

The background of the entire page is a close-up photograph of several bright yellow daisy flowers. The flowers are in various stages of bloom, with some in sharp focus and others blurred in the foreground and background. The sky is a clear, light blue. The text is overlaid on the upper left portion of the image.

Nebraska Child Death Review Report

For Deaths Occurring in 2009

THE 8TH REPORT OF THE NEBRASKA CHILD DEATH REVIEW TEAM

September, 2013

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The Honorable Dave Heineman, Governor
Honorable Members of the Nebraska State Legislature

I am submitting this eighth report on child deaths in Nebraska in accordance with Nebraska Revised Statute §71-3404. The report presents the Child Death Review Team's findings on the 237 deaths to Nebraska resident children ages 0 to 17 years old.

The top five causes of death for the state's children in 2009 were:

- Pregnancy-related causes
- Birth defects
- Motor vehicle-related incidents
- Sudden Unexpected Infant Death (SUID)
- General medical conditions

Since child death reviews began in 1993, child deaths have decreased by over one-third, testimony to the hard work of parents, communities, medical providers and state and private agencies to reduce the number of risks that children encounter.

However, CDRT reviewers agreed that at least one-third of all child deaths in 2009 were either **somewhat or strongly preventable**. In addition, racial and ethnic disparities continue to exist, indicating that improvements have not reached all families. Notably, deaths are only the "tip of the iceberg" and

for each cause of death documented in this report, there are an unknown number of children suffering from the effects of similar but non-fatal incidents. This report includes recommendations around a combination of common-sense actions by caretakers and targeted activities by state and private agencies that would have an appreciable effect on child safety and well-being.

Please note that the views and recommendations in this report are those of the CDRT and are not necessarily those of the Nebraska Department of Health and Human Services.

We thank you for your support and look forward to working with you on continuing efforts to enhance the safety and well-being of Nebraska's children.

Sincerely,



Joseph M. Acierno, M.D., J.D.
Chair, Nebraska Child Death Review Team
Chief Medical Officer
Director, Division of Public Health
Nebraska Department of Health and Human Services

The Child Death Review Team would like to thank the County Attorneys and their staff, hospital Medical Records Departments, Tribal Authorities, State agencies, DHHS staff, family members and other individuals who graciously provided the information that made this report possible.

The following individuals also provided invaluable assistance in interpreting the information:

Dr. Don Belau, Youth Rehabilitation and Treatment
Center (Geneva)
Ms. Christena Baker, MSW
Dr. John Schmidt, Creighton University Medical Center

This report was designed to provide useful information for evaluation, planning and prevention purposes. Any questions or comments regarding the report or the Nebraska Child Death Review Team should be directed to:

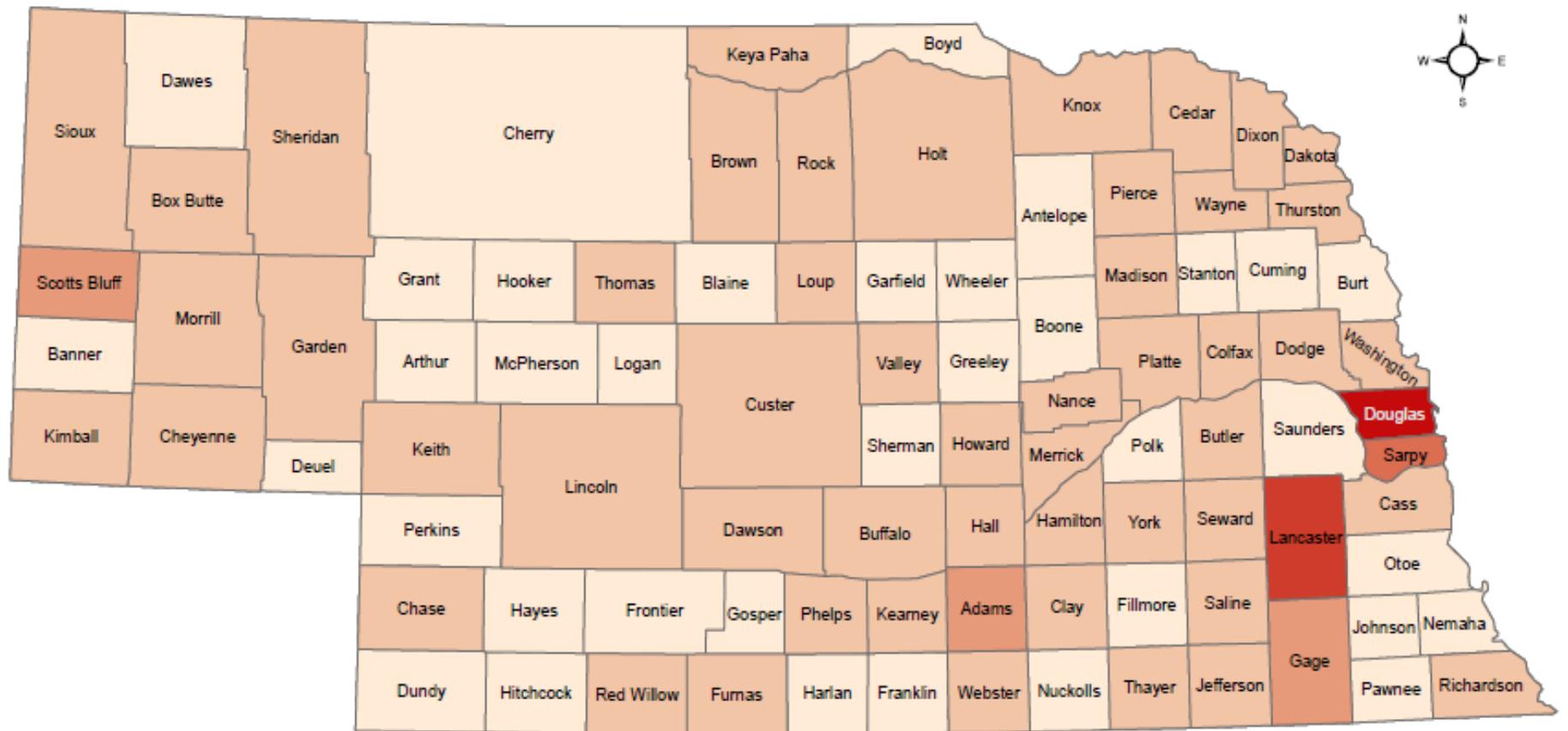
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Infant and Child Deaths (0-17) by County of Residence (237 deaths) Nebraska 2009



LEGEND Infant and Child Deaths, by County

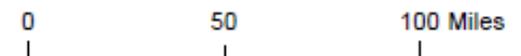


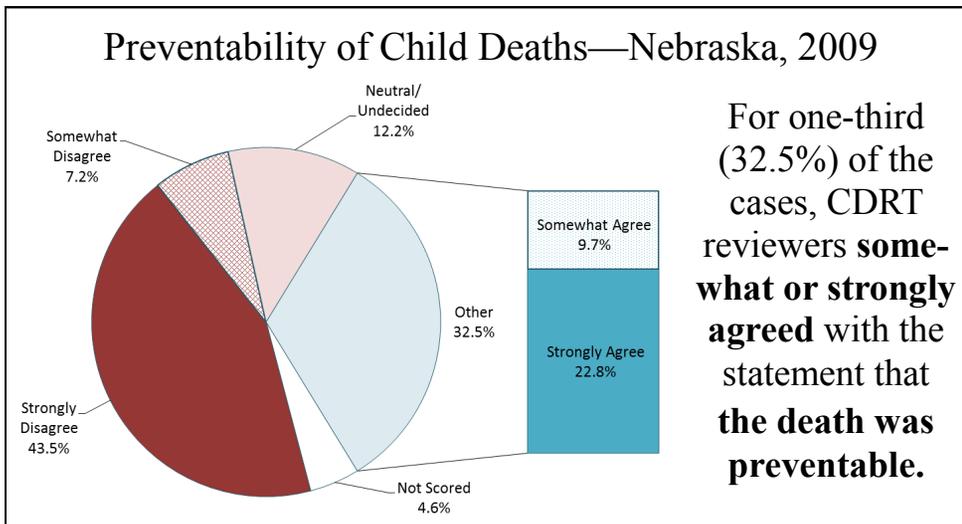
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Review of 2009 Nebraska Child Deaths

Executive Summary

Systematic study of the causes and patterns of child death provides crucial data for the prevention of future deaths. A total of 237 Nebraska children ages 0 to 17 died during 2009, a significant decrease in both the number (-35%) and the rate (-36%) of deaths since child death reviews began in 1993. This decline was seen to varying degrees in each of five racial/ethnic groups; however, only White children have experienced sustained and statistically significant long-term improvement.



Top Five Cause-of-Death Categories

1. Pregnancy-Related – 65 deaths
2. Birth Defects – 56 deaths
3. Motor Vehicle-Related Incidents – 32 deaths
4. Sudden Unexpected Infant Death – 23 deaths
5. General Medical Conditions - 18 deaths

Key Recommendations for Future Prevention

Goal: Promote healthy lifestyles for reproductive age women.

Key Strategy: Include preconception care as a vital and routine part of care for reproductive age women.

Target Audience: Nebraska Medical Association and members

Goal: Improve assistance to children with disabilities and their families/caregivers.

Key Strategy: Nebraska's home visitation programs should increase the priority of service delivery to families of children with severe disabilities.

Target Audience: Nebraska Department of Health and Human Services and local partners

Goal: Promote safe and supportive environments for children

Key Strategy: The Nebraska Medical Association and their members should take the lead on dispelling myths about vaccine safety and promoting infant and child vaccinations.

Target Audience: Nebraska Medical Association and pediatric providers

Goal: Improve the quality of the investigation and documentation of child deaths.

Key Strategy: Actively promote, implement and expand the state's existing protocol on child death scene investigations, including a regional system of experts in death scene investigations.

Target Audience: Nebraska Attorney General's Office, Nebraska Law Enforcement Training Center, Nebraska County Attorneys Association

Review of 2009 Nebraska Child Deaths

The Legislature finds and declares that it is in the best interests of the state, its citizens and especially the children of this state that the number and causes of death of children in this state be examined. There is a need for a comprehensive integrated review of all child deaths in Nebraska and a system for statewide retrospective review of existing records relating to each child death. §71-3404 Neb. Rev. Stat.

This report presents the findings and recommendations of the Nebraska Child Death Review Team, based on the review and tabulation of the 237 deaths of Nebraska resident children (newborns through age 17) known to have occurred during 2009. The traditional belief that “things will happen” ignores the reality that many of these deaths could have been prevented.

BACKGROUND

The Nebraska Child Death Review Team (CDRT) was established by the Nebraska Legislature in 1993 and charged with undertaking a comprehensive, integrated review of existing records and other information regarding each child death. At that time, the Nebraska Commission for the Protection of Children had found that about 300 children died each year in the state, but that there was no systematic process in place for consistent review of those deaths to determine contributing circumstances.

The purpose of the CDRT includes developing an understanding of the number and causes of child deaths, and

advising the Governor, Legislature, other policymakers and the public on changes that might prevent them in the future. All child deaths are reviewed, not just “suspicious” or violent ones. The team uses information in written records and the expertise of its members to identify situations where, in retrospect, reasonable intervention might have prevented a death. Members of the original team determined that the specific goals of these reviews would be to:

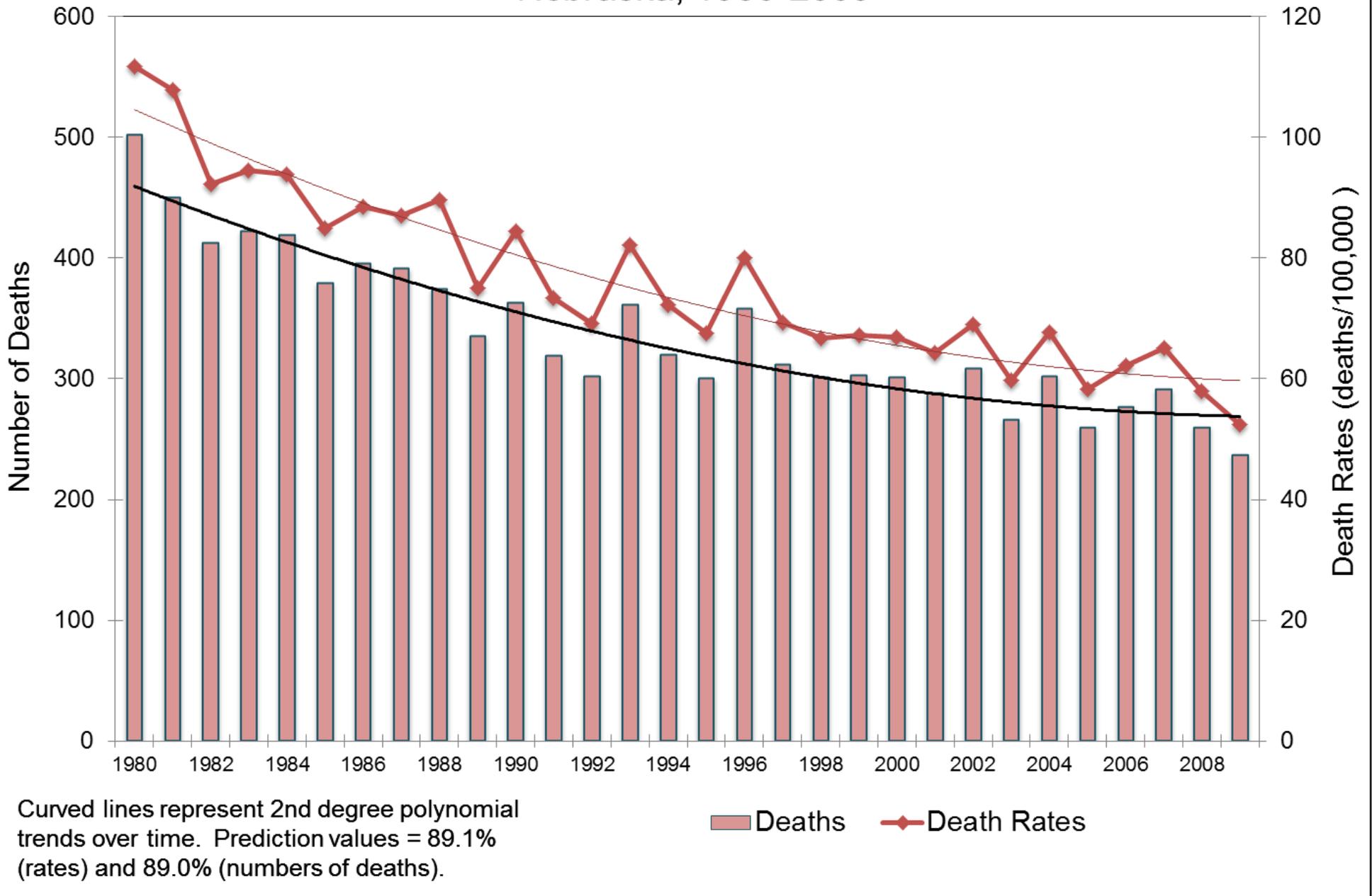
- Identify patterns of preventable child deaths;
- Recommend changes in system responses to child deaths;
- Refer to law enforcement newly-suspected cases of abuse, malpractice, or homicide; and,
- Compile findings into reports designed to educate the public and state policymakers about child deaths.

