

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
999 ASYLUM AVENUE, HARTFORD, CONNECTICUT 06105



Jeanne Milstein
Child Advocate

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NEWS RELEASE
FROM THE CHILD ADVOCATE

**CONNECTICUT CHILD FATALITY REVIEW PANEL RELEASES REPORT THAT EXAMINES
TEN YEARS OF CHILD FATALITIES**

Connecticut's Child Fatality Review Panel (CFRP) released a report today that examines ten years of child fatality data in this state titled "*An Examination of Connecticut Child Fatalities, A Ten Year Review: January 1, 2001 to January 1, 2011.*"

The CFRP, consisting of statewide health, legal, child welfare, and law enforcement officials and chaired by Child Advocate Jeanne Milstein, meets monthly to review all unexpected or unexplained deaths of children in Connecticut. The panel has compiled this first-ever report on the tragedy of children's deaths to shine a light on critically important prevention efforts throughout Connecticut.

This comprehensive 10-year review is part of a national effort to efficiently compile and analyze nationwide data on child fatalities. The report's recommendations seek to strengthen efforts to prevent deaths of children due to homicide, suicide, and accidents. Milstein emphasized that "the goal of child fatality reviews is to put forth recommendations that, if implemented, will help prevent other tragedies from occurring. Most of these deaths are preventable."

In the ten year period covered by the report, the CFRP examined the deaths of 1,529 children in Connecticut. The CFRP examined 400 accidental child fatalities, more than half of which involved teen drivers and teen passengers. Drowning, fire, asphyxia, and overdoses accounted for a significant number of accidental deaths. Accidents are often the leading cause of preventable death for children.

Over the 10-year reporting period, seven percent of child deaths in Connecticut were homicides. The majority of child homicide victims were boys, and most were killed by someone they knew or to whom they were related. Homicides of children under two are most often attributed to abusive trauma, such as when babies are shaken. The majority of homicide victims ages 13 to 17 were killed by gunshot wounds.

Infant deaths were discussed extensively in this report. Seventy-seven percent of the 106 Undetermined deaths were infants; many of those were in unsafe sleep environments, such as adult beds.

The CFRP reviewed the deaths of 77 children and youth who have committed suicide in Connecticut over this 10-year period. Two of the CFRP's published reports, regarding the suicide deaths of Falan F. and Joseph Daniel S., have led to significant reforms in the practice of incarceration for youth, and intensive

ongoing bullying prevention efforts. Bullying has been identified as a significant risk factor for suicide among youth in Connecticut and throughout the country. Leaders in Connecticut's legislature, school systems, and communities have responded with strong efforts to create protective environments and support systems for children and youth in Connecticut.

The Child Fatality Review Panel's 10-year review identified some important overall trends in child deaths, such as a reduction in the rate of fatal motor vehicle accidents. The report offers a number of recommendations for further conversations and intensified efforts toward prevention of child fatalities in Connecticut.

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For further information contact: Jeanne Milstein at 860-566-2106