residents participate in the showers so we can assess the efficacy of the showers' ability to increase pediatric resident's knowledge of and comfortability with discussing injury prevention with families.

Results: We expect our intervention to improve expectant parents' knowledge of and comfortability with infant injury prevention topics. We hope by providing some infant safety devices parents will endorse adherence to infant safety practices. Additionally, we expect pediatric residents' knowledge and comfortability with discussing injury prevention topics to be on the lower side at baseline since they do not receive much training on these topics at present. We hope the residents that attend the showers will have improved knowledge and comfortability with infant safety topics as opposed to their colleagues who did not attend.

Conclusions: Infant safety is a wide array of topics that can be overwhelming for both parents and healthcare providers. We believe that safety baby showers will improve both parents' knowledge and comfortability in practicing infant injury prevention along with improving pediatric resident knowledge and comfortability discussing these topics with parents.

Objectives: 1. Key components of safety baby showers. 2. Safety baby showers can be implemented into existing programs. 3. Areas pediatric residents may improve in their knowledge of infant safety.

Injury prevention program development driven by top-down commitment to distribute firearm safety kits in a large metropolitan area

Sarah Beth Abbott, BS, EMT-LP
Injury Prevention and Outreach Education Coordinator
Children's Memorial Hermann Hospital
sarah.abbott@memorialhermann.org

Authors: *Sarah Beth Abbott, BS, EMT-LP*

Background: Firearm injury is a leading and preventable cause of death for adolescence in the United States. Our region, which encompasses several large metropolitan areas, is particularly concerning for injuries and fatalities caused by firearms. In response to the crossing of the lines of the Center for Disease Controls and Prevention mortality data, validation of local TraumaBase© Registry System data, and increased prevalence of school shootings, our President and Chief Executive Officer, of one of the largest not-for-profit health systems, publicly pledged to provide thousands of firearm safety kits to individuals and families in our community. The Level I Pediatric Trauma Center Injury Prevention and Outreach Education Coordinator was then delegated by leadership to develop a program that is committed to reducing injuries and death from firearms by increasing awareness and education of protective measures and risk factors.

Methods: The Injury Prevention Coordinator utilized a systematic approach in developing a firearm safety kit distribution program that would be ideal for the 11-hospital system in the large metropolitan area. The coordinator used the five core components of Model Level I and Level II Trauma Center injury and violence prevention programs: Leadership, Resources, Data, Effective Interventions and Partnerships. Literature review and Logic Model development were significant early in the process. Recruitment of key champions, content experts, system communications/public relations, material management and marketing for the project occurred during 7/2022-12/2022 with kit distribution during 1/2023-4/2023. Evaluation design included mixed-methods approach with data collected from champions after the 22 specific interventions for quantitative and qualitative data.

Results: In a mere 94 calendar days, the injury prevention champions vested into this firearm safety kit project, disseminated 10,000 kits into the metropolitan community at 22 unique locations during outreach events. Outreach events included internal (hospital locations) and external (community partners, art/health fairs, major sporting events, standing hemorrhage control courses and health clinics). Firearm safety kit contents included: Master Lock Cable Lock, Babysitter Information Tear Pad (asking if there is an unlocked gun in the home?), 988 Suicide and Crisis Lifeline Flyer and Fact Sheet: Firearm Injury Prevention Education for Parents (English/Spanish).

Conclusions: With using injury prevention core components, thorough program planning, having transparent conversations and keen diligence of all stakeholders led to a plan that can be replicated in large metropolitan areas when top-down decisions arise. The project also resulted in establishing the foundation and support of a more robust firearm safety program within the large not-for-profit health system in the future.

Objectives: 1. Discuss the five core components of Model Level I and Level II Trauma center injury and violence prevention program. 2. Understand the importance of logic model development in a firearm safety kit distribution program. 3. Recognize the significance of collaboration and community resources in relation to firearm safety.

Review of Pediatric Pedestrian Fatalities Through a Safe System Lens to Prevent Future Deaths: Differences in Child and Adolescent Risk Factors

Tanya Charyk Stewart, MSc
Injury Epidemiologist & Data Specialist, London Health Sciences Centre
Adjunct Research Professor, Depts of Paediatrics and Pathology & Laboratory Medicine, Schulich School of Medicine & Dentistry at Western University
Associate Scientist, Lawson Health Research Institute
Motor Vehicle Safety (MOVES) Research Team, Western University

Authors: *Tanya Charyk Stewart, MSc; Kevin McClafferty, BESc; Moheem Halari, MBBS; Allison Pellar, MEng; Pascal Verville, PEng; Michael Pickup, MD; Douglas Fraser, MD; Jason Gilliland, PhD; Mike Shkrum, MD*

Background: Pediatric pedestrians are a particularly vulnerable road user group, comprising an increasing proportion of road traffic injuries and deaths. The objective of this study was to review the epidemiology of child and adolescent pedestrian fatalities to identify risk factors to target via a safe system approach.

Methods: Fatal pedestrian collision and injury data were collected from the Office of the Chief Coroner (2013-19), with selected crash investigations. Descriptive analyses were undertaken. Child (< 14 years) and adolescent (15-19 years) pedestrian crashes were compared with Pearson chi square