FINDINGS

A total of 237 Nebraska children ages 0 to 17 died during 2009, a 9.2% decline from the previous year. Although there is considerable year-to-year fluctuation, the overall historical trend has been towards fewer deaths (Figure 1). Results from 2009 represent a 35% decrease in the number of deaths (from 361 deaths) and a 36% decrease in the rate of deaths (from 82.2 deaths per 100,000 children 0-17 to 52.5 deaths per 100,000) since child death reviews began in 1993.

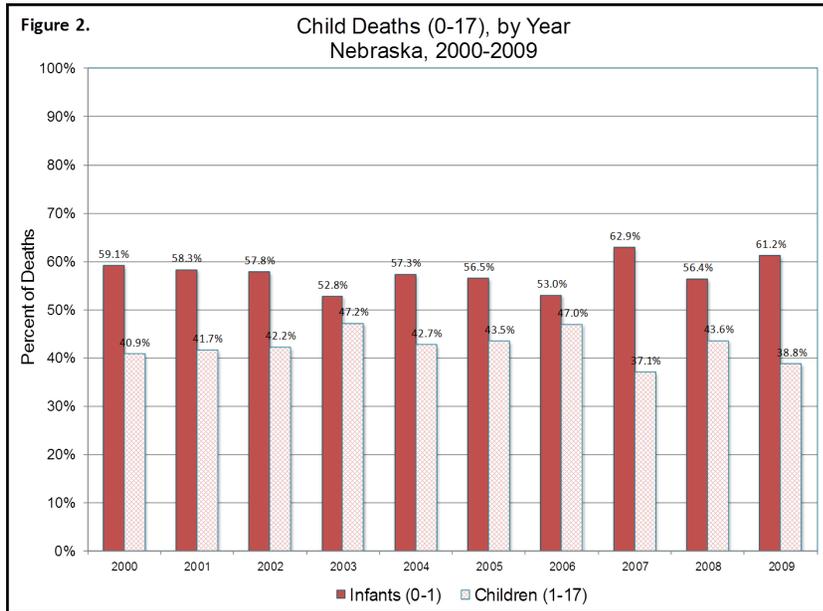
Figure 1.

Child Deaths (0-17) and Death Rates Nebraska, 1980-2009



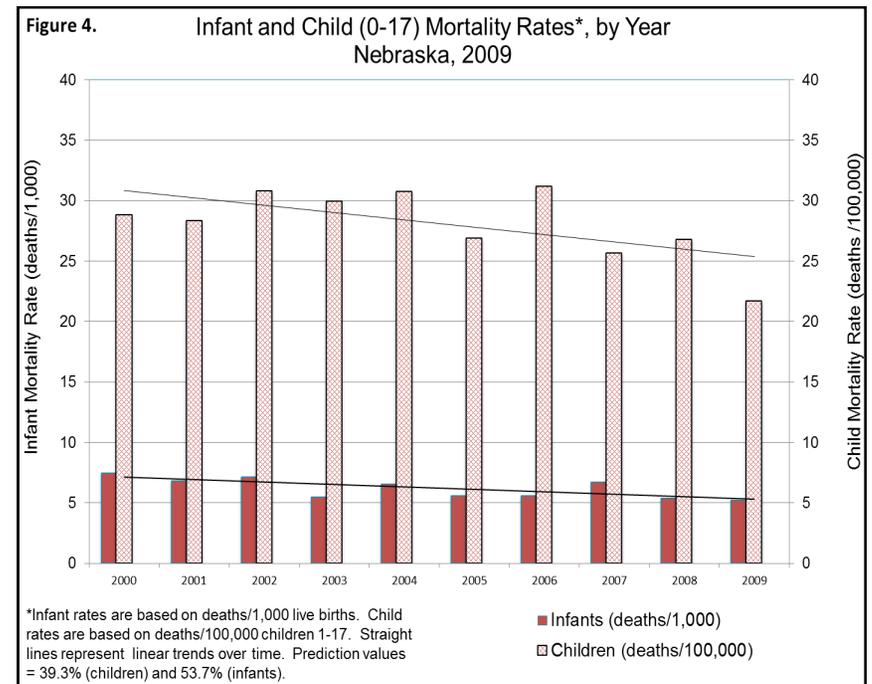
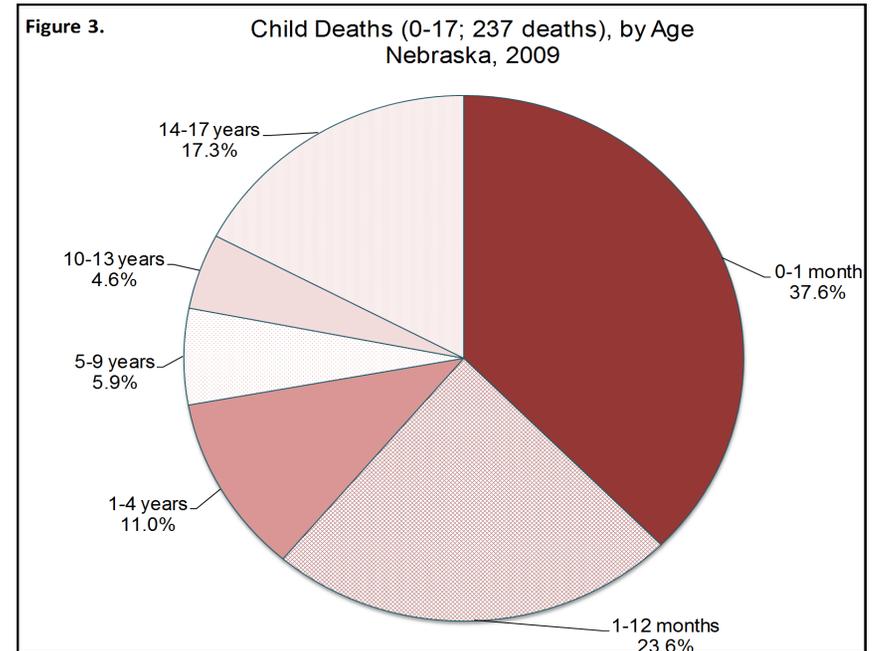
Demographics

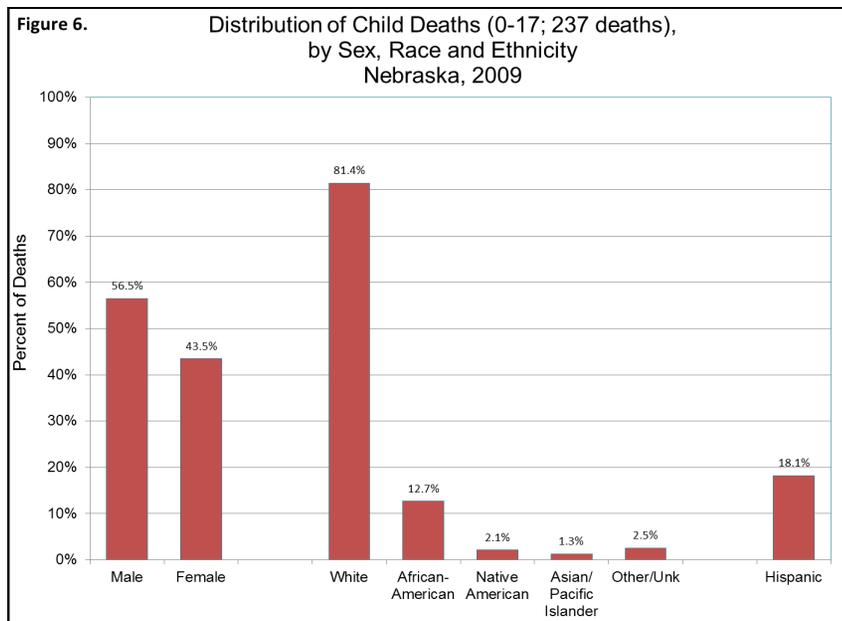
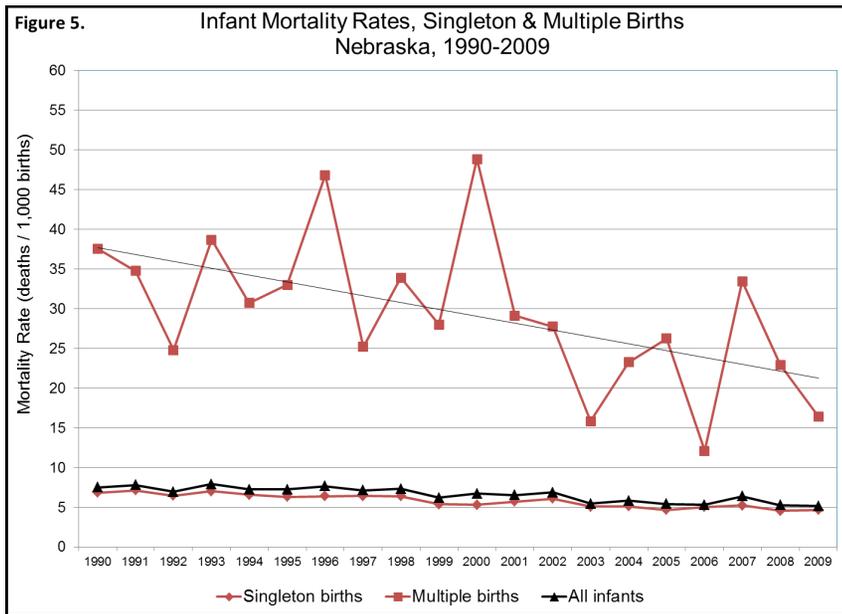
Infants continued to account for 60% of all child deaths (Figure 2). Approximately two-thirds of infants died within their first month. Among children at least 1 year old, the largest proportion of deaths was for ages 14 to 17 (Figure 3).



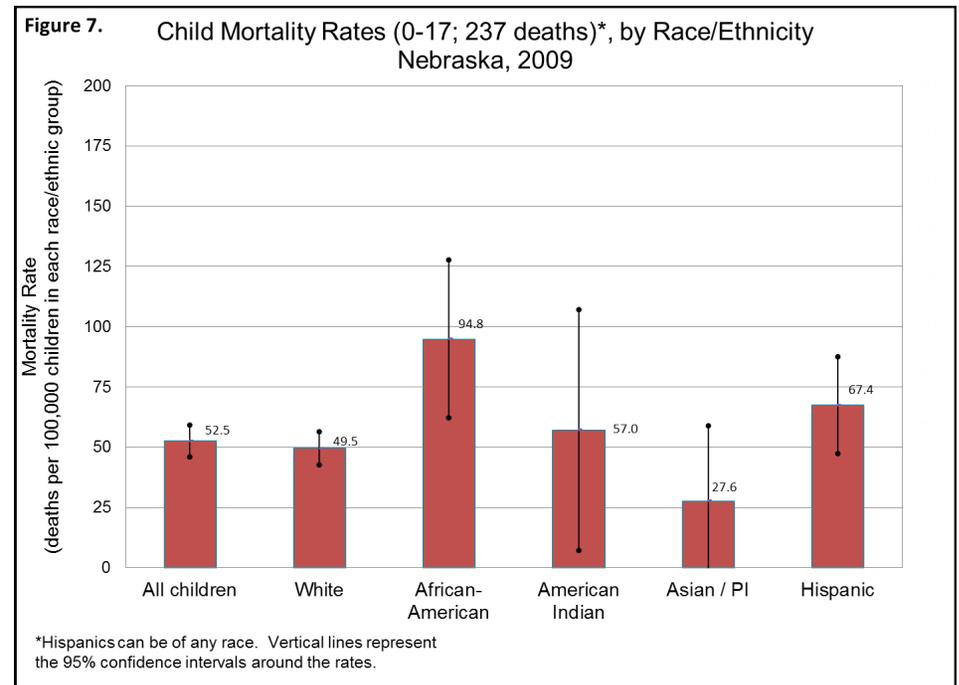
Overall, mortality rates for both infants and children are declining over time (Figure 4), although among infants the decline is more pronounced among multiple gestation infants than among singletons (Figure 5). Slightly over one-half (56.5%) of all child deaths were boys (Figure 6).

