

**An Examination of Connecticut Child Fatalities
A Ten Year Review
January 1, 2001 to January 1, 2011**



Sudden Infant Death	Accidents	Bullying	Fires	Undetermined
Acute Illness	Trauma	Gun Shot Wounds	Hanging	Infant Safe Sleep
Suicide	Overdose	Drowning	Weapons	Substance Use
Teen Driving	Falls	Asthma	Shaken Baby	Risky Behavior
Abuse	Stabbing	Crashes	Homicide	Youth Violence

Child Fatality Review Panel (CFRP) Membership—2011**EX-OFFICIO MEMBERS**

Office of the Child Advocate: Jeanne Milstein, Chairperson

Office of the Chief State's Attorney: Anne Mahoney, Esq.

Office of the Chief Medical Examiner: H. Wayne Carver, M.D.

Department of Emergency Services and Public Protection: Sgt. Seth Mancini, Esq.

Department of Children and Families: Fernando Muniz, M.P.A.

Department of Public Health: Margie Hudson, R.N., M.P.H.

APPOINTED MEMBERS

Yale New Haven Hospital, Pediatrician: Kirsten Bechtel, M.D. by Governor

Public Welfare Practitioner: Richard Dallavalle, by Senate Minority Leader

Community Service Representative: Jane Norgren, M.Ed., M.B.A. by Speaker of the House

Connecticut Children's Medical Center, Pediatrician: Michael Soltis, M.D. by CFRP

Connecticut Coalition Against Domestic Violence: Tonya T. Johnson, by CFRP

Injury Prevention: Russell A. Kimes, Jr., Esq. by House Minority Leader

Psychologist: Kathleen J. Murphy, Ph.D. by House Majority Leader

Law Enforcement: Chief Margaret Ackley, by Senate Pro Tempore

University of Connecticut Health Center, Neonatology: Ted Rosenkrantz, M.D. by CFRP

The Child Fatality Review Panel's "fatality investigations" are public documents and can be obtained from the Office of the Child Advocate upon request. You may also view the reports online (www.ct.gov/oca). Along with the annual child fatality report, there were additional in-depth fatality investigations that were made available to the public over the course of the past decade. The OCA has also participated in numerous other fatality reviews that are posted on the DCF website (www.ct.gov/DCF).



Dear Friends of Connecticut's Children,

December 2011

The Child Fatality Review Panel (CFRP) is providing you with data and information related to ten years of reviewing deaths of Connecticut's children. The CFRP was first established in 1995, following public outcry over the tragic death of Baby Emily. We have published annual reports summarizing findings on the fatalities of children in the state for over a decade. The CFRP shares this comprehensive report with the hope that the tragedy of these children's deaths will continue to shine the light on critically important prevention initiatives. The loss of any child has untold and incalculable consequences for their families, friends, and community. However, what we learn from these deaths will help us serve and support other children and hopefully prevent further tragedies.

The CFRP reviews deaths of children from birth through age 17 that are unexpected or unexplained, and primarily focuses its investigations on the fatalities of children involved in state systems. This review presents findings of the past decade. We have observed positive trends, such as an overall decrease in the number of suicide deaths, but other negative trends persist, which are discussed in this report. We continue to partner with community providers and other state agencies to bring forth a coherent message about the importance of safe sleeping conditions for infants. Connecticut is side-by-side with most other states across the country working on a safe sleep message.

As chair, I would like to acknowledge the hard work and dedication of the members of the CFRP. I would also like to thank the members of the CFRP who are no longer panel members but who have given so much over the past ten years. We come together each month to endeavor in the difficult task of discussing the deaths of children, always with our eyes towards how we can make a difference for other children and families. I would like to specifically thank Faith Vos Winkel, Assistant Child Advocate, who has provided strong, tireless leadership to the Panel. Her efforts have made the Connecticut CFRP a model for the country.

In recognition of this dedication and commitment, I present to the people of Connecticut this ten-year review by the Child Fatality Review Panel.

On behalf of the panel,

Jeanne Milstein
Chairperson, Connecticut Child Fatality Review Panel

“If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped.”

*C. Everett Koop, MD, ScD
Former United States Surgeon General
Chairman, The National SAFE KIDS Campaign*

Dedication

We dedicate this report to the children of Connecticut who have lost their lives through accidents, homicides, suicides, natural causes, and in ways that remain undetermined.

To the families, we are deeply sorry for your loss.

