Mississippi's Children. . .

Our Most Precious Resource

Mississippi Child Death Review Panel

2008 Annual Report

LETTER FROM THE CO-CHAIRS

Infant and child deaths are unique in the profound effects that they have upon individuals and communities. The deaths are all tragic, but those that could have been prevented are particularly so. Over the years, our state has made efforts to prevent and reduce infant and child mortality and morbidity; however, there have always been instances that remained largely unexplained. Preventing child fatalities requires further understanding of the causes and circumstances surrounding these deaths. It is to this task that the Mississippi Child Death Review Panel is dedicated.

The CDRP was established by House Bill 560, which became effective July 1, 2006. We have since met at least quarterly, with subcommittees meeting as necessary. The CDRP was given the specific duty of preparing an annual report to be submitted to the Chairmen of both the House and Senate Public Health and Human Services Committees. This report is written to display our findings and to make recommendations to legislators regarding policy additions and changes which would begin to reduce the number of infant and child deaths in our state.

This year's annual report also includes a factor that is paramount for legislators and others to see and become aware of – the number of **"preventable"** deaths. This data is listed at the top of each Cause of Death category and is highlighted in yellow. It serves as a reminder to us all that we CAN make a difference in the lives of our state's children. By educating parents, educators, caregivers and the general public about risk factors and safety issues - even when the education may challenge traditional habits and practices - we can and will make a significant impact on Mississippi's child mortality and morbidity.

Regarding preventability, the most glaring numbers are seen this year in the Cause of Death categories of *Motor Vehicle Accidents and Suffocation/Strangulation*. We are extremely grateful for the passage of the booster seat bill during the 2008 legislative session, but more vigilance is needed. As for Suffocation/Strangulation deaths, we ***strongly recommend*** the implementation of a statewide, state funded "Cribs for Kids" program. Above all, please note the recommendations on the corresponding pages as vital areas of opportunity to decrease the number of lives lost to these causes.

Mississippi's Child Death Review Panel remains committed to the simple, yet incredibly important goal of preventing child deaths in our state. Through public awareness, education, and prevention efforts via safety legislation, we intend to do just that.

Sincerely,

Tami H. Brooks, MD
Appointee, Speaker of the House

Jamie Adams Seale
Appointee, Lt. Governor

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STATE TEAM MEMBERS

Sam Howell	Mississippi State Medical Examiner's Office
Elizabeth Christ, MD	Past Chairman, Ex-Officio Member
Phyllis Epps	March of Dimes
Rex & Faye McCord	The Compassionate Friends
Cathy Files	Mississippi SIDS Alliance, Inc.
Leslie Threadgill	Mississippi SIDS Alliance, Inc. *(Ad Hoc Member)*
Judy Moulder	Mississippi State Department of Health – Office of Vital Statistics
Steven Bigler, MD	University of Mississippi Medical Center – Pathology Department
Dedria Mitchell	UMC Morgue Services Manager *(Ad Hoc Member)*
Tami H. Brooks, MD	Appointee – Speaker of the House
Sheriff Tim Perkins	State Sheriff's Association
Chief Jimmy Houston	Mississippi Police Chief's Association
Anita Bell-Mohammed	Department of Human Services
Patti Marshall, JD	Attorney General's Office
Jamie Adams Seale	Appointee – Lieutenant Governor
Lynn Walker, MD	American Academy of Pediatrics
Lonnie Weaver	State Coroner's Association
Vacant	Children's Advocacy Center
Hazel Gaines, MS, RN	Child Death Review Panel Coordinator, MS State Department of Health
Gloria Salters	Attorney General's Office
Stephanie Baskin	State Medical Examiner's Office
Diana Joiner	State Medical Examiner's Office
Dr. Scott Benton	UMC Children's Justice Center *(Ad Hoc Member)*

PREFACE

There were 765 children under the age of 18 who died in Mississippi from January to December 2007. While each one of these deaths leaves a terrible void, each one also provides a powerful opportunity to serve as a warning to other children at risk. To better understand how and why these children died, the CDRP maintains statistical data on child mortality. Ultimately, it is our goal to identify deaths that may be preventable in Mississippi in years to come.

This report is a compilation of Review team meetings where members have volunteered their time to sift through death certificates, toxicology reports, autopsies, death scene investigations, etc. These are our intentions: 1) to identify factors that put children at risk of injury or death; 2) to share information among agencies that provide services to children and families or that investigate child deaths; 3) to improve local investigations of unexpected/unexplained child deaths; 4) to improve existing services and systems while identifying gaps in the community that require additional services; 5) to identify trends relevant to unexpected/unexplained child injury and death; and 6) to educate the public about the causes of child injury and death while also defining the public's role in helping to prevent such tragedies.

In 2008, we were grateful for the passage of legislation that allowed our group to move from the State Medical Examiner's office to the Department of Health. As a result of this move, we also gained vital funding for a part-time Coordinator housed in the DOH. In July, we saw the passage of our state's first booster seat law. We are confident that this passage, over time, will decrease the number of Motor Vehicle deaths in children ages 7 and under. We are extremely pleased with the increase in funding to the Medical Examiner's office, *as it is and has been* our belief that with proper direction and management at that level, the CDRP will receive much more viable data to review and learn from. As Ron Burleson, Director of the Alabama Child Death Review, stated, ***"You cannot change what you cannot measure."***

The 2008 CDRP Annual Report presents key findings from the review team and from Mississippi's child mortality data. It also makes recommendations that can help prevent unexpected/unexplained child deaths. Thus, this report honors the memory of all those children who have died in Mississippi. We hope that it leads to a better understanding of how we can all work together to make our state a safer and healthier place for children.

DEFINITIONS

Cases that meet the criteria for review: These are cases involving the deaths of Mississippi resident infants and children from birth to less than 18 years of age whose deaths are considered unexpected or unexplained.

Cause of death: As used in this report, the term "cause of death" refers to the underlying cause of death. The underlying cause of death is the disease or injury/action initiating the sequence of events that leads directly to death, or the circumstances of the accident or violence that produced the fatal injury.

Reviewed Cases: This term includes those cases that were reviewed by the responsible CDRP subcommittee.

Manner of Death: This is one of six general categories (Accident, Homicide, Suicide, Undetermined Circumstances, Pending Investigation, or Natural Causes) that is found on the MS Death Certificate.

Natural Causes: A manner or cause of death by other than external means (the expected outcome of a disease, birth defect, or congenital anomaly). The CDRP normally will not review such cases. However, many cases in which the cause of death is initially classified as "Pending" or "Undetermined/Unknown" are later discovered to have been death by "Natural Causes." This is why there are so many in this category included in our data. Sudden Infant Death Syndrome (SIDS) is considered a natural cause of death, but our teams are required by law to review all SIDS and SUIDS deaths.

Unexpected/Unexplained: In referring to a child's death, this category includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, other agents, or SIDS.