Although White children made up the vast majority (81.4%) of deaths, the percentage of Hispanic children has been increasing over time - from 8.7% in the 1996-2001 report to the current 18.1%. (Figure 6).



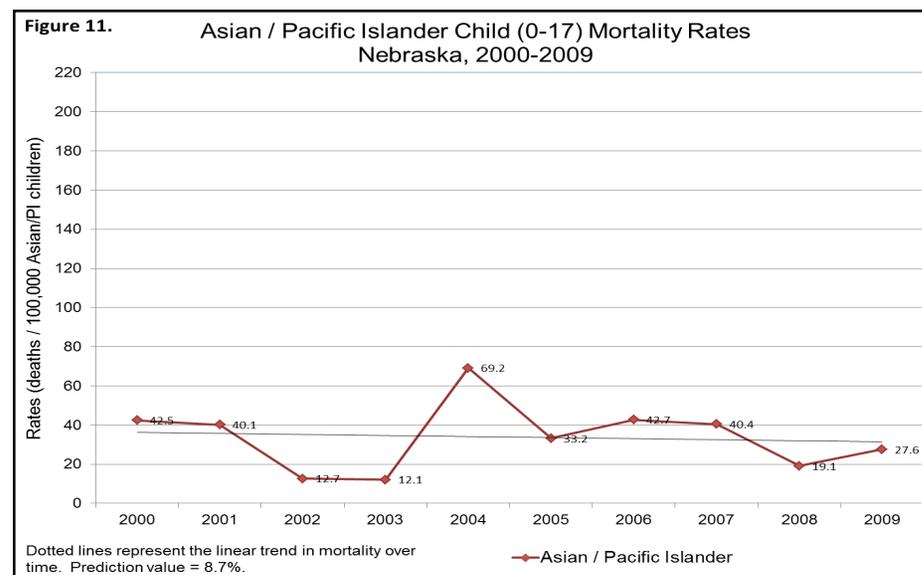
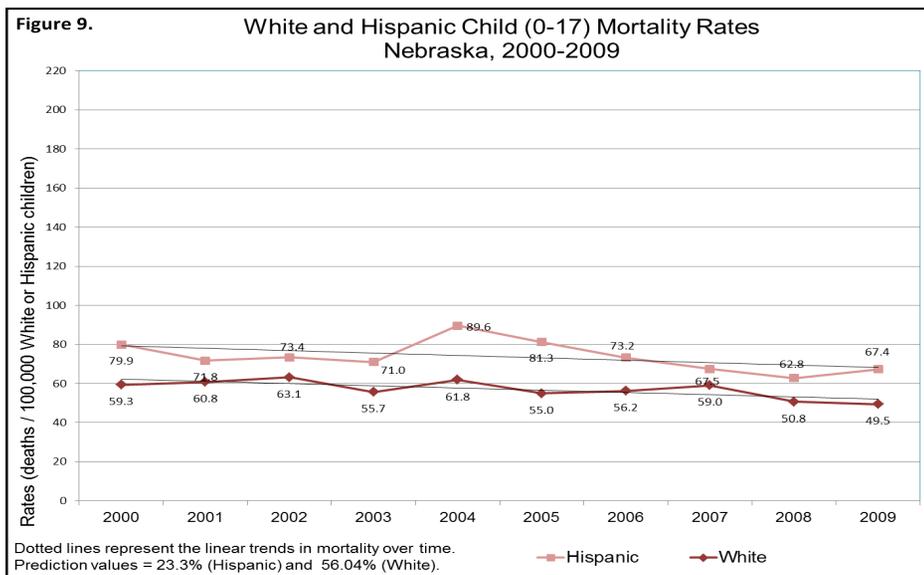
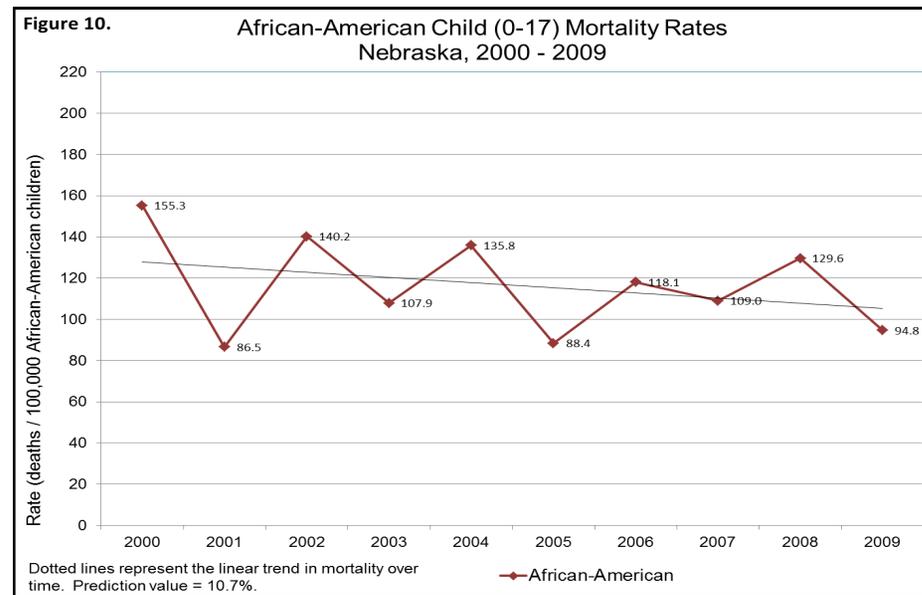
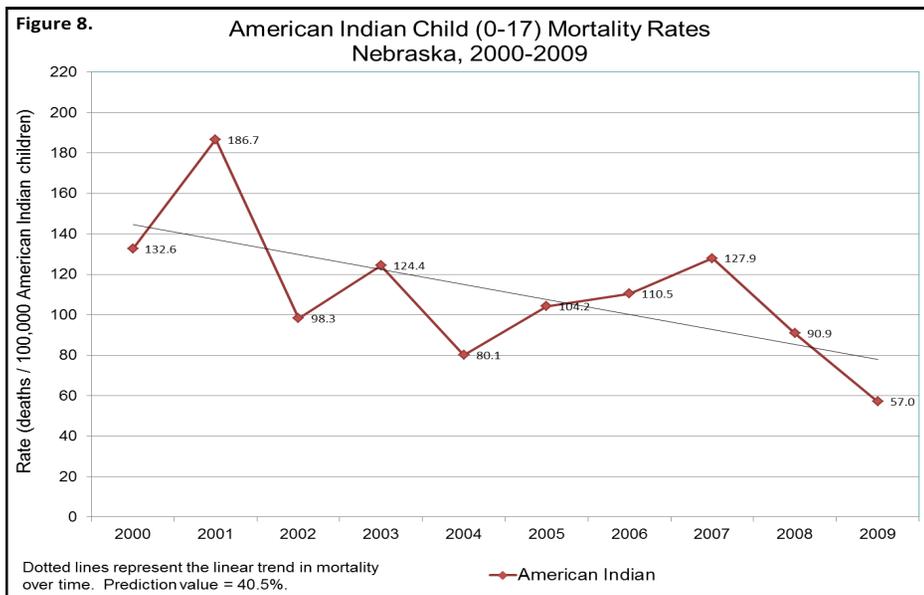


The percentage of African American children among all deaths dropped slightly in 2009, from 14.2% (2007-2008) to 12.7%. However, when calculated as rates of death per 100,000 children, African-American children had higher rates than all other racial or ethnic groups. The differences were statistically significantly for comparisons with Whites, Asians and all children (Figure 7).



When examined over time, rates of death for all racial/ethnic groups showed some level of decline. After several years of increasing rates for Native American children, the 2009 rate decreased sufficiently to create a significant drop in their 10-

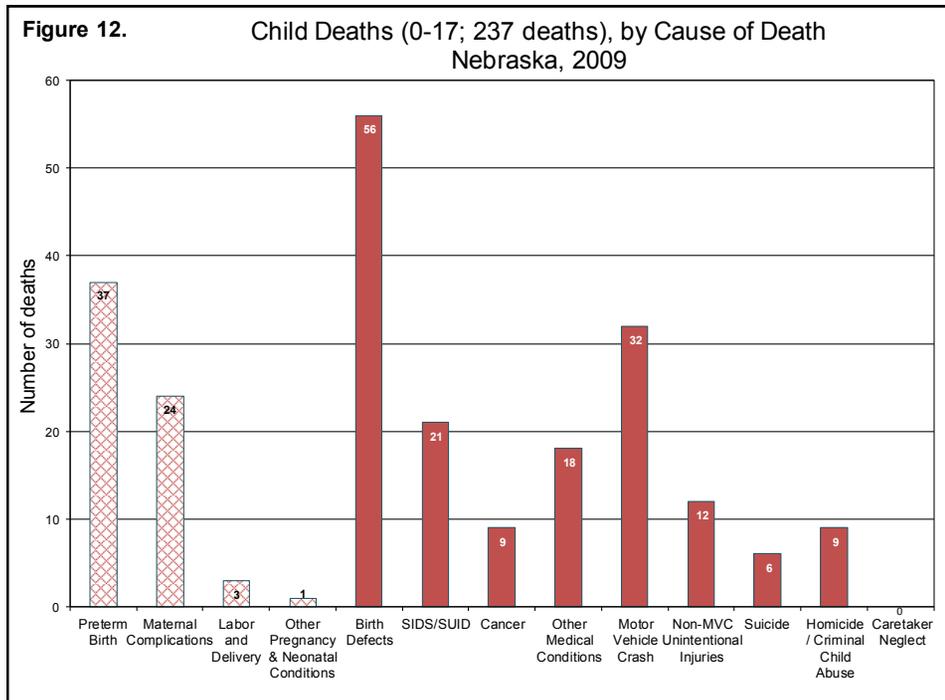
year trend (Figure 8). White children were the only other group whose mortality decline over the past decade was statistically significant (Figures 9-11).



Causes of Death

Overview

Approximately one-quarter (27.5%) of all child deaths during 2009 were attributed to perinatal causes, a category which combines maternal problems during pregnancy, problems during labor and/or delivery, and premature birth (Table 1, Figure 12). Some of these children survived into their teen years, yet the basic problem was determined to have occurred during the perinatal period. Birth defects were the second most common underlying cause of death (23.7%), followed by motor vehicle crashes (13.6%).



Preventability

Cases were individually assessed as to the degree to which they were preventable. For each death, reviewers assessed whether they:

Strongly Disagreed	Somewhat Disagreed	Were Neutral / Undecided	Somewhat Agreed	Strongly Agreed
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with the statement:

This death was preventable - standard-of-care medical management would have changed the circumstances that led to death. (Medical cases)

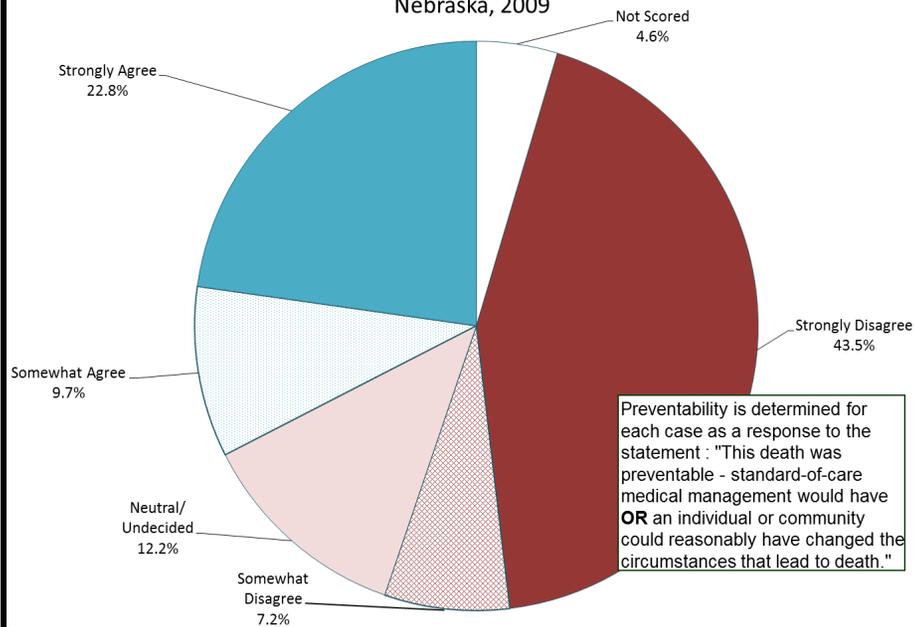
or

This death was preventable - an individual or community could reasonably have done something that would have changed the circumstances that led to death. (Non-medical cases)

All but eleven cases were individually assessed for preventability; the remainder (4.6%) had insufficient information to make a determination. Preventable deaths (“strongly agree” or “somewhat agree”) made up one-third (32.5%) of all cases, and ranged from 100% for Motor Vehicle Crashes and Unintentional Injuries (32 and 13 deaths, respectively) to less than 2% for Birth Defects (55 deaths; Figure 13). No clearly preventable factors were identified for Cancer deaths.

