and Parasitic diseases	2	2
Malignant Neoplasms	4	6
Diseases of the Blood	1	1
Endocrine, Nutritional & Metabolic Disorders	1	1
Diseases of the Nervous System	0	1
Diseases of the Circulatory System	4	5
Diseases of the Respiratory System	2	3
Diseases of the Digestive System	0	0
Certain conditions originating in the perinatal period	25	22
Congenital malformations, deformations and chromosomal abnormalities	9	9
Symptoms, signs and abnormal clinical lab findings not classified elsewhere	2	3
External causes of morbidity and mortality	9	8
Total	**59**	**61**

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

Note: Notable differences in numbers when compared to the NCCFRT 2009-2010 Summary Report will be noted within the text of this 2011-2012 Summary Report.

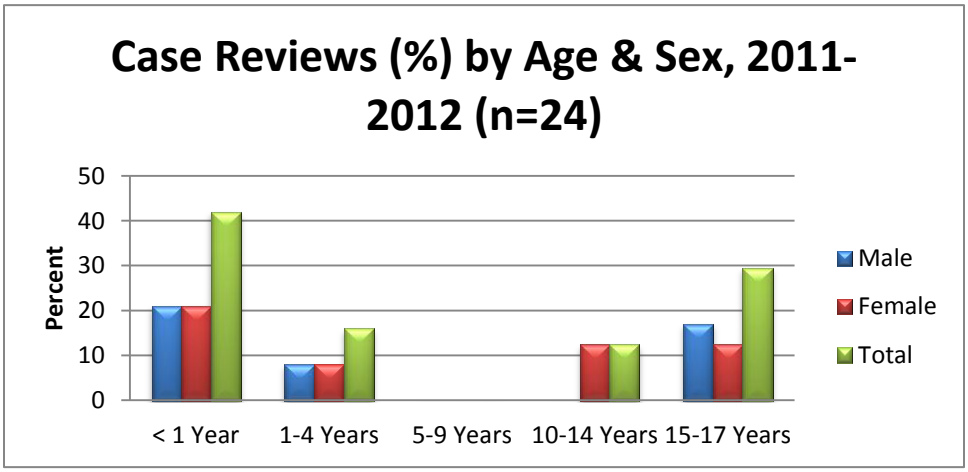
Demographics of Cases Reviewed

Keeping in mind the data presented above for Nassau County, we will now examine the data for the cases that the NCCFRT reviewed in 2011 and 2012. Table 3 shows the cases reviewed by year of death. Figure 6 shows the breakdown of the cases reviewed by age and sex for 2011-2012.

Table 3: Cases reviewed in 2011 and 2012 by year of death

Year of Death	Number of cases reviewed
2007	1
2009	3
2010	5
2011	12
2012	3
Total	**24**

Figure 6: NCCFRT Case Reviews by Age and Sex, 2011-2012 (n=24)



- 46% (n=11) of the deaths reviewed were male and 54% (n=13) were female. (Between 2009-2010, 56% of cases reviewed were male and 44% were female.)
- As shown in Figure 6, 42% (n=10) of the cases reviewed were under the age of 1 year, 16% (n=4) were between 1-4 years of age, 12.5% (n=3) were between 10-14 years and 29.5% (n=7) were between 15-17 years (similar findings between 2009-2010).
- Not shown: 54% (n=13) of cases reviewed were White, 33% (n=8) African American, 8% (n=12) Asian and 4% (n=1) were unknown. (Between 2009-2010, 82% were White, 15% African American).