We thank those throughout the state who work tirelessly to protect and serve our young people, and those who positively impact their lives.

To our communities, schools, legislators, media, and the general public, we are grateful for all that you do to prevent childhood injuries and fatalities.

Each of us can make a difference.

*Connecticut Child Fatality Review Panel
December 2011*



Introduction

Protecting Children

Concern for the safety and well-being of our children begins even before they are born. Primary prevention begins prior to conception with parents doing all they can do to ensure a healthy outcome for their baby. Certainly after the baby arrives, parents and caregivers endeavor to keep their baby safe. As our children grow, prevention of accidents and injuries remains paramount. Sometimes despite our best efforts, childhood tragedies occur and some children die. In order to understand the best ways to prevent danger and protect children, there must be a thorough understanding of the risk factors contributing to child death and a focused interest in preventing the fatality of any child. Every state in the United States considers the prevention of the death of any child to be of utmost importance. All states across the country, as well as in the countries of Canada and Great Britain have a child death review process. For Connecticut, the Child Fatality Review Panel (CFRP) is responsible for investigating and improving the understanding of the factors involved in the deaths of children in the state. The CFRP uses the expertise of its multidisciplinary panel membership to make recommendations in order to reduce future risk or death to any child.

The Child Fatality Review Panel

Connecticut General Statutes §46-13k established the state's CFRP to review the circumstances surrounding all unexplained or unexpected child deaths. The statutory authority for the CFRP is embedded in the Office of the Child Advocate (OCA) statute. The CFRP reviews a child's death to determine whether there were contributing risk factors that could be impacted by systemic interventions. Identified risk factors are then incorporated into proposed prevention initiatives designed to decrease the incidence of such deaths. As outlined in statute, the goal of the child fatality review process is to "facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state". The CFRP reviews all unexplained and unexpected child deaths, but typically conducts a full fatality investigation of deaths where state agencies or state-supported services either were or should have been involved in the child's life. The goal of these investigations is to determine the effectiveness of state programs, and to identify what actions or changes can be made to improve the policies, practices, procedures, or the structure of the programs themselves. The fatality review into the death of Michael B. is an example of the importance of a timely and comprehensive fatality investigation. In May 2010 the OCA released a public report on the homicide of this infant. The report outlined 15 comprehensive recommendations for systemic reform. Throughout the course of the investigation, critical findings were provided to the Department of Children and Families. One of the major findings was related to the long-standing practice of recording reports and investigations of DCF employees in a paper record only, rather than in the Department's electronic database. This practice was halted and a several month process ensued to enter all of those paper records into the database. Other recommendations included improving the recruitment, training, support, and assessment of foster parents, as well as enhancing and expanding family-centered practice to focus on families needing substance abuse and mental health treatment.

The Child Fatality Review Panel works closely with the Office of the Chief Medical Examiner (OCME). The OCME determines the manner (Natural, Accidental, Homicide, Suicide, or Undetermined) and cause of death. Connecticut's medical examiner system has all Board Certified Forensic Pathologists, thereby ensuring a robust forensic examination of child fatality cases that fall under their purview. The OCME provides the OCA/CFRP with timely notice of child deaths as outlined in statute. The CFRP publishes an annual report, which is a section in the OCA annual report. These reports offer a brief analysis of child deaths that occurred in a twelve-month period. Information for these reports, as well as this ten-year review, came from the OCA fatality database that was designed in 2001. Unfortunately, that child fatality data collection system has not been upgraded in nearly a decade. Therefore, some trend data require hand counting. Nevertheless, the database remains a good source of information as it contains all records for this ten year reporting period.

A National Initiative

In response to a report by the United States Office of Government Accountability, the United States House of Representatives held a hearing in July 2011 on the issue of child maltreatment deaths. The primary recommendation from that report was "to improve the comprehensiveness, quality, and use of national data on child fatalities from maltreatment" (www.gao.gov/products/GAO-11-599). Recently, the OCA began entering child fatality data on a secure national server sponsored by the National Center for the Review and Prevention of Child Deaths. This data system is funded by the U.S. Health and Human Services Administration and the Centers for Disease Control and Prevention (CDC). At present, nearly 100,000 cases have been entered from 37 states participating in this effort. Compiling comprehensive child fatality data on this system will help to more accurately identify state and national trends in child death. The National Center also serves as the clearinghouse for child death trends and public policy initiatives related to child fatality issues (www.childdeathreview.org). Connecticut has been involved in many national events surrounding child fatality policy. The National Center and the CDC utilized data collected from 18 states on sudden infant death to support the development of a sudden infant death registry; Connecticut's data was part of that project and will help to shape ongoing policy and practice related to infant death.