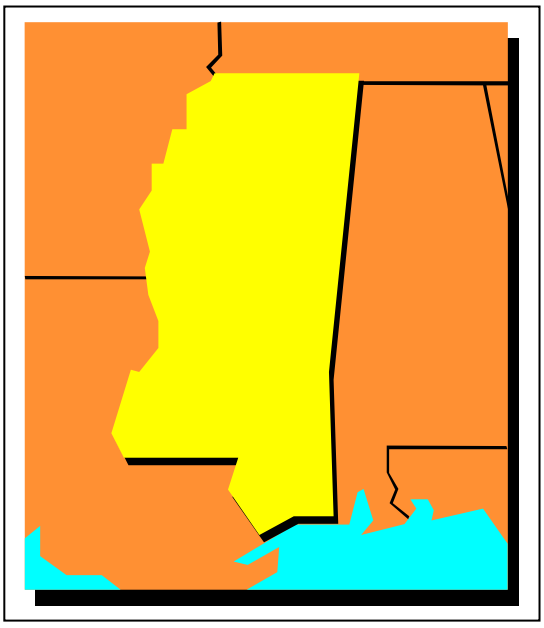
CMEI: County Medical Examiner Investigator

OVERVIEW

- There were 765 infant and child deaths (under the age of 18) in 2007, an increase of 20 children compared to 2006 data.
- 382 cases met the criteria for review, 102 of which were found to be of Medical/Natural causes.
- 77% of all non-medical child deaths were in the following Cause / Circumstance categories: Vehicular, SIDS, Suffocation/Strangulation, or Firearm.
- **41% of all non-medical child deaths were infants under the age of 1.**
- 64% of the non-medical deaths reviewed were male children.
- No significant racial or ethnic disparities were noted: 49% of deaths reviewed were African Americans, 49% were White, and 2% were of other races.
- Increases in Cause /Circumstance of death were most notable in the **Firearm category**. This category grew from 18 deaths reviewed in 2006 to 26 deaths in 2007, ***an increase of 44%.***
- Drownings decreased from 15 cases reviewed to 10 cases, a decrease of 33%.

Top 10 Counties of Residence for Child Deaths Reviewed

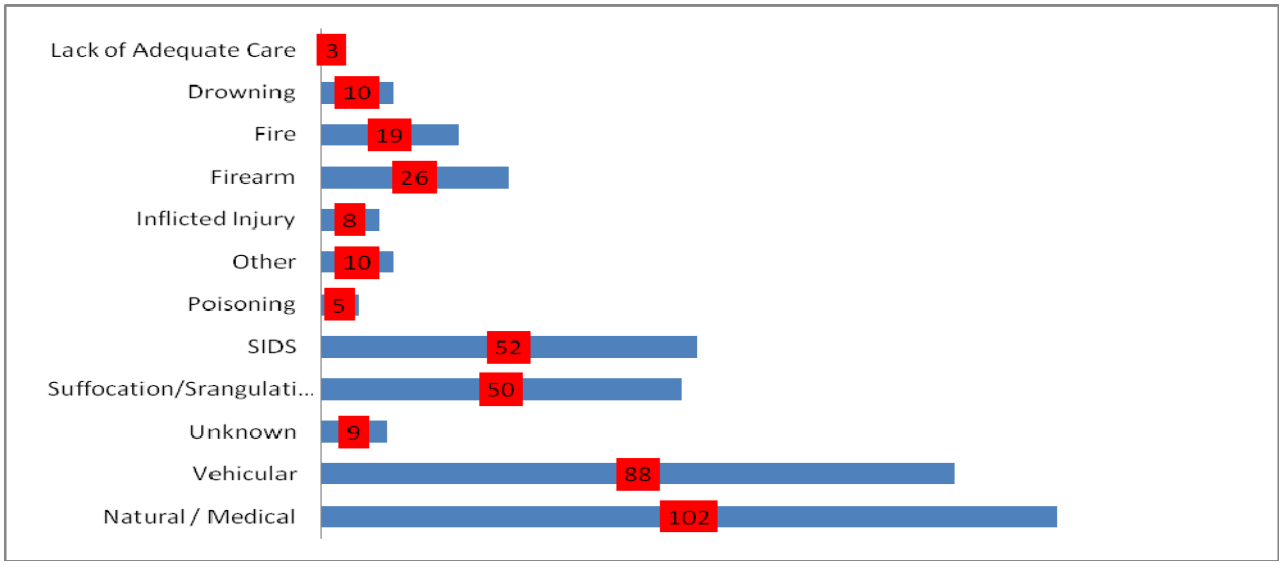
1. Hinds County – 24 Deaths
2. Rankin County – 16 Deaths
3. Desoto County – 13 Deaths
4. Forrest County – 12 Deaths
5. Jackson County – 11 Deaths
6. Harrison County – 10 Deaths
7. Lauderdale County – 10 Deaths
8. Lee County – 7 Deaths
9. Jefferson Davis County – 6 Deaths
10. Jones County – 6 Deaths



CAUSE vs. MANNER OF DEATH

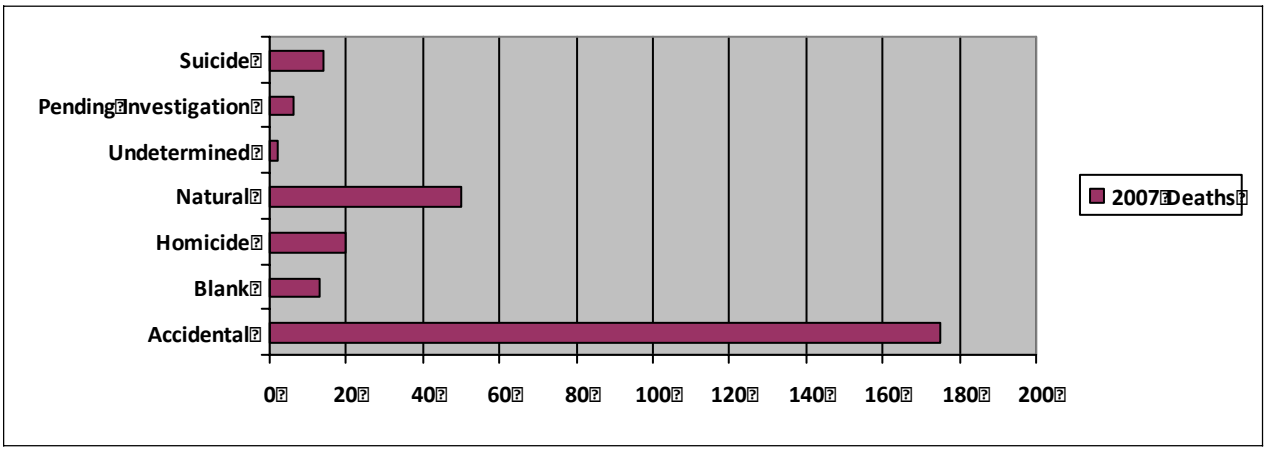
Cause of Death refers to the underlying cause of death. This underlying cause of death is the disease or injury/action initiating the sequence of events that leads directly to death, or the circumstances of the accident or violence that produced the fatal injury. Cause of Death information is reviewed from multiple sources including the MS Death Certificate.

The following graph shows the cause of death in all reviewed cases:



Manner of Death is one of the six general categories that are used by the CDRP to group deaths. They are: Accidental, Blank (not listed), Homicide, Natural, Not Determined, and Suicide. As you can see, the vast majority of all child deaths in our state are accidental, thereby ***largely preventable*** deaths.