- Not shown: 21% (n=5) of cases reviewed were Hispanic.
- Not shown: 38% of the cases reviewed were from the select communities.[7]

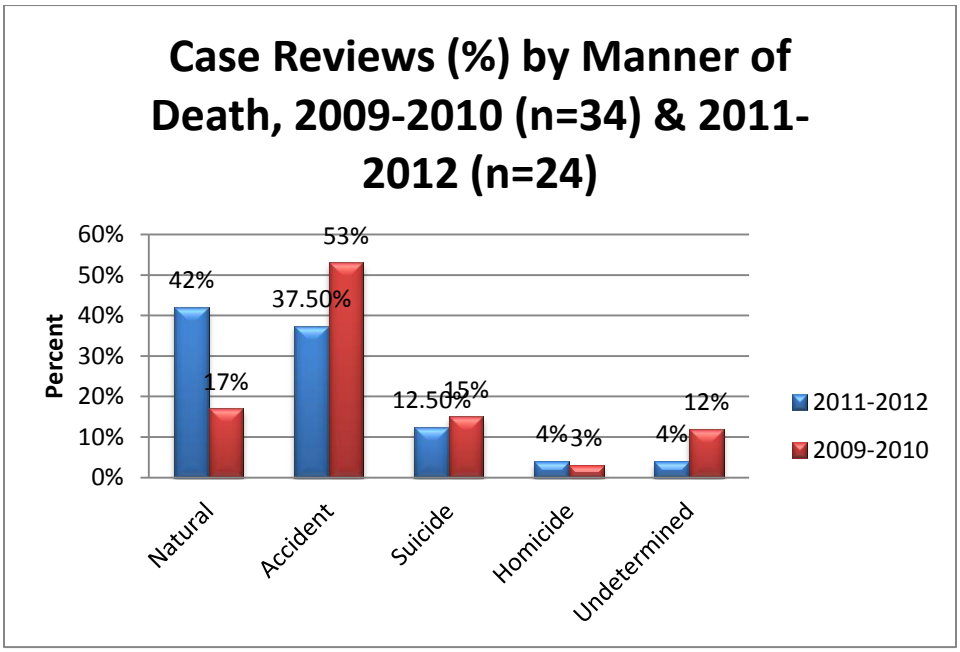
Manner and Cause of Death of Cases Reviewed

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. CFRT reviews all death certificates and identifies deaths that were unexpected/unexplained.

1. Manner of Death

Figure 2 shows the breakdown of cases reviewed by manner of death from 2011-2012 as compared to 2009-2010.

Figure 7: NCCFRT Case Reviews by Manner, 2011-2012 and 2009-2010



[7] 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.

- As shown above for 2011-2012: 42% (n=10) of the deaths reviewed were considered to be natural, 37.5% (n=9) accidental, 12.5% (n=3) suicide, 4% (n=1) homicide and 4% (n=1) were undetermined.
- When comparing 2011-2012 case reviews to 2009-2010 case reviews: More deaths considered natural were reviewed. For both time frames, natural and accidental deaths are the majority of cases reviewed.

Natural Deaths:

- Of the 10 natural deaths reviewed: 7 were under the age of 1 year; 2 of these were considered SIDS; all 7 infants were found unresponsive during a sleep period.
- The remaining 3 deaths in this category ranged from 12-16 years and were cardiac related.
- 60% (n=6) of the natural deaths were male; 40% (n=4) were female.
- 40% (n=4) of the natural deaths were White; 60% (n=6) were African American.
- 40% (n=4) were Hispanic.

Accidental Deaths:

- Of the 9 accidental deaths reviewed: 2 cases were under the age of 1 year; 3 cases were between 1-5 years; 4 cases were 15-17 years.
- 1 was due to electrocution, 2 were due to drowning, 4 were transport related, 1 was due to airway obstruction in an infant sleeping in adult bed, and 1 was secondary to scald burns.
- 56% (n=5) of accidental deaths were male; 44% (n=4) were female.
- 67% (n=6) of the accidental deaths were White; 11% (n=1) were African American; 22% (n=2) Asian.
- No accidental deaths reviewed identified as Hispanic.
- Of the 4 transportation related deaths: 2 were in a motor vehicle, 2 were pedestrian related.