Connecticut Child Deaths

In Connecticut, for the ten year period from January 1, 2001 to January 1, 2011, the CFRP reviewed the deaths of 1,529 children.

Natural Deaths=840
Accidental Deaths=400
Homicide Deaths=106
Undetermined Deaths=106
Suicide Deaths=77

Footnote: The 1,529 death does not include 5 out-of-state deaths and 2 cases that remain pending further study. The CFRP does not typically review the deaths of infants that survive less than 24-hours after birth due to the sheer volume of those infants; nearly all of these deaths are from complications associated with premature birth. In 2010, 242 infant and fetal deaths were reported to the OCA.

Ten Year Overview

The categories below provide a brief overview of the child deaths over the past decade. Each classification is more thoroughly explained and examined throughout the report.

Natural deaths of children, as with all age groups, accounted for the largest percentage of fatalities for each year. Over the past decade, the CFRP reviewed 840 natural child deaths. However, this is not representative of all natural child deaths in the state. It excludes many natural deaths from cancer, complex heart conditions, chronic health conditions, asthma, complications associated with prematurity, and other acute illnesses. The CFRP does not conduct a thorough review of most of these natural deaths with the exception of Sudden Unexplained Infant Death (SUID)/ Sudden Infant Death Syndrome (SIDS) cases.

Accidental deaths of children are the second leading manner of death in children as well as in people across the life span. Over the past decade, the CFRP reviewed 400 accidental child deaths. Often, accidental deaths are the leading cause of “preventable” death. Examples of accidental deaths include drowning, falls, and motor vehicle crashes. Automobile related fatalities account for over half of the accidental deaths. Overall, the incidence of accidental deaths has decreased in ten years. In 2001, accidents caused 31% of child deaths reviewed by the CFRP. In 2010, accidents accounted for 20% of child deaths reviewed.

Homicide deaths represent the leading cause of intentional injuries of children. During the ten year period, homicides accounted for 106 child deaths in Connecticut. In 2001 and 2004 homicide accounted for 7% of child fatalities. While the number of child homicides peaked in 2006, it has not decreased to a level below that of 2001. Overall, child homicide rates are not significantly different today than they were ten years ago.

Undetermined deaths of children have increased in the past decade. This is largely due to the examination of infant deaths more closely, with a particular focus on the scene. Over the past decade, the CFRP reviewed 106 Undetermined child deaths. Many of these deaths no longer fit into the SIDS category, and instead fall into an undetermined manner of death. In fact, 73% of the undetermined deaths were among infants.

Suicide deaths accounted for the lowest number of child fatalities in Connecticut. Over the past decade the CFRP reviewed 77 child-youth suicides. Suicides represented 9% of child fatalities in 2001 and 2% in 2010. While it is typically teenagers who die by suicide and youth suicide has been considered a ‘teen’ issue, children as young as 10 years old have died by suicide.

“The most important reason to review child deaths is to improve the health and safety of children and to prevent other children from dying.”

Michigan Public Health Institute

Natural Deaths

The CFRP reviewed 840 natural deaths over the past decade. Children with heart disease, cancer, medically complex conditions, and complications associated with prematurity accounted for nearly 50% of those natural deaths reviewed. Another 117 cases were classified as Sudden Infant Death Syndrome (SIDS). A great deal of focus and prevention efforts have been on the SIDS cases. SIDS had historically been associated with a natural manner of death. However, the Centers for Disease Control and Prevention (CDC) has put forth a more comprehensive sudden infant death protocol. According to the CDC, *"each year in the United States, more than 4,500 infants die suddenly of no obvious cause. Half of these Sudden Unexplained Infant Death (SUIDs) are due to Sudden Infant Death Syndrome (SIDS), the leading cause of SUIDs and of deaths among infants aged 1 month to 1 year. Only sudden infant deaths that remain unexplained after a thorough examination of the death scene, a review of the clinical history, and an autopsy should be classified as SIDS. However, since 1999, some deaths due to SIDS are classified as due to an unknown cause or to accidental suffocation. Inaccurate or inconsistent classification of causes of infant deaths impedes prevention efforts because researchers cannot monitor national trends, determine risk factors, or evaluate prevention programs"*. Connecticut, along with many other states is working to implement a model similar to what is recommended by the CDC (www.cdc.gov/SIDS).