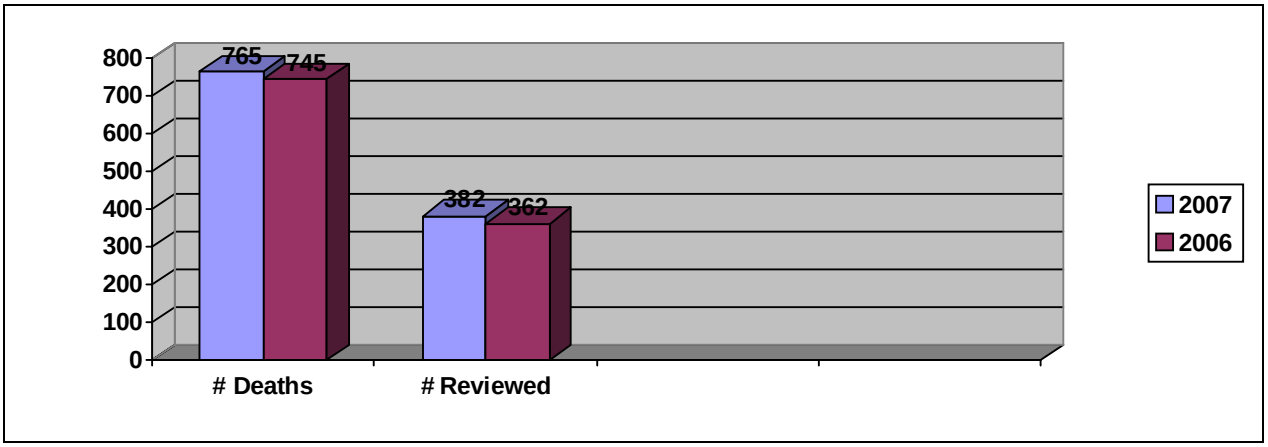
The following graph shows the manner of death in all reviewed cases:



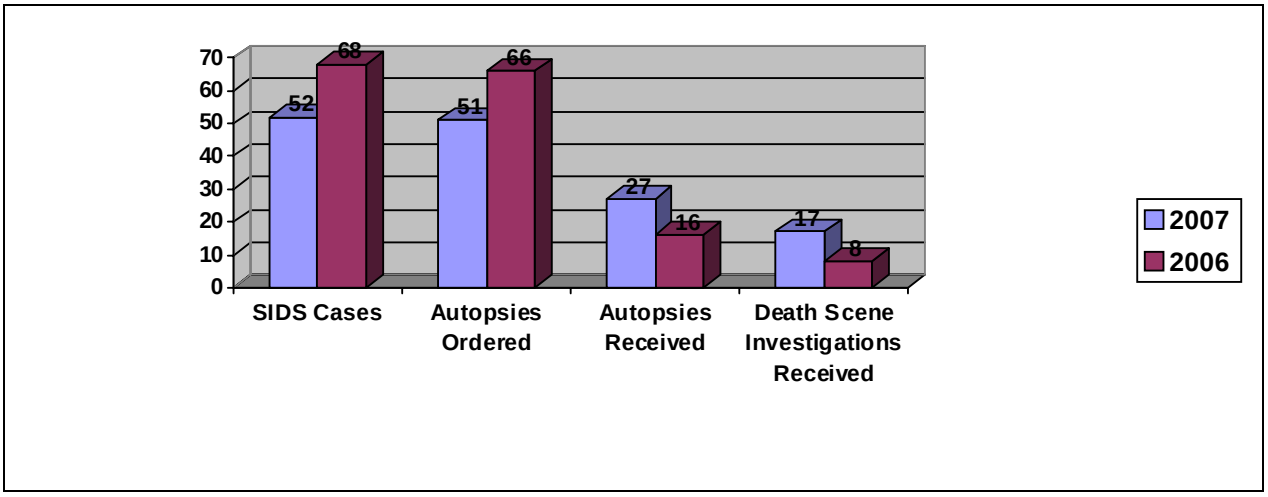
THE REVIEW PROCESS

Since inception, the Child Death Review Panel has been party to a very large learning curve. As our first Chairperson, Dr. Elizabeth Christ wrote bylaws and gave our group direction based on national guidelines of the Child Death Review process. We had an increase of 20 child deaths from 2006 to 2007, and we also increased the number of cases reviewed. It is our goal to review as many as possible - as thoroughly as possible – focusing especially on those deaths that are preventable.

The following chart show the number or deaths in 2007 and 2006 vs. the number reviewed:



Though we believe that progress is being made, we are still plagued by an overall lack of viable and meaningful data. We remain hopeful that as the system of payment for timely Death Scene Investigation reports is implemented, there will be a marked increase in the number of reports completed by CMEIs. *(CMEIs are **required by law** in our state to complete these reports for all SIDS cases, and the county coroners are now receiving **additional compensation** of $100 (HB 1523) for getting this information to the State Medical Examiner's office in a **timely** manner.)* As the chart below indicates, information is still greatly lacking from CMEIs in our state in spite of the legal mandate.



MOTOR VEHICLE ACCIDENTS

88 deaths
85 preventable

Key Findings:

- Over 1/3 of MVA victims were unrestrained
- 67% of all vehicular deaths were male children
- Restraint usage was undetermined in 20% of the cases due to lack of information
- **40 of the 88 deaths were in children ages 15 to 17 years old (45%)**
- 31 deaths were drivers, 40 were passengers, 11 pedestrians, 1 unknown, and 5 "other"
- 40 children were traveling in a car prior to death, 5 were in an SUV, 17 in a truck or RV, 5 cases were ATV related, 1 was go-cart related
- 96.6% of all MVAs were accidental
- Drivers were impaired in 5 cases, another violation was made by the vehicle operator in 7 cases, and speed or recklessness was cited in 16 cases
- Only 1 of the 6 ATV/go cart victims was known to be wearing a helmet

Recommendations:

- Continue to educate the public regarding highway safety, use of restraints, and ATV safety, especially targeting young drivers. ***(See Addendum 1)***

- Consider promoting the passage of graduated licensing legislation.

- Continue to enforce current legislation mandating booster seats for all children under 80 lbs. and 7 years of age or younger, including thorough enforcement of ***all*** seatbelt statutes.

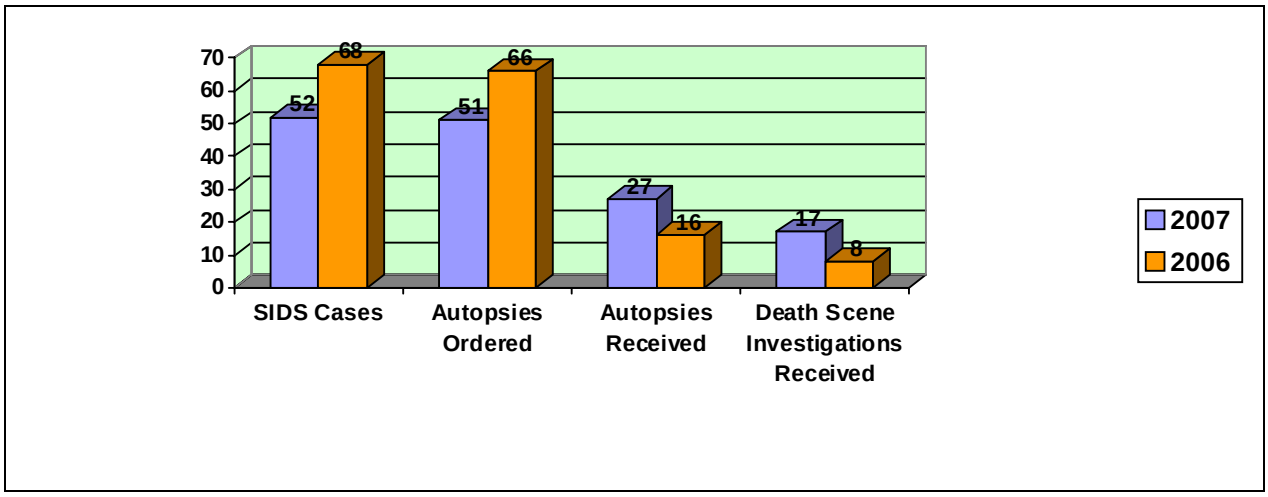
- Consider mandating ATV safety courses with the purchase of a new vehicle. 4-H groups offer free safety courses, as well as ATVsafety.gov. Owners simply type in their zip codes and are then routed to the closest ATV safety course.