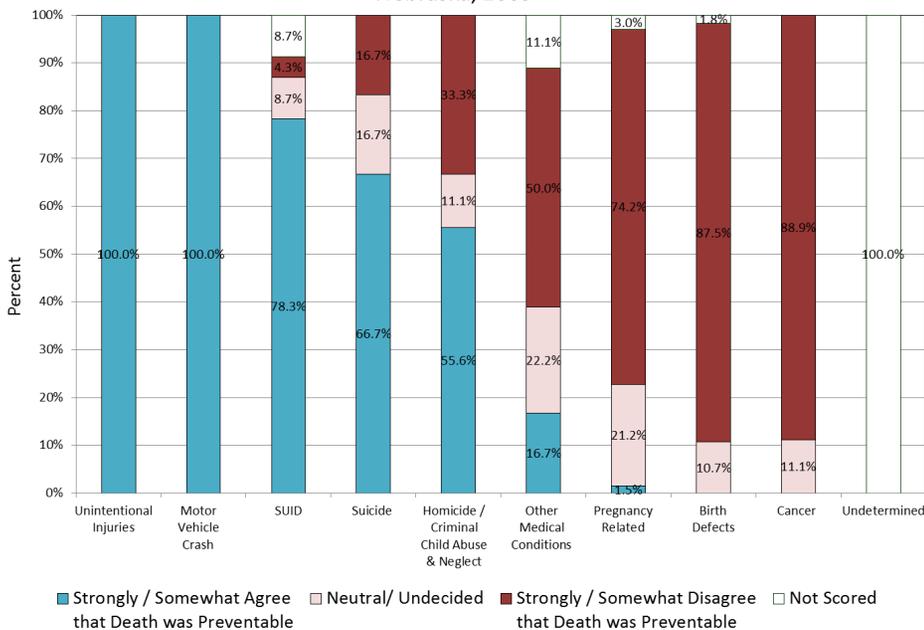
Figure 13.

Preventability of Child Deaths
Nebraska, 2009



Preventability is determined for each case as a response to the statement: "This death was preventable - standard-of-care medical management would have OR an individual or community could reasonably have changed the circumstances that lead to death."

Distribution of Preventability Levels of Child Deaths, by Cause
Nebraska, 2009



Perinatal Deaths – Key findings

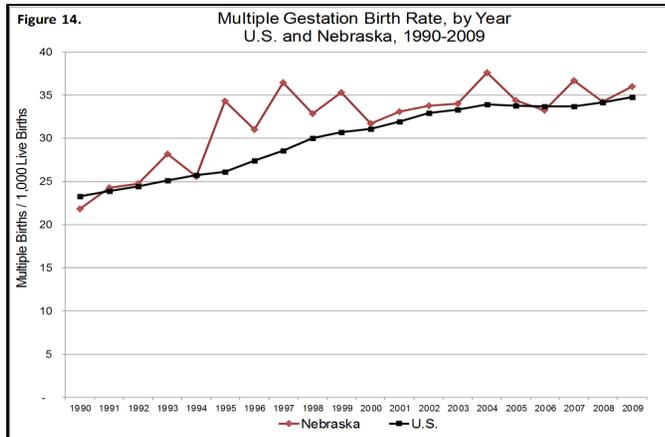
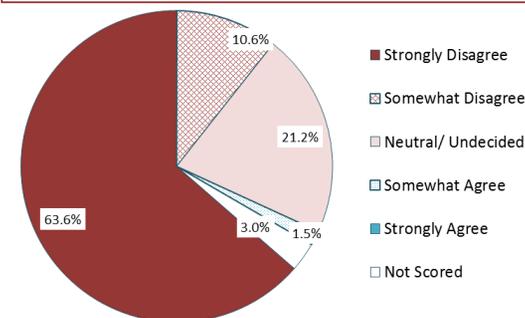
Pregnancy-related issues continue to be the leading cause of death category for Nebraska children. Reviewers were able to find preventable aspects for fewer than one-quarter (22.7%) of these deaths.

Nearly all infants (95.3%) with pregnancy-related deaths were born prematurely. However, at least one-third (34.4%) had a documented cause for their prematurity, most commonly maternal placental abruption or incompetent cervix (Table 2). One-third (35.1%) of the premature infants with no identified causes were from multiple gestations. The rate of multiple gestation births appears to be increasing after several years of stability (Figure 14).

One focus for the prevention of premature births is improving obstetric care for women known to

have dangerous conditions such as hypertension. However, while in most cases delivery is not preventable once premature labor has begun, timely interventions can often *delay* the actual

Preventability of Pregnancy-Related Deaths

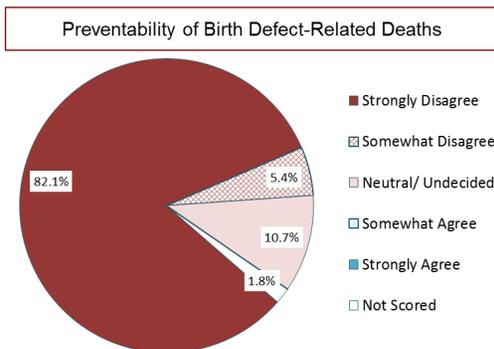


birth sufficiently to lower the risk of death. Medical records received for review often did not clearly document that women had received adequate education around signs of premature labor, or what to do if those signs occurred.

Birth Defects – Key findings

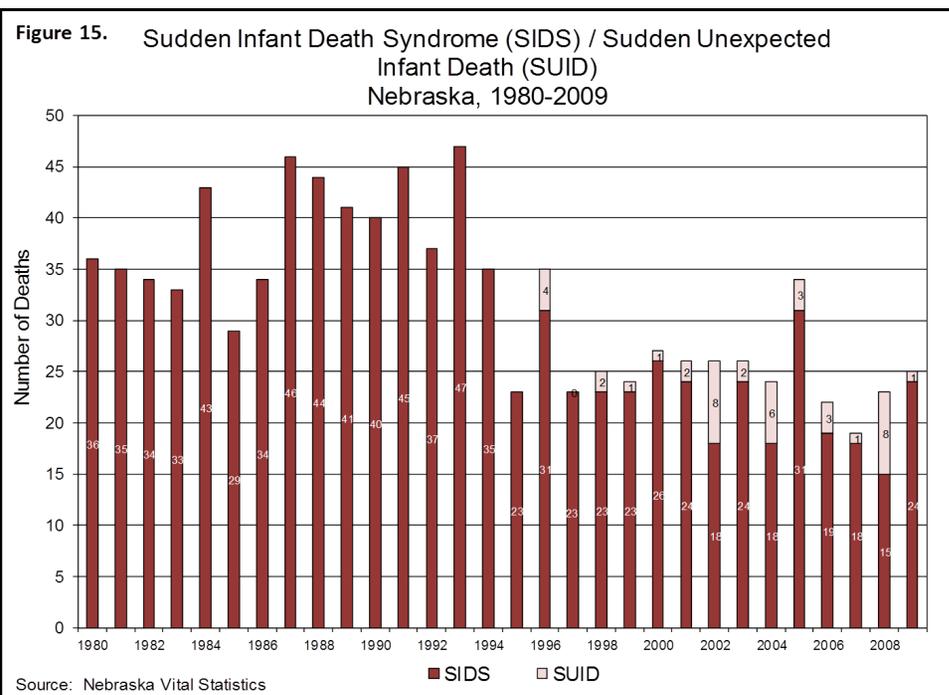
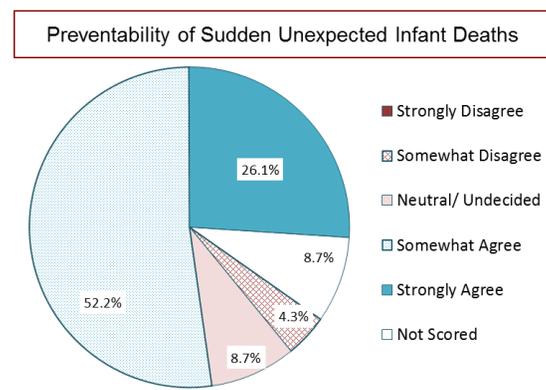
Birth defects are the second largest cause of death category for children in Nebraska. However, only one-tenth (10.7%) of birth defect-related deaths appeared to involve any circumstances that were possibly preventable during the prenatal period, or involved questionable care after birth.

The primary defects noted during 2009 were chromosome abnormalities (32.1% of birth defects) – most notably Trisomy 18 (Edwards Syndrome) and congenital heart disease (19.6% of birth defects; Table 3). Certain congenital anomalies and chromosomal abnormalities, such as Down Syndrome (Trisomy 13) are known to be more prevalent in children born to younger and older women. Ten percent (10.7%) of lethal birth defects were neural tube defects (NTD). While most birth defects are not preventable, preconception intake of folic acid is known to significantly decrease the risk of NTDs and these cases accounted for the majority of cases with possibly preventable conditions.



Sudden Infant Death Syndrome (SIDS) / Sudden Unexpected Infant Death (SUID) – Key findings

2009 marked a sharp reversal in the trend of fewer sudden infant deaths (Figure 15), with 24 SIDS cases recorded in Nebraska Vital Records.

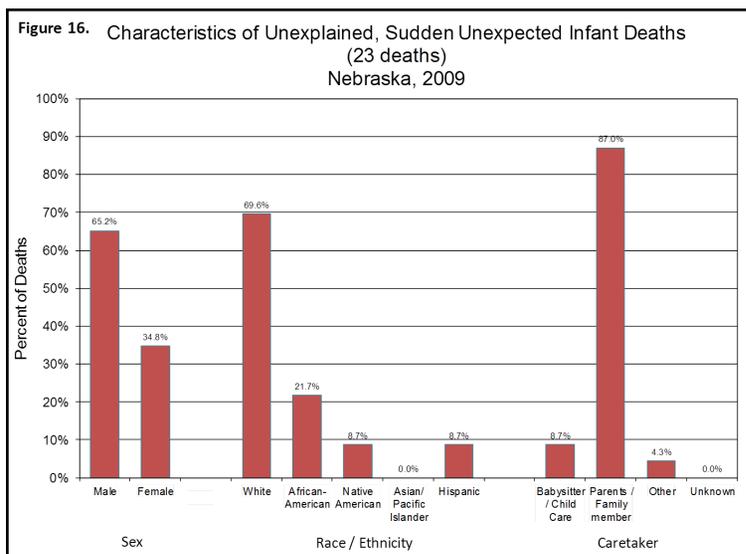


However, sudden infant deaths encompass a variety of circumstances, and the CDRT follows the definitions recommended by the federal Centers for Disease Control and Prevention:

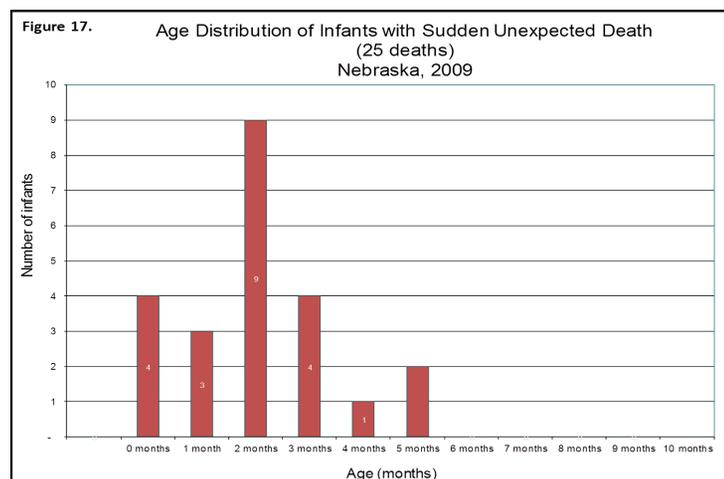
- SUID – sudden, unexpected infant deaths that are unexplained after a thorough investigation; and,
 - SIDS – the subset of SUID cases that occur in a safe sleep environment.

The SIDS designation was rejected for two of the 24 cases, with reviewers agreeing that one was clearly an accidental suffocation from defective furniture (Unintentional Injury; Table 4). Reviewers also felt that a separate death was highly suspicious for intentional injury by the parents, but available investigative records were inadequate and the case was reclassified as Undetermined. One additional infant death was added to the SUID category after CDRT physician reviewers rejected the original diagnosis of heart disease. Of the final group of 23 SUID cases, reviewers **somewhat or strongly agreed** that most (78.3%) were felt to be **preventable**.

As in past reviews, the final group of 23 SUID cases continued to be disproportionately African-American and male (Tables 5 & 6; Figure 16). Only two sudden infant deaths occurred



while the infant was in the care of a babysitter or child care provider (Table 7; Figure 16). Infants appeared to be at highest risk at two months, with only one case occurring after five months (Table 8; Figure 17).