Overall, the percentage of SIDS deaths per year has shown a downward trend which has not translated into an overall decline in infant deaths. There is speculation that the decrease in the diagnosis of SIDS is a result of the increased awareness of the importance of safe sleeping conditions for young children such as the 'Back to Sleep' campaign promoted by the American Academy of Pediatrics. The CFRP has focused on spreading the message that the safest place for an infant to sleep is on his back and in his own sleep environment. In June 2011, the Keeping Infants Safe and Secure (KISS) committee hosted an invitation-only safe sleep forum. Over 100 attendees heard state and national leaders speak on the issue of infant sleep environment. The primary purpose of the event was to begin to lay the groundwork for a statewide safe sleep message.

149 Infant Deaths

86 Boys

63 Girls

54 White

53 Black

30 Hispanic/White

5 Asian-Indian

2 Black Hispanic

1 Asian-other

4 no race identified

The infants were from 46 towns, with New Haven, Harford, Waterbury, Bridgeport, and Stamford accounting for over 40% of cases.

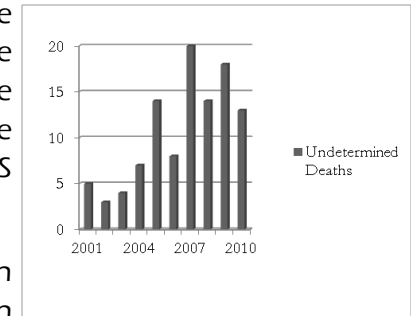
The OCA staff, along with graduate forensic nursing students and graduate social work students, conducted a small research study focusing on 149 infants who died between 2002-2010 and were identified as having one or more risk factors associated with an unsafe sleep environment at the time of their death. Over 100 of the cases reviewed were infants under 5 months of age. The study revealed that these babies were in unsafe sleep environments including in bed with adults, in bed with other children, and in bed with adult pillows, toys, comforters, stuffed animals and other items.

The study suggested that the safest place for a baby is in his or her own bassinet, crib, or pack and play with *nothing* else. Soft items like blankets, pillows, stuffed animals or bumpers are especially hazardous. This safe sleep message is in keeping with the recent guidelines established by the American Academy of Pediatrics (www.aap.org).

Undetermined Deaths



For children who died in a manner that remains “Undetermined” there was not enough evidence to conclude disease, suicide, accident or homicide. Of the 106 child deaths that were classified as “undetermined” over the past decade, 73% were infants. These deaths coupled with the Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) deaths occupy a significant focus for the CFRP. The number of undetermined deaths per year has increased over the course of the decade most likely as a direct correlation to the decrease in the diagnosis of SIDS. The focus on these SUID and SIDS deaths has been a concern in Connecticut as well as across the country.



Nationally, there has been a great deal of attention by the CDC, and the U.S. Department of Health and Human Services Maternal Child Health Bureau on Sudden Unexplained Infant Deaths (SUID). Currently, about a dozen states receive funding related to SUID and the collection of comprehensive data so that a more targeted national prevention initiative can be developed to reduce SUID death rates. The SUID database is a critical component to prevention efforts related to infant fatalities and will help us understand more fully how these babies die. In nearly all other types of fatalities, a robust death scene review occurs. However, for infants there is a “scoop and run” philosophy; first responders try to get the baby to the hospital as soon as possible. While this is a laudable effort, specific scene information is sometimes overlooked. There is tremendous inconsistency across the nation and in the state as to whether investigators return to the scene to obtain critical information. In 2004, the CDC trained a team in every state to begin to work closely with first responders examining the position of the found infant, the contents of sleep environment, and which parent or caregiver was the last person to put the baby to sleep, or see the baby alive. Gathering detailed information and supporting statewide efforts on the importance of infant death scene investigation is a critically important issue and various initiatives will continue.



Recommendations

- * **Continue collaborative efforts to establish a statewide infant safe sleep message, reinforcing the “back to sleep” campaign.**
- * **Support the recently released American Academy of Pediatric Infant Guidelines.**
- * **Explore the feasibility of obtaining additional funding related to the SUID database.**
- * **Collaborate with state and local officials to ensure the utilization of a standard infant death scene protocol.**

Accidental Deaths



Accidents or unintentional injuries are the leading manner of preventable death, both in Connecticut and across the nation. During this ten year period, injuries from accidents caused 400 child fatalities in this state. While the deaths per year showed an up-and-down trend over the decade, there has been an overall decrease in accidental deaths of children since 2007. Nevertheless, accidental deaths still accounted for a substantial number of child deaths.