SUDDEN INFANT DEATH SYNDROME 52 deaths

Key Findings:

- 52 infants were classified as SIDS compared to 68 in 2006, a decrease of 24%
- 26 were African American, 24 were White, 1 American Indian, and 1 Bi-Racial
- 28 infants were male, 24 female
- Upon discovery, 10 babies were on their backs (as recommended by the American Academy of Pediatrics), 14 were on their stomachs, and 27 were unknown regarding position
- 13.5% of infants had a smoker in the household, 23% did not, and 64% were unknown
- Though MS law **mandates** that infant death scene investigations be performed on ***all*** suspected SIDS cases and reported to the State Medical Examiner's office, there still remains a significant lack of information available for CDRP review.

In support of this statement, please refer to the following table:



SUFFOCATION / STRANGULATION

50 deaths
45 preventable

Key Findings:

- 88% of the deaths reviewed in this category were babies under 12 months of age
- At least 40 of the 50 deaths (80%) were the result of co-sleeping (rollovers) or were sleeping in an unsafe sleep environment
- 45 of the suffocation/strangulation cases (90%) were reported as accidental, 2 were homicide, 1 was undetermined, and 2 were suicide
- 4 of the 31 were due to "other" unsafe sleep environments, ex. Infant's head was wedged between the seat cushion and recliner

Recommendations (SIDS and Suffocation/Strangulation):

- Begin an unprecedented public education campaign regarding strategies proven to reduce the risk of SIDS and support existing programs aimed at SIDS awareness and reduction.
- Greatly increase public awareness about the dangers associated with infants sleeping in adult beds and other unsafe sleep environments. ***(See Addendum 2)***
- Financially support the "Cribs for Kids" program which has been shown to decrease rollover occurrences by 50%. ***(See Addendum 3)***
- Continue to educate the CMEI on completing death scene investigations as required by law.
- Require that autopsies of suspected SIDS cases be performed by or in consultation with a pediatric pathologist with expertise in SIDS.
- Continue to provide funding for advanced training in child death scene investigations for CMEIs.

Looks can be deceiving! The infant pictured here is actually in a very unsafe sleep environment due to the following factors: The infant is sleeping on his stomach, not back, too many surrounding objects posing a risk of suffocation, i.e., blankets, pillow, stuffed animals, etc.

DROWNING

10 deaths
10 preventable

Key Findings:

- 6 of the 10 drownings occurred in children under the age of 5 years old
- 9 children were male, 1 was female
- 4 children drowned in a creek, river, pond or lake
- 4 children drowned in a swimming pool
- 2 children drowned in a bathtub

Recommendations:

- Support public education and awareness campaigns about water safety, placing special emphasis on the need for constant adult supervision.
- Encourage the use of floatation devices when in and around open bodies of water.
- Persuade communities to seek ways to make swimming lessons and water safety classes more readily available to children and parents – especially when children are under age 5.
- Utilize the "Risk Watch" program provided by Mississippi's Emergency Medical Services for Children (EMSC) regarding water safety. ***(See Addendum 4)***

FIREARM / WEAPON RELATED

26 deaths
16 preventable

Key Findings:

- 21 of the 26 child deaths due to firearms reviewed (81%) were to teenagers, 15 to 17 years old
- 22 deaths (85%) were male, and 4 deaths (15%) were female
- 16 cases were African American (62%), and 10 were White (38%)
- 8 cases were ruled Homicides (31%), 9 were Suicide (35%), 7 were Accidental (27%), and 1 could not be determined with data provided the CDRP
- 50% of all deaths occurred in the child's home
- 42% of the deaths occurred with the decedent as the gun handler
- **In at least 42% of the deaths, the decedent's home was the source of the firearm**
- Handguns were used in12 cases (46%), a Rifle or Shotgun was used in 11 cases (42%), and 3 cases could not be determined with data provided the CDRP

Recommendations:

- Encourage gun safety education for youth and parents.
- Encourage community based violence prevention programs.
- Use current "McGruff Gun Safety" educational materials available for use from local Police Departments – especially focusing on those at risk. ***(See Addendum 5)***
- Support education on the warning signs for suicide, and widely publicize intervention strategies and helplines like **(800) 273–TALK** (the National Suicide Prevention Crisis Line) before it is too late. ***(See Addendum 6)***

INFLICTED INJURY

8 deaths
5 preventable

Key Findings:

- 4 of the deaths (50%) were children aged 3 or under, 4 deaths (50%) were teenagers 15 to 17 years old
- 3 cases (38%) were ruled Homicide, 3 were Suicide (38%), and 2 were Accidental
- **Injuries occurred at the child's residence at least 63% of the time**
- 6 children were white, 2 were African American
- 6 children were male, 2 were female

Recommendations:

- Widely publicize the National Suicide Prevention Hotline number **(800) 273-TALK** in an effort to offer interventional services to children considering taking their own lives.
- Continue to support educational and awareness opportunities regarding child abuse prevention.
- Widely publicize **(800) 222-8000** as the Child Abuse Hotline # for parents or caregivers in crisis.
- Support the recommendations of Mississippi's Youth Suicide Prevention Council.

FIRE / BURN

19 deaths
17 preventable

Key Findings:

- **68% of all deaths in this category were children 3 years old and younger**
- 13 children were African American, 6 children were White
- 7 children (37%) died while in trailers, 1 was in a wood frame home, and 11were unknown relative to what type of building burned
- A space heater was the ignition source of 6 of the 19 deaths, faulty electrical wiring was the source of 3 deaths, a stove or other appliance was the source of 2 deaths, and 8 cases lacked sufficient information for the CDRP to make a finding
- It is unknown whether smoke alarms were present or sounded in 16 of the 19 cases
- At least 4 of the children were unsupervised at the time the fires occurred

Recommendations:

- Encourage the use of the MS State Department of Health's Mobile Fire Safety House in all Elementary school settings. The MS Emergency Medical Services for Children has developed a Fire Safety Program. The Fire Safety Program includes using a two-story mobile unit that simulates a house, equipped with heated doors, smoke alarms, and a fire escape ladder. Children are taught drills, smoke alarm use and maintenance, and the proper way to exit a burning house. ***(See Addendum 7)***
- Encourage enforcement of laws governing smoke detector installation, testing, and inspection in all homes, including new and used manufactured homes, focusing also on non-owner occuppied and rental dwellings.
- Offer incentives to local fire departments for developing, expanding, and/or implementing fire education activities, particularly for elementary schools and other child care facilities.
- Encourage community education efforts about the need for installation and periodic testing of smoke detectors in homes, businesses, and places of worship.
- Explore the effects of fire safety grants such as the almost $500,000 federal grant awarded to the MS State Fire Marshal's Office. This grant is to be used to provide free smoke alarms to approximately 10,000 households at or below the poverty level. With timely and appropriate use of these dollars, we hope to see a great decrease in the number of child deaths associated with fires in our state. We also recommend obtaining similar grants to promote fire safety and fire prevention strategies. ***(See Addendum 8)***