Nebraska CDRT tracks nine specific environmental risk factors that are known to be associated sudden infant death:

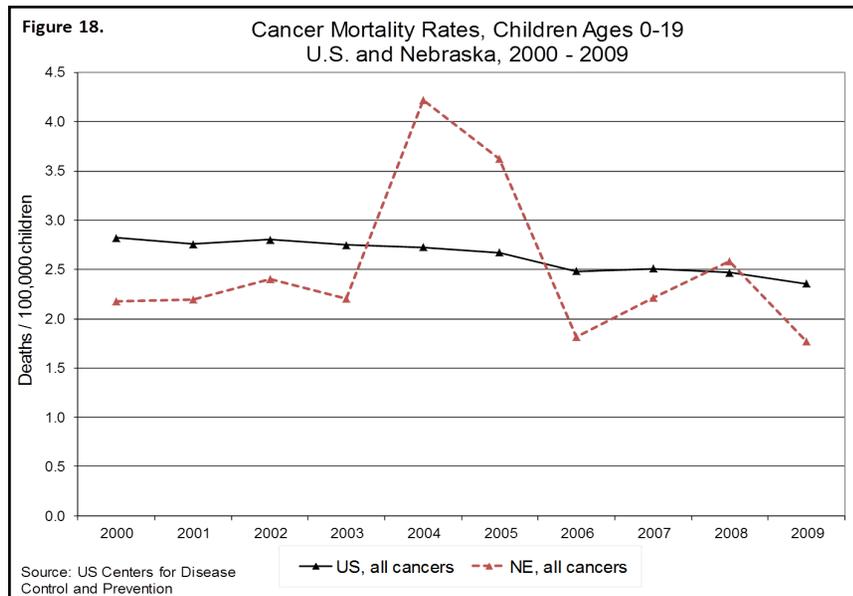
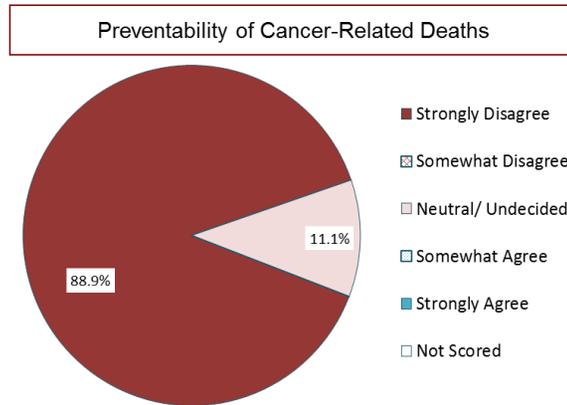
- prenatal drug exposure
- prenatal or postnatal tobacco smoke exposure
- infant sleeping on an age-inappropriate surface
- infant sharing a sleep surface with an adult or other child(ren)
- infant was put to sleep on side or stomach
- deceased infant was found on side or stomach
- current or recent respiratory infection
- excessive bedding or other objects in sleep environment
- issues related to defective furniture

A common aspect of these risk factors is their effect on the infant’s ability to breathe clearly. All but one infant had one or more risks documented in their medical or legal records (Table

8). At least 20 (80%) of the infants were not sleeping in safe environments; following safe sleep practices (Appendix 2) would likely significantly reduce sleep-related infant deaths. Maternal drug exposure is a troubling finding and tends to be poorly documented in medical and legal records; the true exposure may be higher than the three known cases.

Cancer / Malignant Neoplasms – Key findings

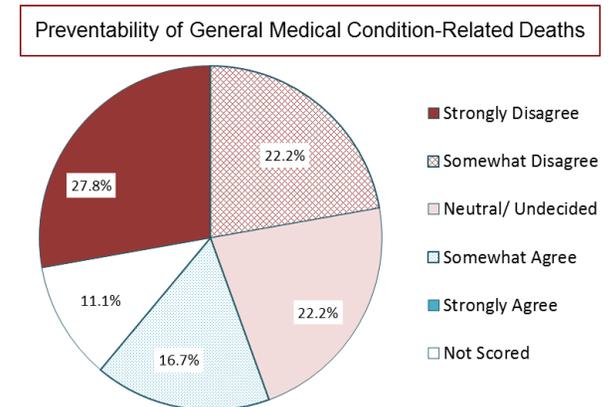
Deaths from childhood cancer have remained at or below national rates since 2006, following a dramatic and unexplained short-term rise in deaths from brain cancer in 2004 and 2005 (Figure 18).



The involvement of specific cancer types followed the same general pattern seen in previous years (Table 9). All of the children had received treatment at specialized cancer facilities, and there were no clear opportunities for prevention.

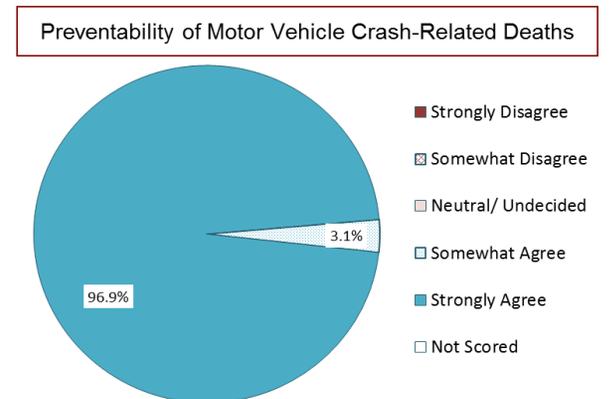
General Medical Conditions – Key findings

General Medical Conditions include infectious, chronic and other disease conditions. In 2009, deaths involved a range of conditions, of which fewer than half (38.9%) showed any possible opportunities for prevention. Respiratory diseases made up the largest category (38.9%; Table 10). Two deaths to asthma occurred in children who were under medical care for their condition. One death from H1N1 flu was reported. No single cause of death occurred in more than two children.



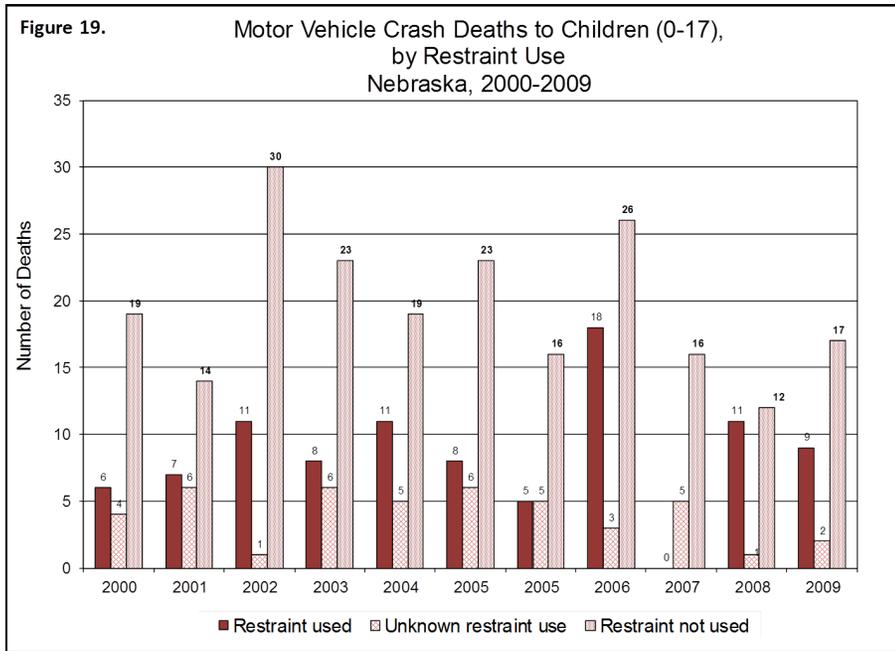
Motor Vehicle-Related Incidents – Key findings

Motor vehicle crashes are the leading cause of death for children over one year old. Reviewers **strongly agreed** that all but one



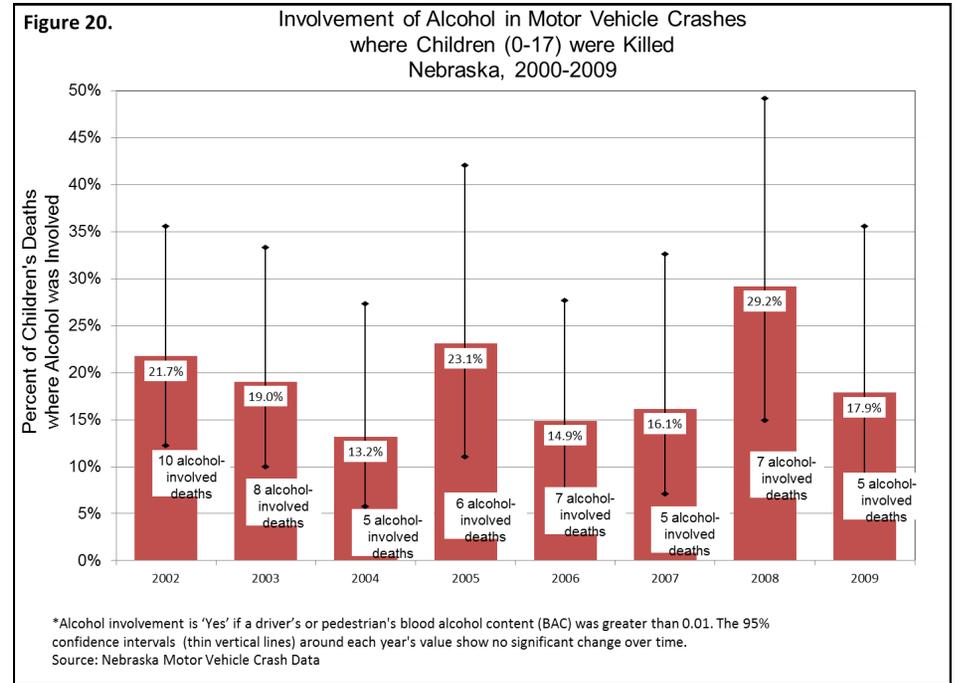
of these deaths were **preventable**; insufficient information was available to make a determination on the remaining incident. One child was killed while riding an all-terrain vehicle (ATV; Table 11).

Seatbelt use remains a factor in many deaths (Figure 19). Of the 31 children killed in a car crash, at least two-thirds (67.7%) were unrestrained or improperly restrained. Among five children under the age of 14, one was in a car seat that was too small, one toddler was secured only by a seat belt instead of in a car seat, and three were completely unrestrained.



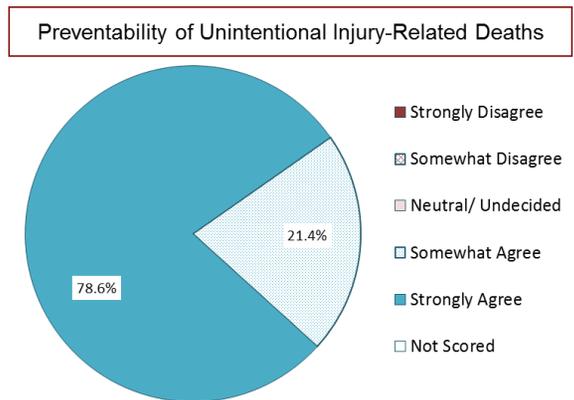
A majority (71%) of teens who were driving when killed were not wearing a seat belt.

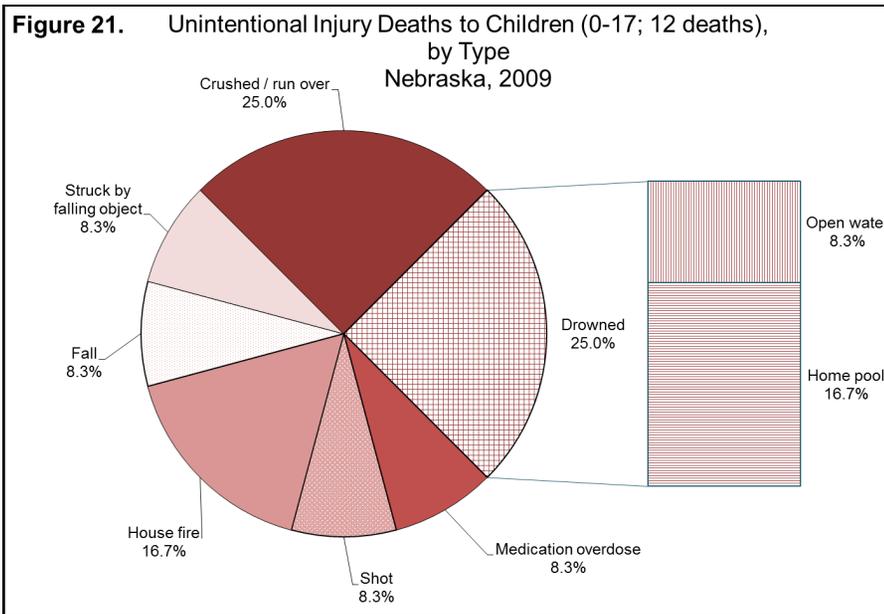
At least five (17.9%) of the fatal crashes involved alcohol use by a driver; this figure has remained statistically stable over time (Figure 20).



Unintentional Injuries – Key findings

In 2009, 13 children died from fatal unintentional injuries. Reviewers **strongly agreed** that the majority (78.6%) of these were **preventable**, with the remainder having at least some preventable factors. Three young children died from drowning; two in unattended home pools while one child



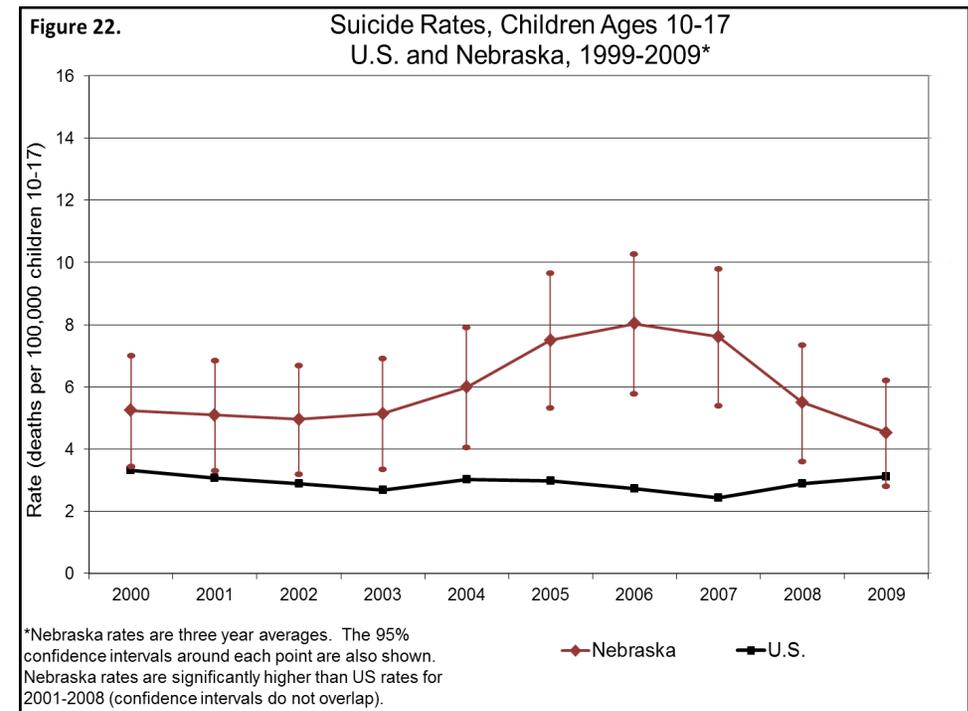
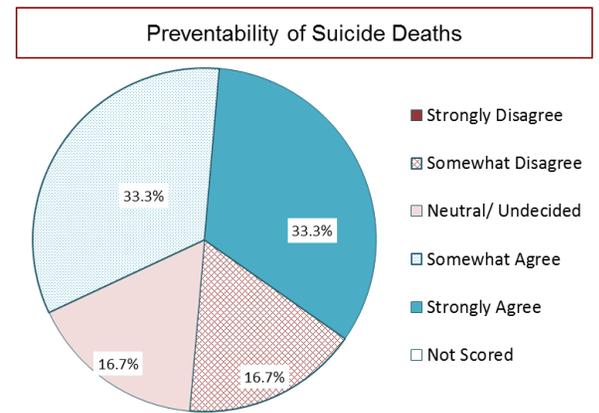


wandered away from home and drowned in a local pond (Table 15; Figure 21). Unfortunately, many parents do not consider installing fencing for inflatable, portable or above-ground pools, which often fall outside of local building codes that require pool barriers. Because they contain such large amounts of water, these pools are often left filled for weeks at a time, presenting a continuous danger for small children.