Motor Vehicles

Motor vehicle crashes are the leading cause of unintentional injury deaths in Connecticut for people ages 1-44 and it is the leading cause of death for children. These motor vehicle fatalities account for over half of all accidental deaths of children. In 2000, 6,466 American children of all ages died in automobile accidents (*The National Resource Center for Child Death Review*). In Connecticut, motor vehicles caused 54% of accidental child fatalities. The number of motor vehicle deaths was highest in the early part of the decade, with annual incidence between 25 to 27 deaths per year through 2004. After a sharp decline to 17 deaths in 2005, the number increased again through 2007. However, the number of motor vehicle accident deaths has been on a general decline since then. The deaths were categorized based on the role of the child in the accident whether the deceased was a teenage driver, passenger, or pedestrian (including bicyclists and skateboarders). For a small percentage of the children, their role could not be determined based on the circumstances of the accidents.

400 Accidental Deaths

Motor vehicle accidents=214

Drowning=67

Asphyxia=27

Fires=20

Drug Overdose=19

Other=53 (choking, falls, poisoning, electrocutions, gun shot wounds, ATV crashes, objects falling, etc.)

Child Motor Vehicle Deaths

Passengers=45%

Driver=30%

Pedestrians=23%

Other=2%

Race

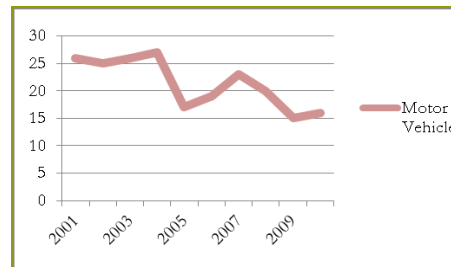
70% White

12% Black

10% Hispanic

3% Asian

5% not recorded



The loss of these children from motor vehicle crashes is devastating to families, friends and communities. The cost associated with these crashes has both incalculable costs and finite cost. According to the Children's Safety Network, Connecticut's "average cost per case of unintentional motor vehicle traffic death for children ages 0-14 was approximately \$2.2 million in 2002-2006 (in 2008 dollars) compared to the national average cost per case of \$1.5 million" (www.childrensafetynetwork.org). The implications for these numbers cut across public policy and prevention efforts and require further study.

Teen driving fatalities remain a significant concern. The enforcement of existing graduated driving licensing laws remains a challenge. The majority (58%) of the children who died in motor vehicle accidents were 16 or 17 years old. Fourteen percent of the children were between 0-4 years of age, 10% were between 5-8 years of age, and 18% were between 9-15 years old. To address the significant concerns about teen driving fatalities the first iteration of a graduated drivers license was passed in 1996 with the latest modification to the law in 2008. The law has subsequently been modified to address gaps in licensing restrictions for new teen drivers. Under the new law (*CGS 14-36g*) teen drivers must first pass a 25 question test to obtain their learner's permit, they must have their permits for a longer period of time before getting their license (120 days if enrolled in a driving school or 180 days if taught at home), they must wait twelve months to drive non-family passengers, and there is a restriction on driving between 11pm and 5am. In October 2011, the Commissioner of the Department of Motor Vehicles formed an advisory committee to continue policy work on teen driving safety.

Connecticut is also the only state that allows police to seize a teen's license and issue an immediate on-the-spot 48-hour license suspension (www.ct.gov/teendriving). The goal of this law was to decrease the number of accidents and deaths caused and associated with young, inexperienced drivers. States with teen licensing laws that are rated as "good" are associated with a 30% decrease in fatal car crashes among 16-17 year old drivers (*Insurance Institute for Highway Safety: Highway Loss Data Institute, Teenagers- Graduated Licensing*). Connecticut's rating is good, and since the 2008 iteration of the graduated licensing law, there has been a decrease in the number of motor vehicle deaths among children per year. However, with just two years of data since the law most recent change, further surveillance will be needed to discern any meaningful impact. Key injury prevention researchers affiliated with The Injury Prevention Center at Connecticut Children's Medical Center looked at the impact of the Connecticut graduated drivers licensing system on teenage motor vehicle crashes. This study examined data from 1999-2008, and determined that the motor vehicle crash rate decreased by 40% for 16 year old drivers and 30% for 17 year olds drivers (<http://journals.lww.com/jtrauma/abstract/2011/110020>).