Suicide:

- All 3 of the suicide deaths reviewed were female.
- Suicide methods used: 2 hanging; 1 train.
- Age range of the 3 suicides was 14-16 years.
- 67% (n=2) were White; 33% (n=1) was African American.
- None identified as Hispanic.
- Risk factors identified for suicide were:
    - Family issues: divorce, verbal abuse
    - Prior suicide attempt
    - Open CPS case
    - History of drug use

- History of mental illness: depression, obsessive compulsive disorder, anxiety, mood disorder

Homicide:

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

Undetermined Deaths

- One death reviewed was considered undetermined by medical examiner.
- This death involved an unsafe sleep environment of an infant.

2. Cause of Death

Transport Related Deaths:

- 6 transport related deaths were reviewed.
- 5 were considered accidents and 1 was considered a suicide.
- 66% (n=4) were White; 17% (n=1) African American and 17% (n=1) Asian
- None identified as Hispanic.
- 2 deaths involved trains; 2 deaths involved pedestrians and 2 deaths involved motor vehicles.
- Risk factors identified for pedestrian deaths:

    - dark clothing
    - crossing mid-block
    - alcohol use
    - crossing while distracted

- Risk factors identified for motor vehicle deaths:

    - improperly restrained child
    - drowsy driving
    - teen driver

Drowning Deaths:

- 2 drowning deaths were reviewed.
- Both were between 1-4 years of age.
- 1 was male, 1 was female.
- Risk factors identified:

    - broken gate
    - missing gate lock
    - 3-sided fencing
    - poor supervision

Infant Deaths:

- 38% (n=9) of all deaths reviewed occurred to infants (<1 year of age).
- 56% (n=5) were White; 44% (n=4) were African American.
- 33% were Hispanic.
- 56% (n=5) were female; 44% (n=4) were male.
- 67% (n=6) were considered natural; 22% (n=2) were considered accidents; 11% (n=1) was undetermined.
- 67% (n=6) involved unsafe sleep. All of these cases were determined by the team to involve a hazardous sleep environment, which places an infant at significant risk of suffocation or asphyxiation. A hazardous sleep environment includes (but is 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
    - Bed-sharing (with parent +/- sibling)
    - Maternal smoking history
    - Male gender
    - Tight swaddling
    - Poor supervision

Cardiac-Related Deaths

- 3 cases were reviewed whose death was due to cardiac causes.
- All 3 deaths were considered natural.
- All 3 were African American.
- 2 of the deaths involved myocarditis.
- Associated factors identified: No AED (not required by law at location); No CPR prior to emergency responders arriving.

Shaken Baby

- Due to the single review, further data is unavailable to be released.

Burns:

- Due to the single review, further data is unavailable to be released.

Department of Social Service (DSS) Involvement

- 62.5% (n=15) of cases reviewed had DSS involvement as indicated below. This is a large increase as compared to the 26% (n=9) of cases reviewed in the 2009-2010 time frame.
- Of these 15 cases:
    - 47% (n=7) were female; 53% (n=8) were male.
    - 53% (n=8) were White; 33% (n=5) African American; 13% (n=2) Asian/Indian.
    - 13% (n=2) identified as Hispanic.
- Age range: 3 weeks to 17 years
    - 47% (n=7) of cases were <1 year of age.
    - 20% (n=3) of cases were between 1-4 years of age.
    - 6.5% (n=1) of cases were between 10-14 years.
    - 26.5% (n=4) of cases were between 15-17 years.
- 73% (n=11) of cases were called into the State Child Register (SCR) at death
    - 33% (n=5) were indicated/substantiated for one or a combination of the following: Lack of Supervision, Inadequate Guardianship, Fatality
- 27% (n=4) had CPS involvement at some point;
    - 50% (n=2) indicated/substantiated
- 7% (n=1) had ongoing Preventive Services at time of death (also had an SCR report)

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 24 deaths reviewed by the NCCFRT during this time period, 58% (n=14) were considered to be preventable, as determined by majority vote, 4% (n=1) not preventable and 38% (n=9) preventability could not be determined.