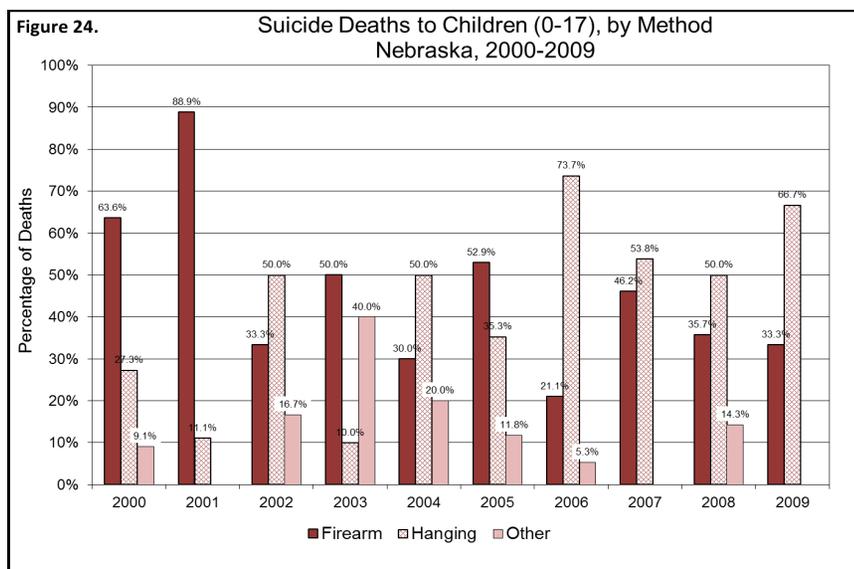
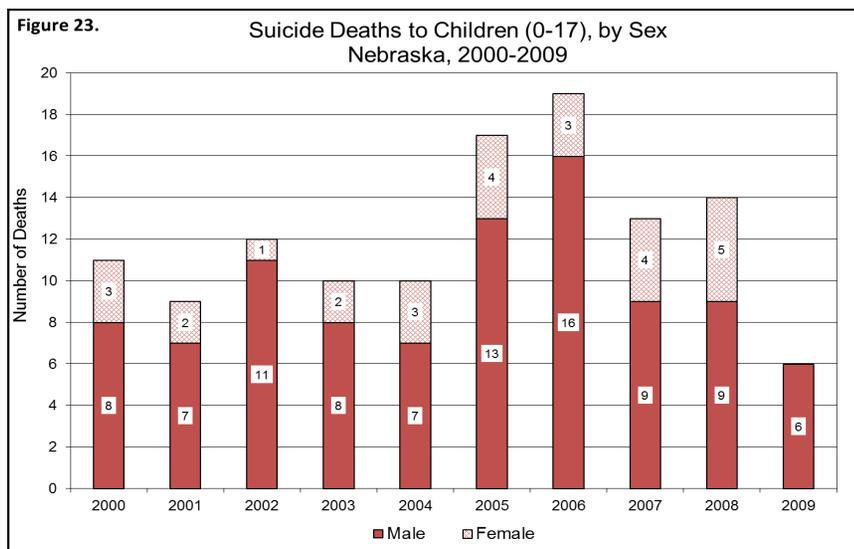
Two children died in a single home fire, started by a child playing with a cigarette lighter. As is common in fire-related deaths, there was no working smoke detector in the home. In two separate incidents, small children were run over by farm equipment. While remaining unintentional injury deaths were from isolated events, reviewers felt all were preventable with more supervision by caretakers.

Suicide – Key findings

The number of teen suicides in Nebraska has been declining since 2006 and in 2009 was at its lowest point – 6 – in a decade (Table 13). However, the national suicide rate showed slight increases between 2007 and 2009 (Figure 22), and sustaining prevention activities is clearly important. Reviewers **some-what or strongly agreed** that at least two-thirds (66.6%) of Nebraska’s suicides in 2009 were **preventable**.



Teen suicide victims continue to be predominantly male (Figure 23). In looking at motives and underlying circumstances, the same themes were noted in 2009 as have been identified in previous reports - particularly access to firearms,



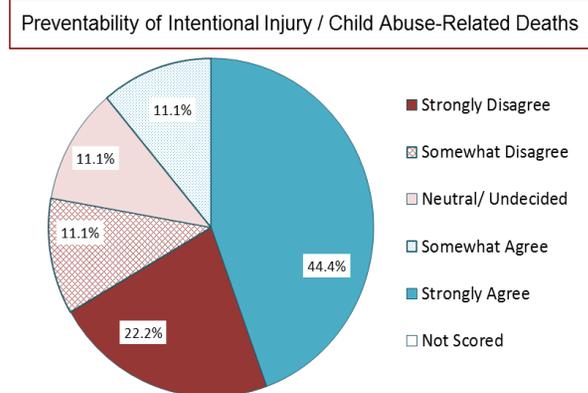
and openly expressed thoughts of suicide that were not taken seriously.

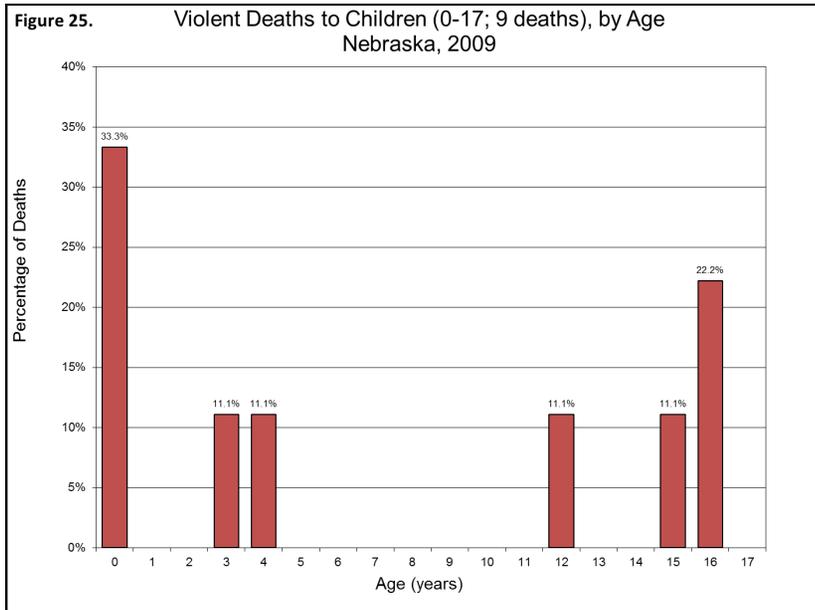
The rise in teen suicides noted from 2004 to 2006 led to considerable resources being devoted to prevention. Over 1,200 Nebraska youth have been screened for suicide risk since the Nebraska Youth Suicide Prevention project began in 2009. Restricting home access to lethal means of suicide is an effective way to increase the chances that a suicidal person will receive the assistance they need, by buying time and making the most deadly means of suicide harder to access. Research indicates that firearms are the method most commonly used in completed suicides. The percentage of teen suicides in Nebraska conducted by firearms dropped considerably from 63.6% in 2000 to 33.3% in 2002 (Figure 24, Table 13), possibly reflecting decreased household access. However, this percentage has remained largely unchanged since then.

Intentional Injuries / Criminal Child Abuse & Neglect – Key findings

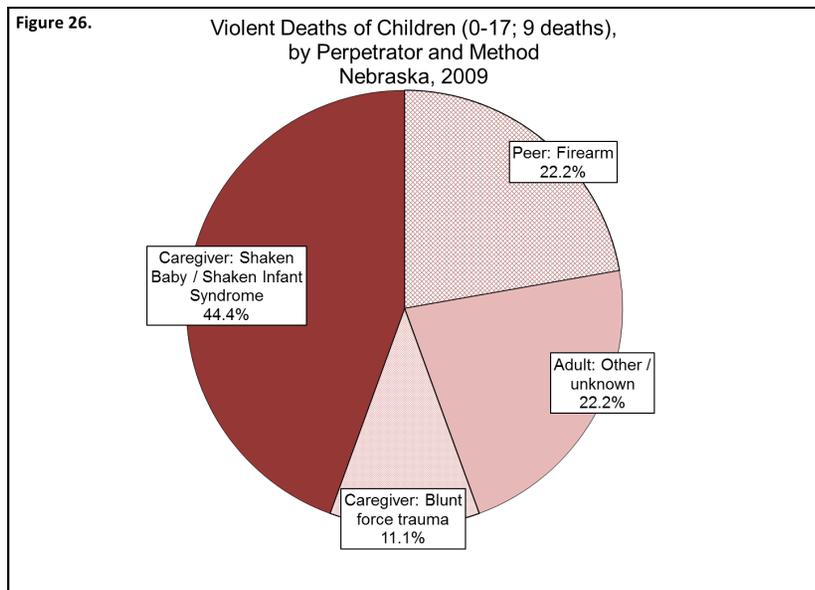
Nine children died of intentionally inflicted injuries in Nebraska in 2009; reviewers **some-what or strongly agreed** that at least

one-half (55.5%) of these deaths were **preventable**. Five children under the age of 12 died due to the actions of a caregiver - parent, relative, or parent's partner, and are thus considered here as child abuse or neglect (Figure 25-26; Table 14). One





young child was killed by a family friend. One teen died from the long-term medical complications of an abusive incident that occurred as an infant while in day care; two teens died



from gun violence.

Quality and affordable child care continues to be unavailable to many families, resulting in small children being left in the care of individuals lacking the necessary skills to provide appropriate care. Poor impulse control by caregivers in response to stress is a frequent factor in these deaths of young children.

Gun violence among teens continues to be a frequent occurrence. Communities must continue efforts to reduce teen violence by working jointly with political leaders, faith based organizations, law enforcement and schools.

Caretaker Neglect

Deaths are attributed to neglect when a child's caretaker(s) knowingly does something that places the child's life in danger or does not remove the child from a dangerous situation. The National Center for Child Death Review recognizes five types of supervisory neglect:

- Failure to protect from hazard
- Failure to provide necessities (food, shelter, other)
- Failure to seek medical care / follow treatment
- Emotional neglect
- Abandonment

Deaths where a caretaker was convicted of child abuse or neglect, or likely would have been if identified, are reported in the category of Criminal Child Abuse / Neglect. CDRT child protection specialists individually reviewed all remaining injury deaths for a possible fit with the categories listed above. While adequacy of supervision clearly played a role, CDRT reviewers did not feel that any of the cases rose to the level of neglect.

Medical Error

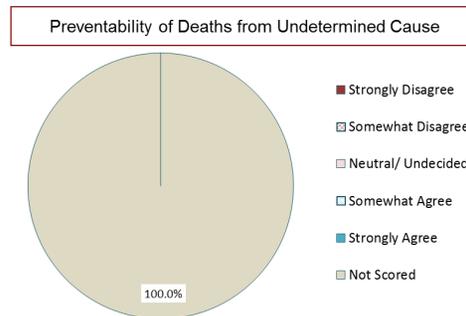
No cases among the 2009 child deaths were attributed to medical error.

Substance Use During Pregnancy

No cases among the 2009 child deaths were attributed to maternal substance use during pregnancy. However, because of the chronic under-documentation of substance use in obstetric and delivery records, it is highly likely that some of the perinatal deaths were related at least in part to such use.

Undetermined

Four children died during 2009 under circumstances that were either highly complex, poorly investigated by local law enforcement, or both. It was thus not possible to determine preventable factors for these cases.



No information available

There were no deaths during 2009 for which the team was unable to obtain at least minimal cause of death information.