Even with fewer motor vehicle fatalities among new drivers, a higher percentage of yearly deaths related to motor vehicle accidents were with the 16 and 17 year olds in 2009 than in 2001. One issue among young passengers is seat belt use; 9.4% of Connecticut high school students reported that they rarely or never wore a seat belt while riding in a car driven by someone else (*Connecticut Youth Behavior Component Executive Summary, 2009*). Alcohol use among both young passengers and drivers is also a significant problem, with 26.7% of high school students reporting that they had ridden in a car operated by someone who had consumed alcohol. Nearly 9% of teens reported that they had driven a car when drinking alcohol. While underage drinking is illegal, it is clear that it is still occurring frequently among youth in our state. The combination of inexperienced drivers and alcohol can make for a dangerous situation behind the wheel. The CFRP has seen all of the factors listed above come into play in the review of these motor vehicle deaths.



Recommendations

- * **Continue to inform statewide prevention efforts of all accidental deaths including partnerships with primary prevention providers.**
- * **Work with stakeholders to continue to monitor trends in teen driving laws.**

Drowning

Drowning accounted for 67 child deaths in Connecticut in the past decade. Drowning deaths are preventable deaths. Since the eight drowning deaths in 2007, the number per year has been on the decline. The type of drowning accident is generally dependent on the age and gender of the child. Infants can drown in just one inch of water, and most often die when left unattended, even for just a moment, in bathtubs. Toddlers are at the highest risk for drowning because they are often curious near bodies of water, such as pools, but most do not yet know how to swim or understand the dangers of water. It is also reported that toddlers often drown silently, rather than shouting for help or splashing for attention and older children are more likely to drown in unsupervised swimming areas (*National MCH Center for Child Death Review: Drowning Fact Sheet*). In July of 2011, the OCA partnered with the Connecticut Children's Medical Center and other community partners to bring attention to summer safety tips for families. Drowning was part of that initiative. Efforts to disseminate summer safety tips will continue.

Asphyxia

This report has already discussed infant deaths in the natural and undetermined categories, infant death is also a concern in the accidental death category. Of the 27 children who died as a result of accidental asphyxia, 17 were infants who were determined to be in unsafe sleep environments. Five other children died from a combination of some type of cord getting wrapped around their neck and playing with plastic. The remaining 5 accidental asphyxia deaths were teenagers engaged in risky behavior that unfortunately ended in tragedy.

Fire

Accidental fires accounted for 20 deaths of children. These fatalities occurred in 12 separate fires. In 7 of the fires there were multiple fatalities including 6 adults. There were no accidental deaths from fires in 2003 or in 2008. Causes of these fires vary and include playing with matches, some electrical/wiring issues, faulty or non existent smoke detectors, or batteries that were removed from smoke detectors. Of the children that died, 12 were Black, 4 White, 3 Asian, and 1 Hispanic. Of the 12 fires, Bridgeport had 4 accidental fires all of which involved multiple fatalities; no other town had multiple accidental fires. Nine of the fires occurred between the months of November to March.

Drowning Deaths of Children

Environment

54% died in natural bodies of water (lakes, rivers, streams, reservoirs)

37% died in pools or hot tubs

9% died in bathtubs

Gender

73% of the drowning victims were boys

27% were girls

Age

40% were 0-4 years old

16% were 5-9 years old

23% were 10-14 years old

21% were 15-17 years old



Recommendation

- * **Continue collaborative efforts related to all child safety initiatives and other public awareness campaigns that keep the focus on safety as the first step in preventing injury and death.**

Overdose

Accidental drug overdoses accounted for the deaths of 19 children over the age of 13 in the past decade. It is also important to note that these numbers do not include drug overdoses categorized by the medical examiner as an undetermined manner. In those cases clear evidence did not exist that the overdose was either accidental or intentional. Over half of deaths from accidental overdose occurred among 17-year-old white males. One-third of the deaths involved use of heroin. In 2004, the Office of Child Advocate (OCA) conducted a comprehensive fatality investigation regarding the drug overdose death of Makayla. Three days before she died, 16 year old Makayla had been drinking alcohol at a party and later took the drug Ecstasy. In the hospital, she suffered seizures that would not stop, before she died she had gained forty pounds from fluid build up as her liver and kidneys ceased to function. Makayla's mother held her and rocked her until her daughters heart stopped beating. The investigative report outlined specific policy recommendations related to schools, health care providers, community based therapies, psychiatric care providers, out-patient services, public safety authorities and public policy makers.