POISONING / DRUG OVERDOSE

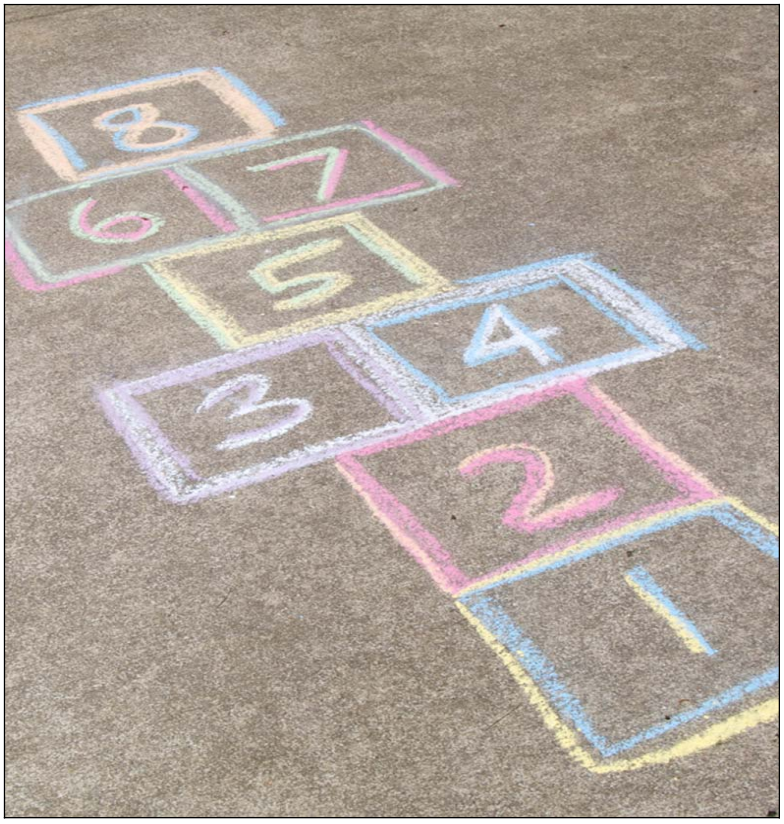
5 deaths
4 preventable

Key Findings:

- 1 infant death was under the age of 1, and 4 children were teenagers 14 or older
- All 5 children were male
- 4 cases were Accidental, and 1 is pending investigation

Recommendations:

- Encourage education and awareness of Poison Prevention Programs.
- Utilize "Watch Out" and "Risk Watch" Programs provided by the Department of Health's Emergency Medical Services for Children Division – a free comprehensive safety and injury prevention curriculum available to all children and youth in our state. ***(See Addendums 4 & 9)***



OTHER CAUSES NOT LISTED

10 deaths
4 preventable

Key Findings:

- 4 cases were accidental deaths, 1 homicide, 4 natural, and 1 unknown
- 8 of the 10 cases were children age 2 or under
- Deaths Scene reports were only received in 3 of the 10 children's deaths
- Autopsy reports were only received in 4 of the 10 children's deaths

Recommendations:

- Continue to encourage education and awareness of injury prevention strategies, placing special emphasis on the need for adult supervision in young children.

LACK OF ADEQUATE CARE

3 deaths
1 preventable

Key Findings:

- This is a new category for Cause of Death reporting purposes in 2007
- All of the children in this category were age 1 or younger
- 1 death was Accidental, 1 was ruled Homicide, and 1 was Blank
- Autopsies were performed in all 3 cases
- In 2 of the 3 deaths, there was an “apparent” lack of adult supervision
- In 1 of the 3 cases, there was an “apparent” lack of medical care due to neglect
- 1 child died due to heat stroke, 1 was left in a car parking lot, and 1 died of malnutrition and dehydration

Recommendations:

- Continue to educate the public on resources available to parents and caregivers in crisis.
- Educate the public on safe places to take babies that are newborn when parents cannot take care of them sufficiently.
- Continue to stress to the public the importance of adult supervision at all times for infants and young children.
- Educate the public by making the child abuse helpline #s available so that intervention is possible before it is too late.

LEGISLATIVE RECOMMENDATIONS

As members of the Child Death Review Panel, and with the best interest in the health and welfare of our state's children, we support the following upcoming legislation for the 2008 session:

1. Financially support the Child Death Review Panel through the Mississippi State Department of Health to allow greater strides in the reduction of child deaths in our state. .

2. Support an aggressive public education campaign regarding co-sleeping and injury prevention strategies for Mississippi's children.

3. Financially support the "Cribs for Kids" program through the Mississippi SIDS Coalition as it has been shown to reduce rollover deaths due to co-sleeping by 50%. **See Addendum #3**

4. Promote the utilization of programs targeting comprehensive injury prevention education which is currently available through Mississippi's Emergency Medical Services for Children (EMSC). **See Addendum #9**

5. Support legislation to alert the public of the importance of ATV safety in children. These courses are provided by local 4-H groups and the national ATV safety website www.ATVsafety.gov.

6. Advance efforts to pass graduated licensing legislation.

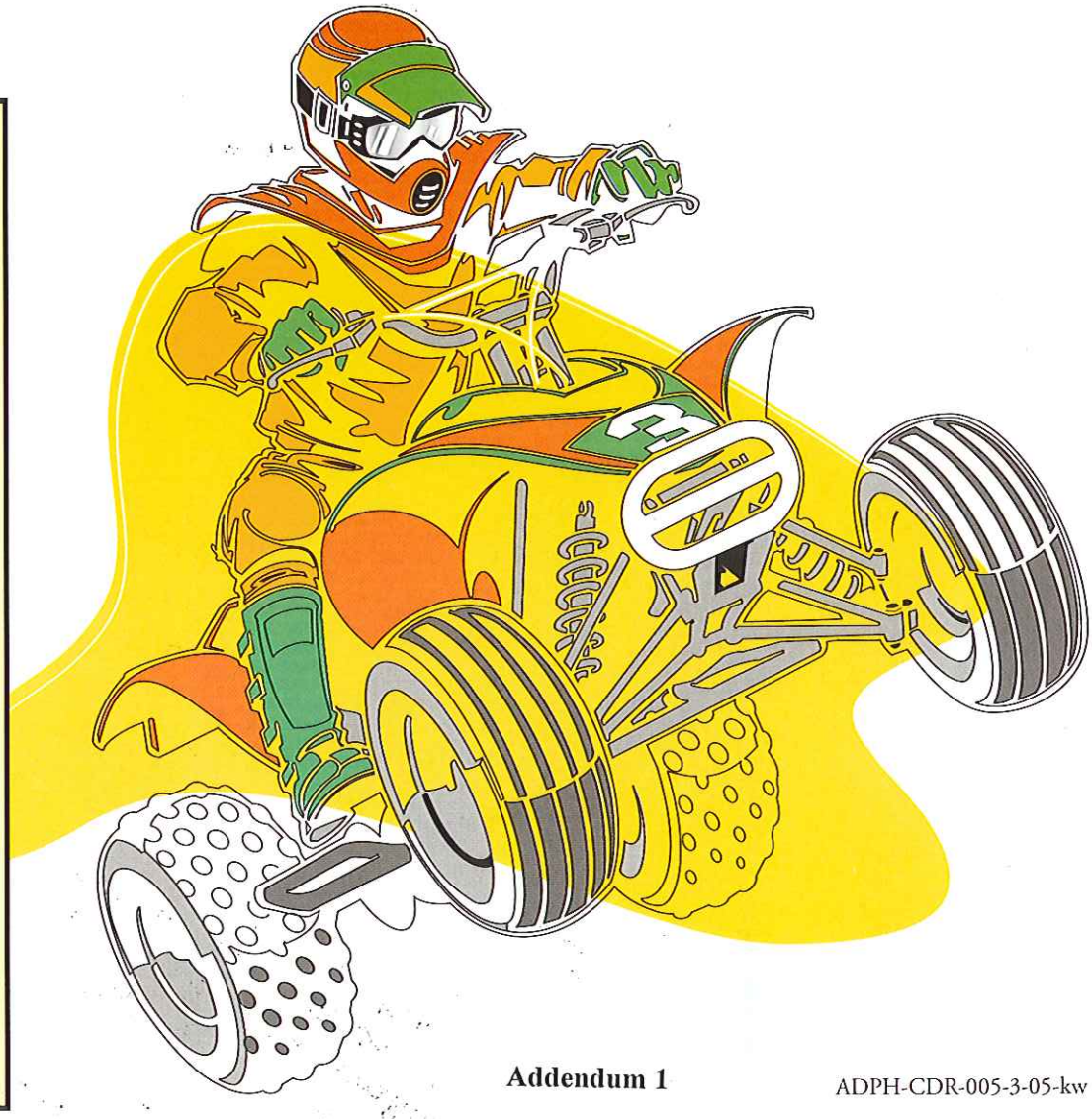
All Terrain Vehicles (ATV's)

Did you know that...