KEY RECOMMENDATIONS FOR THE PREVENTION OF FUTURE DEATHS

Goal	#	Strategies	Target
Promote healthy lifestyles for reproductive age women	1	Preconception care, including healthy lifestyles, preconception medical care, optimal diabetes control and regular folic acid supplements before and during pregnancy, should be a vital and routine aspect of care for reproductive age women.	Nebraska Medical Association
		This strategy addresses: Birth Defects, Cancer, General Medical Conditions, Maternal Substance Use, Perinatal Deaths	
	2	Many programs across the state prioritize admission to treatment for substance-addicted pregnant women. The availability of referral options and specialized resources needs to be more widely advertised and disseminated to consumers and medical providers.	DHHS/Division of Behavioral Health Regional Behavioral Health Authorities
		This strategy addresses: Birth Defects, General Medical Conditions, Maternal Substance Use, Perinatal Deaths	
	3	The Nebraska Legislature should increase funding to Tobacco-Free Nebraska, including the Tobacco-Free Nebraska Quitline which serves adult Nebraskans and has tailored cessation counseling protocols for pregnant women and women considering pregnancy.	Nebraska Legislature
		This strategy addresses: Birth Defects, Perinatal Deaths, SUID	

Goal	#	Strategies	Target
Improve assistance to children with disabilities and their families/ caregivers	4	The Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services (CFS) should provide all CFS staff with specialized training on the relationship between children’s disabilities and abuse and neglect.	DHHS/CFS
		This strategy addresses: Birth Defects, Intentional Injuries, Unintentional Injuries	
	5	Nebraska’s state and privately-funded home visitation programs should place increased priority on delivering appropriate services to families of children with severe disabilities.	DHHS
		This strategy addresses: Birth Defects, Caretaker Neglect, Intentional Injuries, Unintentional Injuries	
	6	Additional resources for the Nebraska Birth Defects Registry would allow it to more effectively and accurately monitor and project the state’s needs around children with congenital disabilities.	Nebraska Legislature
		This strategy addresses: Birth Defects	

Goal	#	Strategies	Target
Optimize the delivery of quality medical care	7	Hospitals should reinforce the work of their quality control committees and peer reviews, and be proactive in establishing safeguards for the proper dispensing of medications.	Nebraska Hospital Association
		This strategy addresses: General Medical Conditions, Medical Error, Perinatal Deaths	
	8	The Nebraska Hospital Association and the Nebraska Medical Association should work with its member institutions and providers to develop and implement formal protocols for prompt transfer of children to facilities with appropriate levels of care when needed.	Nebraska Hospital Association Nebraska Medical Association
		This strategy addresses: Cancer, General Medical Conditions	

Goal	#	Strategies	Target
Promote healthy pregnancies	9	The Nebraska Hospital Association and its member institutions need to develop consensus guidelines on the identification of women who abuse substances during their pregnancy, and on detection and treatment procedures for substance-affected newborns.	Nebraska Hospital Association
		This strategy addresses: Birth Defects, General Medical Conditions, Maternal Substance Use, Perinatal Deaths	
	10	The Nebraska Chapter of the March of Dimes and the Nebraska Medical Association are encouraged to continue their collaboration with Nebraska hospitals and community organizations to promote and expand community education on the importance of babies being born at term, signs and symptoms of preterm labor, and establishing plans of actions when those signs are present.	March of Dimes Nebraska Medical Association Nebraska Hospital Association
		This strategy addresses: General Medical Conditions, Perinatal Deaths	

Goal	#	Strategies	Target
Maximize the access to and use of existing medical and preventive options that help keep children healthy	11	Healthy children age 6 months and older should receive an annual flu vaccination. Children under 2 with chronic lung disease, congenital heart disease or who were born prematurely should receive Palivizumab™ to protect against Respiratory Syncytial Virus (RSV).	Nebraska Medical Association Pediatric providers
		This strategy addresses: General Medical Conditions	
	12	The Nebraska Medical Association and their members should take the lead on dispelling myths about vaccine safety and promoting infant and child vaccinations.	Nebraska Medical Association Pediatric providers
		This strategy addresses: General Medical Conditions	
	13	The Nebraska Medical Association and pediatric providers need to review and strengthen their communication strategies with parents of asthmatic children.	Nebraska Medical Association Pediatric providers
		This strategy addresses: General Medical Conditions	
	14	Community-level collaboratives such as Douglas County's Baby Blossoms should continue to promote comprehensive dialogue among health professionals, consumers, cultural organizations and others on the importance of infant back sleeping and risks of bed sharing.	Nebraska communities
		This strategy addresses: SUID	

Goal	#	Strategies	Target
Promote safe and supportive environments for children	15	The Prevention Partnership and organizations involved with Project Everlast should work together to develop plans focusing on young adults previously in foster care, to help them prepare for the responsibilities of parenting. These plans should be implemented in communities across the state.	Prevention Partnership Project Everlast DHHS/CFS and lead agencies
		This strategy addresses: Caretaker Neglect, Intentional Injuries, Unintentional Injuries	
	16	Local communities and civic organizations should ensure that parenting classes are available and accessible to all parents in their community.	Nebraska Communities
		This strategy addresses: Caretaker Neglect, Intentional Injuries, Unintentional Injuries	
	17	Activities that are eligible for quality incentive payments for unlicensed (exempt) child care providers should be expanded, utilizing key components from the state's child care licensing guidelines. The voluntary training and funding options for licensed child care providers need to be expanded, focusing on protective factors for children and families.	DHHS/CFS/Economic Assistance Unit—Child Care Subsidies and Child Care Grant Fund
		This strategy addresses: Caretaker Neglect, Intentional Injuries, Unintentional Injuries	
	18	The Nebraska Safety Council, Safe Kids chapters and other community partners should work to upgrade Nebraska's child safety seat law to include children up to a minimum of age 8, and Nebraska's safety belt law to primary (standard) enforcement.	Nebraska Safety Council Safe KIDS chapters
		This strategy addresses: Motor Vehicle-Related Deaths	
	19	The Nebraska Safety Council should work with partners and the Legislature to restrict ATV use by children and young teens to those with engine sizes of 90 cc or below. Nebraska's county extension offices should expand the dissemination of materials on ATV safety and use.	Nebraska Safety Council
		This strategy addresses: Motor Vehicle-Related Deaths, Unintentional Injuries	
	20	Local Safe Kids chapters and health departments should ensure continuing inspections of public pools and spas, promote local ordinances on pool fencing and barriers, and actively disseminate key information on water safety to parents and families.	Safe Kids chapters Local Health Departments
		This strategy addresses: Unintentional Injuries	

Goal	#	Strategies	Target
Promote safe and supportive environments for children (continued)	21	All Nebraska state and local government-sponsored drowning prevention and fire prevention materials should be available and distributed in Spanish.	DHHS Local Health Departments
		This strategy addresses: Unintentional Injuries	
	22	Local Safe Kids chapters, local fire departments, and health departments should work together to promote and implement proper use and maintenance of smoke detectors, fire prevention education, and home fire escape plans.	State Fire Marshal's Office Safe Kids chapters Local Health Departments
		This strategy addresses: Unintentional Injuries	
	23	School districts, local Child Abuse Task Forces, state mandated local 1184 teams, local County Attorneys and civic leaders should promote and finance community violence prevention programs in their communities.	School districts Local 1184 teams Nebraska County Attorneys Association
		This strategy addresses: Intentional Injuries	
	24	The Nebraska Departments of Education and Health & Human Services should partner to locate and train Suicide Prevention Specialists in schools and Educational Service Units.	Nebraska Department of Education DHHS
		This strategy addresses: Suicide	
	25	Nebraska's County Attorneys should work with local law enforcement agencies to conduct local media campaigns promoting the secure and locked storage of firearms.	Nebraska County Attorneys Association
		This strategy addresses: Suicide, Unintentional Injuries	
	26	The training modules for DHHS Child Protective Services (CPS) staff and contractors should include how to assess a youth's level of depression and suicide ideation. CPS should modify current assessment protocols to include teens' level of depression and suicide ideation, document existing mental health referrals and contact, and make additional referrals as indicated.	DHHS/CFS
		This strategy addresses: Suicide	

Goal	#	Strategies	Target
Improve the quality of the investigation and documentation of child deaths	27	Continuing education on cause of death determination should be available to and required of all persons who fill out death certificates.	Nebraska Medical Association Medical Schools
	This strategy addresses: All causes of death		
	28	The state's existing protocol on child death scene investigations needs to be actively promoted and implemented, including continuing education credits for training, and the development of a regional system of experts in child death scene investigations.	Nebraska Law Enforcement Training Center Nebraska Attorney General's Office Nebraska County Attorneys Association
	This strategy addresses: Caretaker Neglect, Intentional Injuries, Suicide, SUID, Unintentional Injuries		
	29	A standardized death scene investigation should be conducted for all child deaths. Doll reenactments should be part of the investigative protocol for sleep-related infant deaths.	Nebraska Law Enforcement Training Center Nebraska Attorney General's Office Nebraska County Attorneys Association
	This strategy addresses: Caretaker Neglect, Intentional Injuries, Suicide, SUID, Unintentional Injuries		
	30	Full analyses - toxicological, microbiologic, radiologic and vitreous chemistry, in addition to a complete autopsy, should be performed on all cases of unexpected infant death. Toxicological analyses should also be performed on their caretakers.	Nebraska Law Enforcement Training Center Nebraska Attorney General's Office Nebraska County Attorneys Association
	This strategy addresses: Caretaker Neglect, SUID, Unintentional Injuries		

APPENDIX 1 – Detailed Data Tables

Table 1. Underlying Cause of Death	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000 - 2009 TOTAL
	(N)										
Preterm Birth	47	34	44	24	45	31	32	53	42	38	390
Maternal Complications	38	46	35	34	37	37	30	38	30	24	349
Complications of Labor & Delivery	4	5	7	1	2	1	0	7	1	3	31
Other Pregnancy & Neonatal-Related Conditions	1	5	0	0	3	0	3	3	2	1	18
Total, Pregnancy-Related	90	90	86	59	87	69	65	101	75	66	788
Pregnancy Related	90	90	86	59	87	69	65	101	75	66	788
Birth Defects / Inherited & Chromosomal Disorders	66	69	68	61	74	42	60	62	56	56	614
SIDS / SUID	27	26	19	23	18	33	20	17	13	23	219
Cancer / Neoplasms	11	8	12	9	19	18	7	10	13	9	116
Infectious, Chronic & Other Medical Conditions	20	22	27	17	17	19	18	22	15	18	195
Motor Vehicle Crash	36	38	44	48	40	33	44	35	24	32	374
Non-MVC Unintentional Injuries	19	11	17	15	22	13	21	11	32	14	175
Suicide	11	9	12	10	10	17	19	13	14	6	121
Homicide / Criminal Child Abuse & Neglect	14	7	13	15	13	10	19	12	11	9	123
Caretaker Neglect	6	3	4	3	0	3	2	5	4	0	30
Maternal Substance Use	0	1	0	2	0	2	0	1	0	0	6
Medical Error	0	2	1	0	0	0	1	1	1	0	6
Undetermined	0	0	0	0	1	1	2	1	2	4	11
No / Insufficient Information	1	2	5	5	1	0	0	0	0	0	14
Total (N)	301	288	308	267	302	260	278	291	260	237	2,792
Percent (%)	10.8%	10.3%	11.0%	9.6%	10.8%	9.3%	10.0%	10.4%	9.3%	8.5%	100%
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Preterm Birth	52.2%	37.8%	51.2%	40.7%	51.7%	44.9%	49.2%	52.5%	56.0%	57.6%	49.5%
Maternal Complications	42.2%	51.1%	40.7%	57.6%	42.5%	53.6%	46.2%	37.6%	40.0%	36.4%	44.3%
Complications of Labor & Delivery	4.4%	5.6%	8.1%	1.7%	2.3%	1.4%	0.0%	6.9%	1.3%	4.5%	3.9%
Other Pregnancy & Neonatal-Related Conditions	1.1%	5.6%	0.0%	0.0%	3.4%	0.0%	4.6%	3.0%	2.7%	1.5%	2.3%
Total, Pregnancy-Related	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pregnancy Related	29.9%	31.3%	27.9%	22.1%	28.8%	26.5%	23.4%	34.7%	28.8%	27.8%	28.2%
Birth Defects / Inherited & Chromosomal Disorders	21.9%	24.0%	22.1%	22.8%	24.5%	16.2%	21.6%	21.3%	21.5%	23.6%	22.0%
SIDS / SUID	9.0%	9.0%	6.2%	8.6%	6.0%	12.7%	7.2%	5.8%	5.0%	9.7%	7.8%
Cancer / Neoplasms	3.7%	2.8%	3.9%	3.4%	6.3%	6.9%	2.5%	3.4%	5.0%	3.8%	4.2%
Infectious, Chronic & Other Medical Conditions	6.6%	7.6%	8.8%	6.4%	5.6%	7.3%	6.5%	7.6%	5.8%	7.6%	7.0%
Motor Vehicle Crash	12.0%	13.2%	14.3%	18.0%	13.2%	12.7%	15.8%	12.0%	9.2%	13.5%	13.4%
Non-MVC Unintentional Injuries	6.3%	3.8%	5.5%	5.6%	7.3%	5.0%	7.6%	3.8%	12.3%	5.9%	6.3%
Suicide	3.7%	3.1%	3.9%	3.7%	3.3%	6.5%	6.8%	4.5%	5.4%	2.5%	4.3%
Homicide / Criminal Child Abuse & Neglect	4.7%	2.4%	4.2%	5.6%	4.3%	3.8%	6.8%	4.1%	4.2%	3.8%	4.4%
Caretaker Neglect	2.0%	1.0%	1.3%	1.1%	0.0%	1.2%	0.7%	1.7%	1.5%	0.0%	1.1%
Maternal Substance Use	0.0%	0.3%	0.0%	0.7%	0.0%	0.8%	0.0%	0.3%	0.0%	0.0%	0.2%
Medical Error	0.0%	0.7%	0.3%	0.0%	0.0%	0.0%	0.4%	0.3%	0.4%	0.0%	0.2%
Undetermined	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.7%	0.3%	0.8%	1.7%	0.4%
No / Insufficient Information	0.3%	0.7%	1.6%	1.9%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%
Total (N)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 2. Perinatal Causes of Death		Preterm (< 37 wks)		Not Preterm (37+ wks)		Not an infant		Subtotal		TOTAL	
		(N)	(%)	(N)	(%)	(N)	(%)				
Maternal Complications		21	87.5%	2	8.3%	1	4.2%	24	100%	24	36.4%
	Diabetes, IDDM	0	0.0%	1	100.0%	0	0.0%	1	4.2%		
	HELLP Syndrome	2	100.0%	0	0.0%	0	0.0%	2	8.3%		
	Incompetent cervix	6	100.0%	0	0.0%	0	0.0%	6	25.0%		
	Infection / chorioamnionitis	2	100.0%	0	0.0%	0	0.0%	2	8.3%		
	Infection, CMV	1	100.0%	0	0.0%	0	0.0%	1	4.2%		
	Infection, perinatal HIV	0	0.0%	0	0.0%	1	100.0%	1	4.2%		
	Infection, other*	3	100.0%	0	0.0%	0	0.0%	3	12.5%		
	Lupus (SLE)	1	100.0%	0	0.0%	0	0.0%	1	4.2%		
	Placental abruption	6	100.0%	0	0.0%	0	0.0%	6	25.0%		
	Uterine rupture	0	0.0%	1	100.0%	0	0.0%	1	4.2%		
Complications of Labor and Delivery**		2	66.7%	1	33.3%	0	0.0%	3	12.5%	3	4.5%
Other Perinatal Complications***		0	0.0%	1	100.0%	0	0.0%	1	4.2%	1	1.5%
Prematurity (no cause identified)		38	100.0%			0	0.0%	38	100%	38	57.6%
	Singletons	25	100.0%			0	0.0%	25	65.8%		
	Multiples	13	100.0%			0	0.0%	13	34.2%		
Total (N)		61	92.4%	4	6.1%	1	1.5%			66	100.0%

*Parvovirus, toxoplasmosis.