“Parents can prevent their children from using drugs by talking to them about drugs, open communication, role modeling responsible behavior, and recognizing if problems are developing.”

*American Academy of Child & Adolescent Psychiatry:
Teen, Alcohol and Other Drugs.*

While efforts to implement many of the recommendations have been ongoing, specifically related to trauma informed treatment, understanding the complexity of adolescent mental health, and adolescent brain development, more needs to be done based upon what the youth are reporting about themselves. According to the 2009 Connecticut School Health Survey Youth Behavior Component, “an estimated 36,000 high school students had used marijuana one or more times during the 30 days before the survey ...an estimated 8,800 had used any form of cocaine one or more times during their life ...an estimated 18,000 high school students had sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high ...and an estimated 8,300 had used ecstasy one or more times during their life ...3.2% of high school student had used heroin one or more times during their life ...and 3.3% of high school students had used methamphetamines one or more time during their life” (www.ct.gov/dph or www.ct.gov/sde/healthconnections). The information provided in the survey by the youth themselves is a primary indication that teenage drug use and the potential for overdose is significant. Additionally, significant concerns exist regarding the abuse of prescription medication for teenagers. The Partnership for a Drug Free American recently reported that “1 out of every 5 teenagers has abused a prescription pain killer and most believe that since these drugs are prescription drugs, they are safe” (www.drugfree.org).



Recommendations

- * **Support statewide efforts to reduce and eliminate illicit substance use among children and teens.**
- * **Encourage strong partnerships to reduce underage drinking, binge drinking and prescription drug abuse.**
- * **Explore the establishment of a working group to analyze the per case cost of motor vehicle fatalities.**

Homicide Deaths



Homicides accounted for 1,363 child deaths in the United States in 2008 (*The U.S. Census Bureau, Statistical Abstract of the United States*). In general, children who are victims of homicide most often die from injuries associated with either gunshot or stab wounds, head trauma from abuse, or strangulation. In the past decade, 106 Connecticut children have died as a result of homicide. Child homicide data is analyzed by age cohort: children 12 and younger and teenagers 13 and older. Because these two groups represent different patterns of homicide, and risk and protective factors vary, they are analyzed separately.

Young Children

Death by homicide accounted for 54 intentional deaths of children ages 12 or younger. For most of these children, their death is the tragic consequence of abuse and neglect. Among this group, homicide is most often at the hand of a known perpetrator who is a family member or friend. It is a rare occurrence for a young child to be killed by a stranger. Nearly all of the children in the past decade had an identified known perpetrator. The exception was the 2005 homicides by fire of two young children and their mother in Bridgeport, no perpetrator has been identified and the Cheshire homicides by home invaders in 2007. The geographic distribution for this age group represents over 30 different communities in Connecticut.

Mechanism

Abusive Trauma=66%
(blunt force & head trauma)

Penetrating Trauma=17%
(gun shot wounds & stabbing)

Fire=5%

Drowning=4%

Strangulation=4%

Hyperthermia=2%

Other=2%

Over the past decade data shows an increase in annual deaths among children under 12 that peaked in 2006. Seventy-three percent of the children 12 and under who died as a result of homicide were 2 years old or younger. The average age at death was 4.8 years. The majority of children died as a result of blunt force trauma. Some children who suffered Shaken Baby Syndrome/Abusive Head Trauma died years later as a consequence of the effects of those injuries.



Recommendations

- * Continue statewide efforts to prevent abusive head trauma and other forms of child abuse.
- * The CFRP will work in collaboration with the Domestic Violence Fatality Review Committee to strengthen the review process for children who are victims, witnesses, or directly impacted by domestic violence fatalities.

All Homicides

Race

White=53%

Black=24%

Hispanic=18%

Other=5%

Gender

62%=boys

38%=girls

Children Under 2

About three-quarters of children under 2 years-old died as result of blunt force trauma. The vast majority of the homicides were perpetrated by individuals who knew the children. The perpetrators were most often relatives of the victim, or otherwise intimately involved with the child's family. The most common perpetrators were fathers, followed by boyfriends and ex-boyfriends of mothers, which is consistent with the national data on child homicide perpetrators (www.childwelfare.gov). Fourteen-percent of the homicides had companion cases, which is to say that there was another victim of homicide as well. These companion cases involved domestic violence and in all of those cases it was the mother of the child(ren) that was killed.