- **ATV's come in all sizes** – from small and cute, to big and powerful?
- **ATV's can be dangerous** and **require considerable skill** to operate safely?
- it's **against Alabama Law** to operate an ATV on public roads?
- unfortunately, neither an **operator's license nor a safety course graduation are required** prior to operating an ATV in Alabama?
- **appropriate safety equipment**, such as a helmet, knee/elbow padding, and suitable clothing **can help protect you** while riding an ATV?
- since January 2000 the Alabama Child Death Review System has reviewed at least **20 ATV related infant and child deaths**? Of these…:
  - sixteen had **operators 16 years old or younger!**
  - at least **4 deaths occurred to a "passenger"** on the ATV!
  - **"passenger" fatalities** ranged in age from **10 to 2 years old!**
- **your Local Child Death Review Team wants you to know** of these dangers!

What does all this mean?

- ATV's are not TOYS! Regardless of size they can be very dangerous.
- At the very least, don't let unsupervised children ride on or operate an ATV – regardless of the size of the ATV!
- Always require ATV operators to wear appropriate safety equipment.
- Never allow children to ride as passengers on an ATV.
- Always require children to complete an approved ATV safety course prior to allowing them to operate an ATV (solo or supervised)!



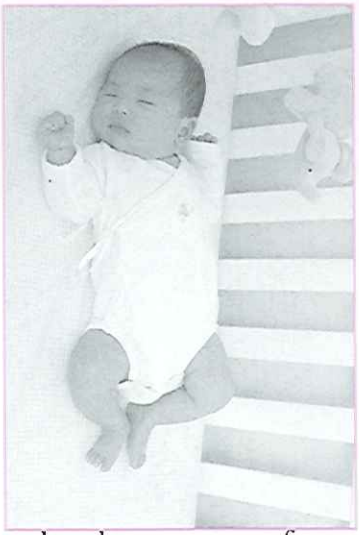
Addendum 1

Addendum 2

Safety for Sleeping Babies

Decisions, Decisions... Where to Sleep?

- A crib that conforms to the safety standards of the *CPSC is the desired sleeping environment for your baby.
- The American Academy of Pediatrics recommends a separate but proximate (in the same room) sleeping environment.
- You may also choose to put the baby's crib in her/his room.
- Sometimes mothers who breastfeed fall asleep with their baby in their bed. Some parents will choose to sleep with their baby in bed with them. Experts do not agree on the potential benefits of sharing a bed with your baby. Experts do agree, however, that there are many factors that can make sharing a bed with your baby unsafe (see "The Dangers of Sharing a Bed With Your Baby").



* Consumer Product Safety Commission

Sleeping Position Safety Recommendations!

BACK TO SLEEP:

- Always place your baby on her/his back to sleep (unless you are instructed not to for other health reasons by your baby's doctor).
- Avoid putting your baby on his/her side or stomach because this increases the risk of Sudden Infant Death Syndrome (SIDS).
- The use of special devices such as wedges and cushions when positioning your baby is NOT recommended.
- Remember to put your baby on her/his tummy ("tummy time") while awake and supervised.
- Consider offering a pacifier at nap time and bedtime.

Never smoke or allow anyone else to smoke in the car, house or anywhere else your baby will be!

Instructions For a Baby-Safe Bed.

Your baby's bed should have:

- Railings that are no more than 2 3/8 inches apart (you can't fit a soda can through them);
- A firm mattress that fits snugly in the frame;
- A fitted sheet that is tight around the mattress;
- No quilts, comforters, duvets, heavy blankets, stuffed animals, bumper pads, sheepskins, etc.

Also keep in mind:

- Make sure your baby's head and face remain uncovered during sleep.
- Do not let your baby get overheated.
- Keep the room temperature comfortable for a lightly clothed adult.
- Your baby should be in a one-piece sleeper with nothing over her/him.
- If it's cold, layer the baby's clothing (for example, add a tee-shirt and socks under their sleeper) and use only a light receiving blanket, if necessary.
- Avoid commercial devices marketed to reduce the risk of SIDS.
- Do not use home monitors as a strategy to reduce the risk of SIDS.
- Assure that others caring for the infant (child care provider, relative, friend, babysitter) are aware of these recommendations.

Based on the Recommendations Provided by the American Academy of Pediatrics (November 2005)

Sudden Infant Death
Network of Ohio

Providing Support,
Compassion, Education and Research

"Back to Sleep" & "Cribs for Kids" Campaigns

Since 1992, the SID Network of Ohio has been at the forefront of promoting the "Back to Sleep" Campaign. This national campaign has been successful in reducing SIDS rates by 50% over the past ten years. In addition to *Placing babies on their backs to sleep, on a firm crib mattress,* the campaign stresses:

Bedding- Making sure the baby sleeps on a firm crib mattress, not on soft surfaces such as sofas, cushions, waterbeds or sheepskins. Remove soft, fluffy and loose bedding and stuffed toys from the baby's sleep area
Temperature-Keeping the temperature in the baby's room between 68 and 70 degrees
Smoke-free environment- Making sure no one smokes around the baby
Doctor or clinic visits- Making sure the baby receives immunizations
Prenatal Care- Making sure mothers receive early and regular prenatal care, including the elimination of alcohol or drugs during pregnancy
Breastfeeding- if possible

According to the Ohio vital statistics, like most other states in the country, Ohio has experienced a decrease in the number of SIDS deaths between 1992-2002. This decrease is attributed to public awareness that the SID Network of Ohio has created surrounding the " *Back to Sleep*" campaign.

In general, the reduction in SIDS deaths has been accompanied by a reduction in over-all-infant mortality, indicating that the fall of SIDS rates are real and not just the consequence of a change in the way SIDS is diagnosed. Research into the physiological mechanisms that might explain why back sleeping is protective is ongoing. Suggested mechanisms include a reduction in the potential for re-breathing of expired air, which lowers the oxygen level in the infant's blood. The infant who lacks the normal mechanism that allows him to arouse during asphyxia, should be safe sleeping on its back. At this time, however, we cannot predict which infant is at risk.

A recent study conducted at the Barnes-Jewish Women's Health Center in St. Louis, Missouri, looked into sleep practices among African-American infants who were at high risk for sudden infant death. The chief investigator was J.S. Kemp. (Kemp Study). The primary purpose of the study was to increase the rate of back sleeping by educating grandmothers and senior caregivers (SCG) that very often influence a mother's choice of sleep practices. The study attempted to understand why infants bedshare, defined as sleeping on the same surface with another person(s) for longer than 4 hours.

The American Academy of Pediatrics has discouraged bedsharing with infants, because of the possibility that it may increase risks for SIDS. Results from many studies demonstrate that infants whose mother's smoke are at particular risk of dying if they bedshare. True risk associated with bedsharing has not been assessed in a population where smoking rate among mothers of sudden death victims is $\leq$50%. Preliminary results from this country, where smoking rates among mothers of victims is much lower than in England and New Zealand, point out the importance of understanding the impact of bedsharing on risk of death among African–American infants. More than 50% of sudden deaths among African-American infants occurred during bedsharing.