- Of the 10 natural deaths reviewed, 10% (n=1) were considered preventable. (compared to 67% found to be preventable in 2009-2010 case reviews) ; 70% (n=8) were considered not preventable.
- Of the 9 accidental deaths reviewed, 100% were considered preventable.
- Of the 3 suicide deaths reviewed, 67% (n=2) were considered preventable and 33% (n=1) the team could not determine preventability.
- The 1 homicide death reviewed was considered preventable.
- The 1 undetermined death was considered preventable.

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.
- Improved communication between participating agencies has occurred due to case reviews.
- Improved collaboration between participating agencies has occurred due to case reviews.
- Professional training:

    - CFRT sponsored training with a national expert from the National Center for the Review and Prevention of Child Deaths: October 2011.

- Seminar held for DSS and DOH staff: Understanding Child Fatality: A Nassau Perspective.
- Based on case review findings, the team invited an adoption specialist from the State to discuss local regulations regarding public and private adoptions.
- Mandated Reporter education session for team members.
- Based on case review findings, the team invited an expert on Sudden Cardiac Arrest to educate the team.

- New Protocols and Procedures manual drafted and approved by team.
- New Memorandum of Understanding between the NCDOH and all team members approved and executed by team.
- Outreach to NYC medical examiner office to obtain autopsy report for Nassau cases that die in NYC.
- NCCFRT website created within the NCDOH website.
- Team continues to promote use of the SUIDI form by Police Department.
- Safety education materials given to Early Intervention program by intake providers to new families.
- Even though some of the deaths reviewed were not deemed preventable, there are lessons learned that can be applied to the community. For example: Parents and caretakers should understand infant/child developmental milestones in order to adhere to appropriate safety guidelines, including appropriate supervision.

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 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

Accomplishments

- OCFS safe sleep guidelines for day care reviewed by team. Recommendations for revisions were sent to OCFS to update policy to reflect AAP guidelines.[8]
- Team education on safe sleep from the NYC satellite office of the NYS Center for Sudden Infant Death.
- Posting bilingual safe sleep information in DSS waiting areas and on DOH website.
- 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

[8] 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.

developing leadership skills. The team members attended a training, participated in webinars and are working towards assessing safe sleep messaging in birthing hospitals.
- Health Department newborn mailings continue to include information on safe sleep for infants.
- 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 B for caregiver handout
- Doll reenactment for infant deaths.
    - A thorough description of the death scene provides valuable information to assist with identifying manner of death.[9]

- Create local Cribs for Kids chapter (Steps for this process have already been initiated) to distribute cribs to low-income families and provide safe sleep education.
- NLAPH team members will continue, in conjunction with the CFRT, to assess infant safe sleep messaging at local birthing hospitals.
- Professionals (i.e. newborn nursery personnel, physicians, nurses) should teach parents and child care personnel safe sleep practices and SIDS reduction strategies.
- Community leaders and policy makers should support safe sleep campaigns.
- 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.[10]
    - Wedges, sleep positioners and other products advertized 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.11

III. Choking Prevention

Accomplishments (Note that the choking cases were reviewed in 2009-2010)

[9] 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
[10] 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.
[11] 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.

- 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 the project to create a bilingual choking prevention poster was 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. The winning poster will now be a major piece of the Team's choking prevention campaign in Nassau.

Recommendations

- Food choking campaign with target to Hispanic community identified in reviews as being particularly at risk.
- The bilingual choking poster will be sent along with a choking prevention brochure and informational release to Nassau County pediatricians.

IV. Drowning Prevention

Accomplishments

- Three members of team participated in Long Island Drowning Prevention Task Force.
- Health Department newborn mailings continue to include information on drowning.
- Pool safety placards have been printed and are distributed as appropriate.