**Nuchal cord, obstructed delivery.

***Necrotizing enterocolitis.

TABLE 3. Birth Defects / Inherited & Chromosomal Disorders	Preterm (<37 wks)	Not Preterm (37+ wks)	Unknown gestational age	Not an infant	(N)	(%)
Chromosomal anomaly, Trisomy 13 (Patau syndrome)	3	0	0	0	3	5.4%
Chromosomal anomaly, Trisomy 18 (Edwards syndrome)	4	4	0	0	8	14.3%
Chromosomal anomaly, Trisomy 21 (Down syndrome)	2	0	0	0	2	3.6%
Chromosomal anomaly, other	3	2	0	0	5	8.9%
Cockayne Syndrome	0	0	0	1	1	1.8%
Diaphragmatic hernia	0	2	0	0	2	3.6%
Head / brain anomalies	2	1	0	1	4	7.1%
Heart disease, hypoplastic left	0	4	0	1	5	8.9%
Heart disease, other	2	3	0	1	6	10.7%
Hurler Syndrome	0	0	0	1	1	1.8%
Kidney defect / anomaly	1	1	0	0	2	3.6%
Limb-body wall complex	1	0	0	0	1	1.8%
Marfan Syndrome	0	1	0	0	1	1.8%
Metabolic disorder	0	1	0	0	1	1.8%
Mitochondrial disorder	0	1	0	0	1	1.8%
Multiple congenital anomalies	1	1	0	0	2	3.6%
Muscular dystrophy	1	0	0	0	1	1.8%
Neural tube defect, anencephaly	0	2	0	0	2	3.6%
Neural tube defect, encephalocele	1	0	0	0	1	1.8%
Neural tube defect, hydrancephaly	0	2	0	0	2	3.6%
Neural tube defect, schizencephaly	0	0	0	1	1	1.8%
Posterior urethral valve	2	0	0	0	2	3.6%
Pulmonary hypoplasia	1	0	0	0	1	1.8%
Spinal muscular atrophy	0	1	0	0	1	1.8%
Total (N)	24	26	0	6	56	100%

TABLE 4. Sudden Unexpected Infant Death – Diagnoses	Vital Records	CDRT
SIDS / SUID	24	23
Suffocation / Unspecified threat to breathing	0	1
Heart disease	1	0
Drug toxicity	0	0
Pneumonia	0	0
Assault	0	0
Undetermined	0	1
Total (N)	25	25

TABLE 5. Sudden Unexpected Infant Death – Race / Ethnicity	Total	(%)
White	16	69.6%
African-American	5	21.7%
Native American	2	8.7%
Asian/ Pacific Islander	0	0.0%
Total (N)	23	100.0%
Hispanic Ethnicity	2	8.7%

TABLE 6. Sudden Unexpected Infant Death– Sex	Total	(%)
Male	15	65.2%
Female	8	34.8%
Total (N)	23	100%

TABLE 7. Sudden Unexpected Infant Death – Caretaker	Total	(%)
Babysitter / Child Care	2	8.7%
Parents / Family member	20	87.0%
Other	1	4.3%
Unknown	0	0.0%
Total (N)	23	100.0%

TABLE 8. Sudden Unexpected Infant Death – Risk Factors	Number	(%)
Pre- or post-natal smoke exposure	16	64.0%
Age-inappropriate sleep surface	15	60.0%
Found on side or stomach	13	52.0%
Bed-sharing	12	48.0%
Bedding-related issues	11	44.0%
Put to sleep on side or stomach	9	36.0%
Current / recent respiratory infection	9	36.0%
Prenatal drug exposure	3	12.0%
No known risk factors	0	4.0%

TABLE 9. Cancer / Neoplasms	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total	
	Age (yrs)	Age (yrs)	Age (yrs)	Age (yrs)	Age (yrs)	Age (yrs)	(N)	%				
Adrenal gland			9y	5y							2	1.8%
Bone, all sites	10				13						2	1.8%
Brain (total)	2	4	6	3	10	4	2	3	3	2	39	35.8%
Astrocytoma / glioma		15	3, 5, 16	7	10, 13, 13	4, 11, 15, 15	9, 14	11	6, 7	1	18	13.8%
Brain stem, unspecified					3, 6					1	3	2.8%
Choroid plexus						8					1	0.9%
Ependymoma					6						1	0.9%
Glioblastoma									8		1	0.9%
Medulloblastoma				8	13	4, 8					4	3.7%
Rhabdoid					1			3 wks, 9			3	2.8%
Unspecified	10, 11	4, 6, 11	4, 9, 10	2	2, 10, 12, 14, 16						11	10.1%
Ewing's sarcoma	9					2	New-born, 14	8			5	4.6%
Hepatic carcinoma / hepatoblastoma				5		7, 7, 15					3	2.8%
Leukemia, acute or chronic	3, 12, 12	13, 16			2, 4, 17	13		3, 10, 13	3, 3, 4, 8, 14, 16	2, 7, 16	21	19.3%
Lung, squamous cell carcinoma								14			1	0.9%
Lymphoma, Hodgkin's		17		17							2	1.8%
Lymphoma, non-Hodgkin's ("lymphoblastic")			11							5	2	1.8%
Medulloblastoma										4	1	0.9%
Mesothelioma, peritoneal		17									1	0.9%
Neuroblastoma	3, 4, 4		5			3, 8, 17	5	2	7, 10	15	12	11.0%
Osteosarcoma				4	17		17		15		4	3.7%
Palate tumor				16							1	0.9%
Pelvic sarcoma			14								1	0.9%
Rhabdomyosarcoma	7					4	15	7		3	5	4.6%
Wilms' tumor			3, 6	16	4	7, 12			8		7	6.4%
Unspecified type											0	0.0%
Total (N)	11	8	12	9	19	18	7	10	13	9	109	100.0%

TABLE 10. Infectious, Chronic and Other Disease Conditions	(N)	%
Respiratory Diseases	7	38.9%
Asthma, treated	2	11.1%
Bronchitis / bronchopneumonia	2	11.1%
H1N1 Influenza	1	5.6%
Pneumonia, aspiration	1	5.6%
Respiratory Syncytial Virus	1	5.6%
Circulatory System	2	11.1%
Arrythmia, unknown origin	1	5.6%
Myocarditis, viral	1	5.6%
Other	9	50.0%
Autoimmune enteropathy	1	5.6%
Cerebral palsy (complications)	2	11.1%
Giant cell hepatitis	1	5.6%
Neonatal cardiac failure	1	5.6%
Perforated bowel	1	5.6%
Post-partum sepsis (maternal death)	1	5.6%
Renal failure	1	5.6%
Unknown medical cause	1	5.6%
TOTAL	18	100.0%

TABLE 11. Motor Vehicle-Related Incidents¹	(N)
Motor Vehicle Crash - Restraint status²	
Restrained	6
Not restrained ³	21
Unknown	4
MVC Subtotal	31
Other Motor Vehicle-Related Incident	
Bicycle / scooter	0
All-Terrain Vehicle	1
Other Subtotal	1
Total (N)	32
¹ Only includes motor vehicles engaged in traffic. Categories refer to the location of the child. ² Age-appropriate restraints: car seat or booster seat for children through age 8; seatbelt and/or shoulder harness for older ages. ³ Includes two cases of improper use of car seats.	

TABLE 12. Unintentional Injury	(Age)
Codeine overdose	16y
Crushed in tipped-over forklift	17y
Struck by falling furniture	3y
Drowned, home pool	1y, 2y
Drowned, open water (boating / swimming / walking)	2y
Fall from playground slide	2y
Fire, house*	9m & 6y
Run over by farm equipment	1y, 3y
Hit by ricocheting bullet	16y
Suffocation/strangulation, sleep-related	1m
Swallowed toxic object	3y
Total (N)	14
Ages are given in years (y) or months (m).	
*Deaths connected with "&" are from the same incident.	

TABLE 13. Suicide		Firearms (Age)		Hanging (Age)		Overdose (Age)		Other (Age)		Subtotal (N) %		Total (N) %	
2000	Male	13, 17, 17, 17, 16		14, 16		16		-		8	72.7%	11	9%
	Female	14, 16		17		-		-		3	27.3%		
2001	Male	14, 15, 15, 15, 16, 16, 17		-		-		-		7	77.8%	9	7%
	Female	15		14		-		-		2	22.2%		
2002	Male	16, 16, 17		11, 12, 15, 17, 17, 17		16		13		11	91.7%	12	10%
	Female	16		-		-		-		1	8.3%		
2003	Male	12, 13, 13, 16, 17		15		-		17, 17		8	80.0%	10	8%
	Female	-		-		-		14, 16		2	20.0%		
2004	Male	13, 17		13, 14, 16, 17		-		15		7	70.0%	10	8%
	Female	16		15		-		16		3	30.0%		
2005	Male	14, 14, 15, 15, 16, 16, 16, 17, 17		11,14,14,17		-		-		13	76.5%	17	14%
	Female	-		14, 15		-		14,16		4	23.5%		
2006	Male	15, 15, 16, 17		13, 13, 13, 14, 14, 15, 15, 15, 15, 16, 17, 17		-		-		16	84.2%	19	16%
	Female	-		16, 17		17		-		3	15.8%		
2007	Male	13, 15, 16, 16, 17, 17		15, 15,17		-		-		9	69.2%	13	11%
	Female	-		13, 14, 14, 17		-		-		4	30.8%		
2008	Male	16, 16, 16, 17		9, 16, 16, 17		-		16		9	64.3%	14	12%
	Female	16		14, 15, 16		17		-		5	35.7%		
2009	Male	13, 16		12, 15, 16, 16		-		-		6	100.0%	6	5%
	Female	-		-		-		-		0	0.0%		
Subtotal	Male	47	88.7%	40	74.1%	2	50.0%	5	50.0%	94	77.7%	121	95%
(N)	Female	6	11.3%	14	25.9%	2	50.0%	5	50.0%	27	22.3%		
Total (N)		53		54		4		10		121			
		44%		45%		3%		8%		100%			

TABLE 14. Intentional injury	(Age)
Criminal child abuse or neglect (alleged or convicted)	
Blunt force trauma	15y*
Shaken Baby / Shaken Infant Syndrome	3m, 7m, 8m, 4y
Subtotal (N)	5
Homicide / manslaughter (alleged or convicted)	
Smothered	3y
Firearm	16y, 16y
Unknown method	12y
Subtotal (N)	4
Total (N)	9
Ages are given in years (y), months (m) and weeks (wks). Cases separated by "&" refer to siblings.	

APPENDIX 2 – Safe Sleep Environment for Infants

Safe Sleep Tips for your Baby:

1. Put baby on his/her back to sleep and be sure to tell other caregivers about a safe sleep place.



- Childcare providers
- Grandparents and other family members
- Babysitters

2. Use a firm mattress covered with a fitted sheet in a safety-approved crib.



3. There shouldn't be more than a soda can's width between bars.



4. Remove pillows, blankets, stuffed toys and other soft objects from the crib. Don't use devices to prop baby on side.



5. Consider using a "blanket sleeper" instead of blankets, which can get wrapped around baby's head.

6. Avoid overheating; baby shouldn't be sweating or hot to the touch. The ideal room temperature is one that's comfortable to a lightly clothed adult.

7. Consider offering a pacifier once breastfeeding is established.

8. Create a smoke-free zone around baby, particularly when sleeping.



NO SMOKING

9. Baby should have a separate sleeping space in the parent's room. Don't let baby sleep on an adult bed, waterbed, armchair, couch or other soft surface. Baby shouldn't share any sleep surface with another child or adult.

10. Remember to have supervised tummy time when baby's awake.



Copies of this brochure are available from 1-800-801-1122 or <http://dhhs.ne.gov/publichealth/Documents/SIDSBrochure.pdf>

Nebraska Child Death Review Report

For Deaths Occurring in 2009

New report, 9/2013

Department of Health & Human Services

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