At 24 weeks gestation, in a Medicaid managed-care obstetrics clinic, 223 mothers and 99 grandmothers and other senior caregivers (SCG) were enrolled in a study of sleep practices. (Kemp Study). Both mothers and SCG were asked questions about beliefs regarding sleep practices, including position and bedsharing. At 8 weeks post-natally, the mothers were asked how and where their infants were placed to sleep. This allowed the researchers to analyze how prenatal beliefs and intentions influenced eventual sleep practices. Although both mothers and SCG were instructed about benefits of supine sleeping on firm mattresses, they were not given specific instructions about bedsharing.

The mothers were, on average, 18 years old the SCG 47. All were self-identified as African-American. Fewer than 15% of mothers who bedshared were smokers.

The night before the post-natal inquiry, 49% of the infants had bedshared, and 61% had bedshared in the previous 2 weeks. A prenatal intent to bedshare predicted eventual bedsharing ($X2, P<0.001$). Several other prenatal beliefs were identified that significantly increased the likelihood of bedsharing:

1) The belief that cribs somehow caused "crib deaths"
2) The belief that bed sharing mothers sleep better, and
3) A general lack of confidence in one's ability to afford a safe sleep environment

Prenatal concerns about inability to afford a crib did not predict bed sharing, but postnatally, the most compelling factor that contributed to bed sharing was the perceived lack of money to purchase a crib and crib mattress.

Description, Needs, Objectives of the "Cribs for Kids" Campaign

Unfortunately, from recent national data gathered, infant mortality rates in low income communities has decreased very little, making the overall mortality rate for African-American infants, 2.9 times that for white infants. Educational programs in communities of color are not reaching those most affected by risk factors, the low socioeconomic status groups.

To eliminate this disparity, the SID Network of Ohio began an education program in the spring of 1999, targeting Ohio's African-American communities. Through our education efforts, it has come to our attention that one of the basic tenets of the "Back to Sleep"

campaign, placing babies on their backs to sleep on a firm mattress, was not being adhered to by this population. Armed with the results of the Kemp study regarding bed sharing, i.e., and recent data from a successful demonstration project in the state of Pennsylvania, more than 50% of sudden infant deaths among African-American infants occur during bed sharing and that bed sharing is common due to a lack of money to purchase a crib.

The SID Network of Ohio created the "CRIBS FOR KIDS" campaign in September, 2004. The campaign targets low-income infants less than one year of age. The goal of the campaign is to get "Reduce the Risk" information, and a safety approved crib to Hamilton county's indigent families. Studies suggest that this proactive measure would help to reduce the risks of sudden infant death syndrome and accidental asphyxiation.

Community outreach workers who deal with new and indigent mothers first identify families. Upon receipt of a recommendation from targeted community agencies, and a letter from the needy family, including a copy of the baby's birth certificate, a letter will be sent to the participant. The letter will include information about our "Back to Sleep/Reduce the Risk" campaign. It will also include a voucher that can be redeemed for a crib.

Considering the positive impact the "Back to Sleep" campaign has had on the infant mortality rate since 1992, with the main tenet being to place babies to sleep on their backs in a safety approved crib, the *"Cribs for Kids"* campaign is a natural progression to assure that babies are not only born healthy, but remain that way. The SID Network of Ohio is a natural source of implementation for this project.

If successful, the SID Network of Ohio's *"Cribs for Kids"* campaign will be duplicated throughout the state to help reduce infant mortality. The Network is currently in the process of implementing this program in the Cleveland area. Hopefully the subject of proper bedding and sleep environment will rise to the importance of car seats for infants. Babies are not permitted to leave the hospital without a proper car seat but are taken home placed in an environment that is not safe for sleeping. This place them at a 2.5 times greater risk of dying of SIDS or accidental suffocation, according to the Center for Disease Control.

Evaluation of Project

The Sudden Infant Death Network of Ohio evaluation plan reflects a goal-oriented evaluation. Its basic premise is that the mission, goals and objectives guide evaluation. The evaluation includes questions to be asked, data sources, and evaluation procedures. To date, 24 cribs have been placed in the homes of indigent, Hamilton county families since December, 2004.

For more information on Sudden Infant Death Syndrome, please contact:

Sudden Infant Death Network of Ohio
421 Graham Road, Suite H. Cuyahoga Falls, OH 44221
1-800-477-SIDS (7437)
www.sidsohio.org

Risk Watch

About Risk Watch

Risk Watch is an injury prevention program for children in preschool through eight grade. It is designed to help children and families create safer homes and communities by teaching them skills and knowledge they need to make positive choices about their personal safety and well-being.

More Risk Watch

- Champion Project
- Participating Schools

Risk Watch is the first comprehensive injury prevention curriculum available for use in schools. It is developed by the National Fire Protection Association and Lowe's Home Safety Council.

The program provides students with an unprecedented opportunity to learn about injury prevention, to apply that knowledge in practice situation, and to develop and expand each students safety knowledge, risk awareness, independent thinking and social responsibility, prevention behaviors and motivation to protect oneself and others.

The Mississippi EMSC program is federally funded designed to provide programs to decrease childhood injuries and provide education to health professionals to ensure that critically injured children receive the best possible care available in Mississippi.

The Risk Watch curriculum and the teacher workshop are provide to each school at no cost. Each school wishing to participate in the Risk Watch Program must designate a person to be the Risk Watch Coordinator for the school.

Any school interested in obtaining information about the program may contact:

Alisa Williams, RN
Trauma System Manager
Mississippi State Department of Health, The Office of Emergency Planning and Response
P.O. Box 1700
Jackson, MS 39215

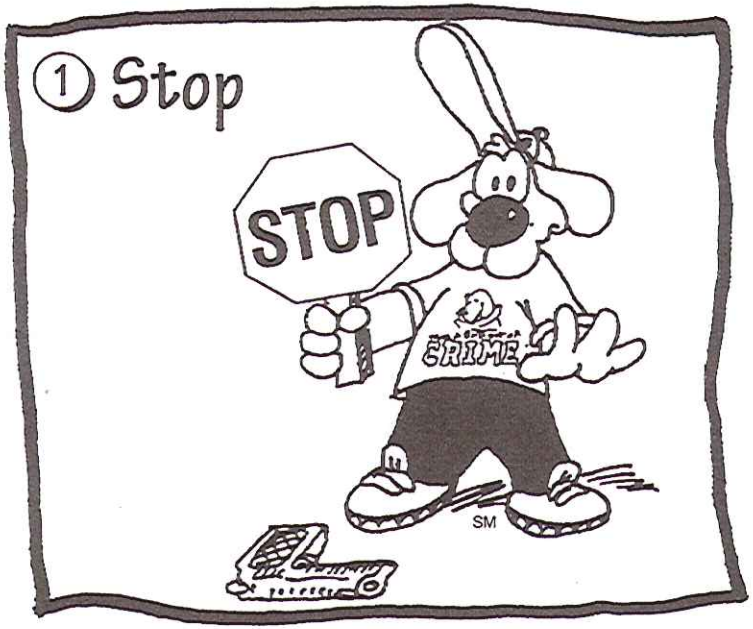
or call **601-576-7380**.