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 10/2011

Recommendations

- Photojournalism project for High School affected by pedestrian deaths.
- 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

Accomplishments

- The team was educated on teen suicide by the Long Island Crisis Center and the Office of Mental Health, Chemical Dependency and Developmental Disabilities Services.
- Informal survey of school districts about suicides prevention/postvention plans, crisis teams, policies, awareness presentations and trainings was conducted by the Office of Mental Health, Chemical Dependency and Developmental Disabilities was conducted.
- A letter was sent to all Nassau County Superintendents with current recommendations regarding suicide and development of a suicide prevention plan.
- Teen Suicide article submitted and printed in Mental Health News (May 2011).

Recommendations

- Parents and caregivers should know the signs that indicate a child is at risk for suicide. A extensive list can be found at: http://www.preventsuicideny.org/Warning_Signs.html

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 second such report that the NCCFRT has produced. It is meant to provide general findings of the 24 cases reviewed from 2011-2012, with comparisons to the 2009-2010 report when appropriate. 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 A

Nassau County Child Fatality Review Team: Team Members[12]

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 Office of Children and Family Services
Central Islip, 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.

[12] Agencies listed are the current 2013 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
Pediatric Critical Care & Trauma Departments
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 Serices
Uniondale, N.Y.

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

Nassau County Fire Marshal
Westbury, N.Y.

Nassau County Perinatal Services Network
Uniondale, 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.

Winthrop University Hospital
Department of Neonatology & 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

- Safe sleep brochure
- Choking prevention poster (English & Spanish)
- Choking prevention brochure
- Bath tub drowning brochure
- Pool drowning poster

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.
- Your baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.
- 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.
- 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.

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

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
106 Charles Lindbergh Blvd.
Uniondale, NY 11553

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.
- Su bebé no debe dormir solo ni acompañado en una cama de adultos, un sofá o una silla. Mantenga los objetos suaves, juguetes, protectores de cuna o ropa de cama suelta fuera del área donde duerme su hijo para 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, 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.

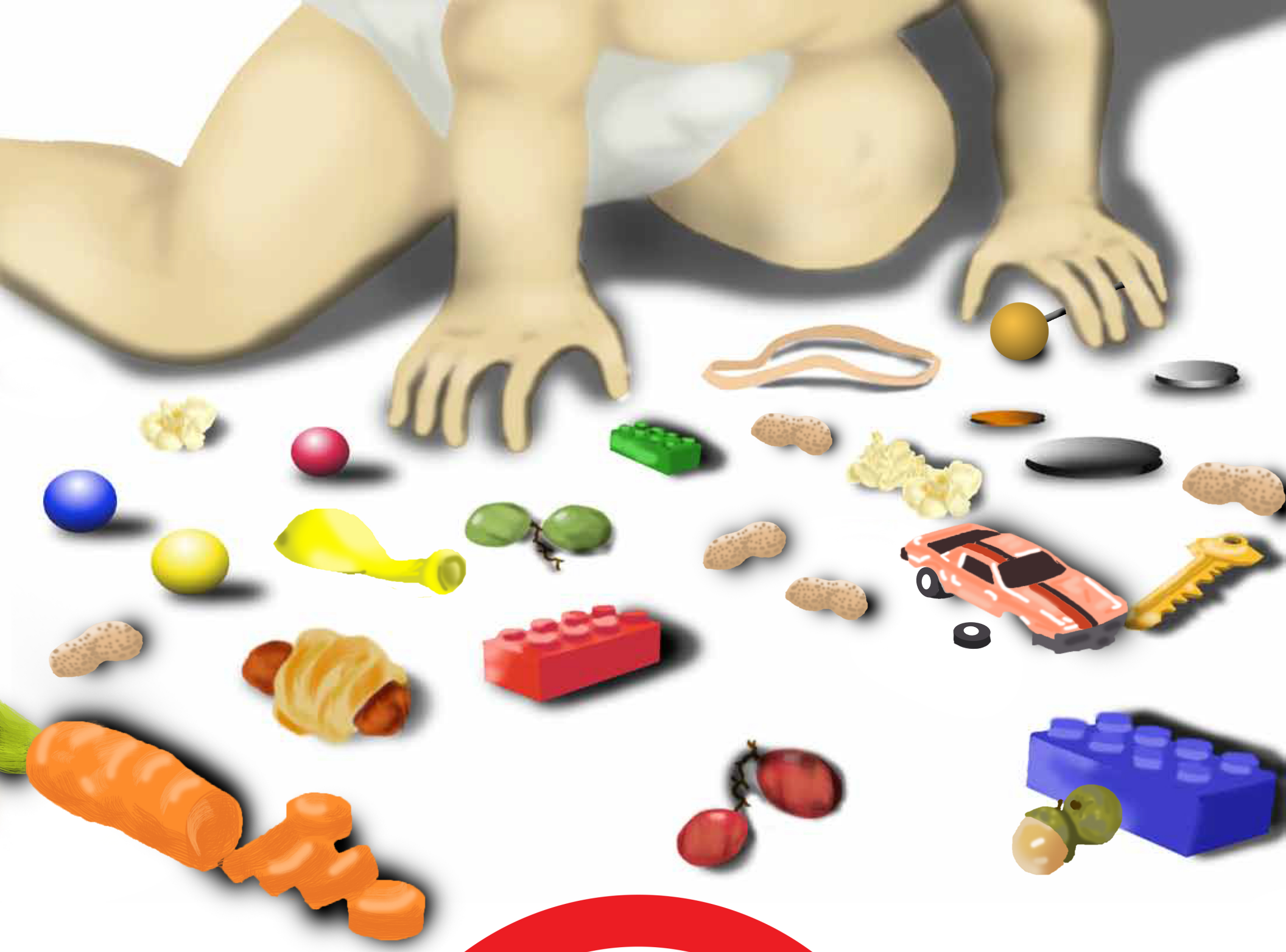
*Para obtener más información sobre las normas de seguridad de las cunas, llame gratis a la Comisión de Seguridad de Productos del Consumidor al 1-800-638-2772 (en español o en inglés) o visite su página electrónica en http://www.cpsc.gov.