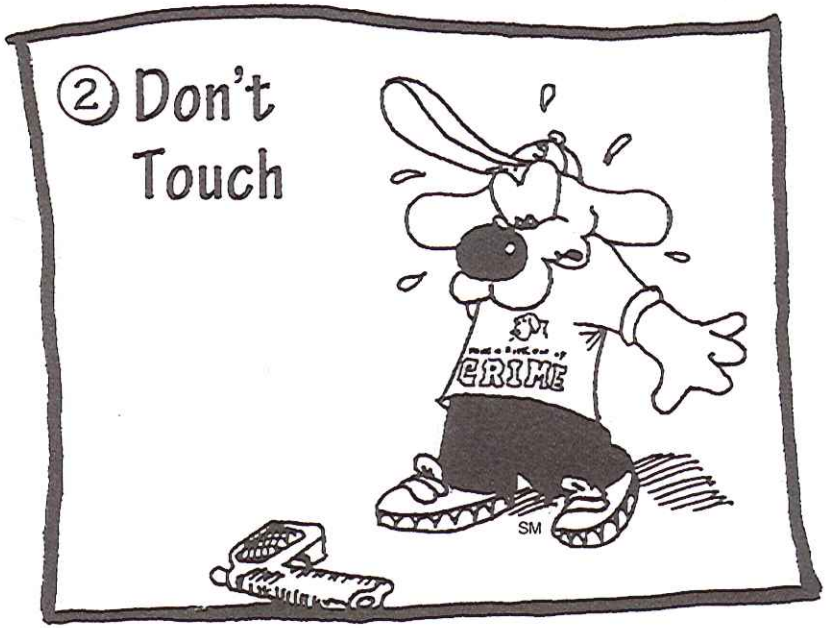
Participating Schools

The following are schools in Mississippi that are participating in the Risk Watch Program:

- Tchula
- Bassville
- Bogue Chitto
- Lipsey
- Louisville
- Loyd Star
- Mendenhall
- Prentiss
- Gulf Coast Schools
- Brookhaven
- Covington County Schools
- Enterprise

If You Find A Gun . . .





Addendum 5

NCPC
NATIONAL CRIME PREVENTION COUNCIL
1000 Connecticut Avenue, NW, Thirteenth Floor, Washington, DC 20036, 202-466-6272, www.ncpc.org, www.mcgruff.org

WARNING SIGNS

Most suicidal young people don't really want to die — they just want their pain to end. There are several signs to watch for that may indicate someone is thinking about suicide. The more signs, the greater the risk.

- A previous suicide attempt
- Current talk of suicide or making a plan
- Strong wish to die, preoccupation with death, giving away prized possessions or "veiled" threats ("I'll be going away" or "I won't be needing this")
- Signs of serious depression such as moodiness, hopelessness and withdrawal
- Increased alcohol and/or other drug use
- Recent suicide attempt by a friend/family member or any recent significant loss/setback

There are other key "risk factors" to keep in mind that increase the likelihood of suicide attempts by young people. Again, the more signs observed, the greater the risk.

- Readily accessible firearms
- Impulsiveness and taking unnecessary risks
- Lack of connection to family and friends (no one to talk to)

Youth of all races, creeds, incomes and educational levels attempt or complete suicide. There is no typical suicide victim.

About 80% of the time people who kill themselves have given definite signals or talked about suicide. The key to prevention is knowing what the warning signs are and what to do to help.

Addendum 6

PREVENTION STEPS

If you're worried about a young person and suicide has crossed your mind as a concern, trust your judgment. Do something now! Here's what you might say to a young person who is thinking about suicide:

1. SHOW YOU CARE

Let the person know you really care. Talk about your feelings and ask about his or hers. Listen carefully to what he/she has to say.

"I'm concerned about you...about how you feel."
"Tell me about your pain."
"You mean a lot to me and I want to help."
"I care about you, about how you're feeling."
"I don't want you to kill yourself."
"I'm on your side...we'll get through this."

2. ASK THE QUESTION

Don't hesitate to raise the subject. Talking with young people about suicide won't put the idea in their heads. Chances are, if you've observed any of the warning signs, they're already thinking about it. Be direct in a caring, non-confrontational way. Get the conversation started.

"Are you thinking about suicide?"
"What thoughts or plans do you have?"
"Are you thinking about harming yourself, ending your life?"
"How long have you been thinking about suicide?"
"Have you thought about how you would do it?"
"Do you have _____?" (insert the lethal means they have mentioned.)
"Do you really want to die? Or, do you want the pain to go away?"

3. CALL FOR HELP

The first steps toward instilling a sense of hope are: showing your concern, raising the issue and listening to and understanding the young person's feelings. Keep moving forward together. Call for help.

Again, here are some non-threatening things you might say to a young person considering suicide:

"Together I know we can figure something out to make you feel better."

"I know where we can get some help."

"I will stay with you...Let's call the crisis line."

"I can go with you to where we can get some help."

"Let's talk to someone who can help...let's call the crisis line, now."

"It's difficult to know what to do, but I know where we can get some help."

"You're not alone. Let me help you."

If the young person has expressed an immediate plan, or has access to a gun or other potentially deadly means, do not leave him or her alone. Get help immediately.

1-800-273-TALK

Mobile Fire Safety House

About the Mobile Fire Safety House

The purpose of the EMS Mobile Fire Safety House is to provide fire safety education to children and youth throughout the state. It will create an opportunity to provide fire safety education to communities, cities, towns and schools. It will target schools, fairs, conferences and civic organizations.

This unit simulates smoke as from a house fire and education is done on how to escape safely. Stations are set up to demonstrate stop drop and roll if your clothes catch on fire. There are other stations with activities that participants can participate in also for fire safety education.

Find this page at

http://www.msdh.state.ms.us/msdhsite/index.cfm/48,0,321,392,html

INSURANCE JOURNAL

Southeast News

Federal Grant to Aid Attack on Fire Deaths in Mississippi

August 22, 2008

Mississippi's rank as the leader in fire deaths in the nation could take a major blow soon and state fire officials couldn't be happier.

Their latest tool in the fight for fire death prevention is a nearly half-million dollar federal grant awarded to the Mississippi State Fire
Marshal's Office. The grant will be used for a statewide smoke alarm installation program and will provide free smoke alarms to nearly 10,000 households that are at or below the poverty level.

The U.S. Department of Homeland Security's Assistance to Firefighters Grants Fire Prevention and Safety Program awarded the $497,025 grant. County fire coordinators will coordinate installation efforts with the fire departments in their respective counties. Smoke alarms will then be delivered and installed by firefighters.

During the visit firefighters will provide fire prevention and home escape planning education and leave educational brochures for the residents to review after the firefighters have left.

A special sealed smoke alarm with a 10-year battery will be used for the program. Because the alarm is sealed, it removes the ability to unplug the battery.

According to statistics compiled by the State Fire Marshal's office for the grant application, as of November 28, 2007, there had been 69 fire deaths in 51 fires reported. Of those reported, smoke alarms were present in 18 fires resulting in 23 deaths; smoke alarms were not present in 28 fires resulting in 40 deaths; in five fires resulting in six deaths, it was unknown if smoke alarms were present.

Source: Mississippi Insurance Department

Find this article at:
http://www.insurancejournal.com/news/southeast/2008/08/22/92982.htm

Addendum 8

Watch Out Program

About the Watch Out Program

The purpose of the Watch Program is to provide comprehensive safety education to children and youth throughout the state. It will target schools, children's clubs, fairs, conferences, communities, cities, towns and civic clubs.

The program has a safe house to aid in the demonstration and education of home safety programs. Areas within the unit will be utilized for video presentations and computer education program in which the participant can participate.

The program also has a smoke house trailer to aid in the demonstration and education of fire safety. This unit simulates smoke from a house fire and education is done to show how to escape from this fire safely. Stations are set up to demonstrate stop drop and roll if your clothes catch on fire along with other situations that participants can participate in.

- Water Safety Programs
- Bicycle Rodeos
- Fire/Burn Safety Programs
- Fall Prevention Programs
- Car/Seat Belt Safety Programs
- Pedestrian Safety Programs
- Poison Prevention Programs
- Home Safety Programs
- Call 911 Programs

Find this page at

http://www.msdh.state.ms.us/msdhsite/index.cfm/48,0,321,390,html

This Annual Report is dedicated to the memory

of all 765 children who lost their lives

in our state in 2007.

May we use the information contained herein

to prevent any future harm

to our most vulnerable citizens.