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

NIH Pub. No. 12-5759(S)

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



Tener Cuidado con Juguetes y Comidas Peligrosas!

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.

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.

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

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

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

CHILD WATER SAFETY TIPS FOR ADULTS

- **NEVER** leave a child alone in the water... Always maintain visual contact.
- **NEVER** leave tempting objects such as floats or toys at poolside or floating on water surface.
- Research has shown that barrier devices such as **four-sided isolation fencing** can reduce the incidence of drowning among toddlers and young children.
- Keep chairs, stools, tables away from fences & poolsides.
- **ALWAYS** lock gates and remove ladders/steps when pool is not in use.
- Keep a phone at poolside for use in an emergency.
- **NEVER** rely on a flotation device as a substitute for constant supervision.
- Use pool alarms for short periods of time and cover pool when not in use for long periods of time.
- Door alarms, pool alarms and automatic pool covers, when used correctly, can add an extra level of protection.
- **IN AN EMERGENCY DIAL 911**. Follow the instructions of the operator. Do not hang up until you are told. **LEARN CPR AND EMERGENCY FIRST AID**.

WATER SAFETY TIPS FOR CHILDREN

- **NEVER** swim alone.
- **NEVER** dive headfirst into a pool or shallow water.
- **NEVER** run around pool area or wet surfaces.
- If you use flotation device, have an adult check it to make sure it fits properly.
- **NEVER** swim during a thunderstorm.
- **NEVER** push or hold another person underwater.
- Keep all glass bottles such as those used for soda, iced tea and fruit drinks away from the pool area.
- **IN AN EMERGENCY DIAL 911**. Follow the instructions of the operator. Do not hang up until you are told.
- **LEARN CPR AND EMERGENCY FIRST AID**.

Safe Kids NASSAU COUNTY LED BY North Shore LIJ

Funded in part by a grant from the New York State Office of Children and Family Services

(06/11)