Teenagers

Fifty-two (52) children between 13 and 17 years of age died as a result of homicide in Connecticut over the past decade with the number increasing substantially as the age increases from 15 to 17. Forty-four percent of the deaths in this category were 17-year-olds, 36% 16-year-olds, and 10% were 15-year-olds. Four percent of the children died at age 14, and 6% at age 13. This pattern matches the national trend of children most likely to be victims of homicide before age 1, and then again at ages 16 and 17 (*Trends in the Murder of Juveniles: 1980-2000 OJJDP Bulletin, September*). Forty-five boys that died from homicide, 37 of those boys died from gun shot wounds, 7 were stabbed to death, and 1 was intentionally run-over by a vehicle. Nationally, as well as in Connecticut, homicide in this age group is considered a major concern for Black and Hispanic males, their families, and their communities. The State of Connecticut matches the national trend of higher homicides among the 13-17 grouping occurring in urban communities. (*Homicides of Children and Youth, OJJDP Bulletin, October 2001, www.OJJDP.gov*).

These homicides are often precipitated by arguments and fighting between people who know each other. According to the 2009 Connecticut School Health Survey, "28.3% of high school students had been in a physical fight one or more times during the 12 months before the survey ...an estimated 6,500 high school students carried a weapon (gun, knife, or club) on school property on the least 1 of the 30 days before the survey."

Teenagers

Race

Black=61%

Hispanic=25%

White=14%

Gender

Boys=87%

Girls=13%

Urban Geographic Distribution

Over 60% of the teen homicides are from 3 urban communities: New Haven, Hartford, and Bridgeport



Recommendations

- * Support efforts for positive ways for youth to deal with anger. (www.cdc.gov).
- * Continue statewide efforts to prevent abusive head trauma stemming from abuse in infants and children.
- * Support efforts related to stemming youth violence and access to weapons.

Suicide Deaths



Suicide deaths per year have decreased in the past decade. While the three suicides in 2010 compared to the fifteen suicides in 2001 certainly shows progress in the field, it is important to note that there has been significant fluctuation with these numbers increasing and decreasing over the years. Continued work and attention to this issue will be necessary in order to continue the downward trend visible since 2008. Over the past decade the CFRP/OCA has been involved with a variety of statewide suicide prevention initiatives including the Youth Suicide Advisory Board, the Interagency Suicide Prevention Network, and the Garret Lee Smith Suicide Prevention Grant. Activities included youth specific training, public education, screening and brief intervention activities, as well as coalition building in various communities.

Youth Suicide

In Connecticut...

74% =hanging

14% =weapon

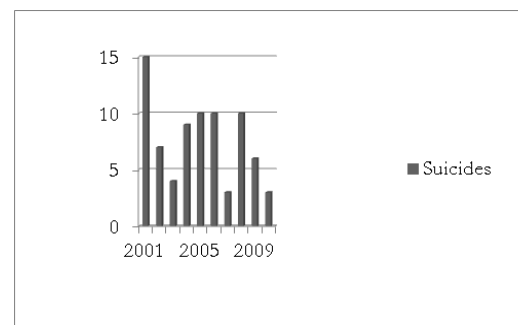
8%=drug overdose

4% =other means

In Connecticut, as well as nationally, girls attempt suicide more often, but males are four times more likely to actually die by suicide (*The National Resource Center for Child Death Review*). Correspondingly, in Connecticut 69% of the child suicides were male compared to 31% female. White children accounted for 77% of the child suicides, with Black children at 16%, Hispanic 5%, and Asian 3%. The CDC reports that on the national level, "Native American/Alaskan Native and Hispanic youth [have] the highest rates of suicide-related fatalities and Hispanic youth [are] more likely to report attempting suicide than their Black and White peers" (*Youth Suicide: www.cdc.gov*). Over the ten years, November was the most common month for suicides to occur, followed by June and October.

For youth, risk factors or stressful events that may increase the potential for greater suicidal behavior include hopelessness, impulsivity or aggressive tendencies, trauma, abuse, and relational or social loss. Protective factors, or things that help keep youth safe include strong connections to families and others, access to clinical supports and services, restricting lethal means, a positive belief about the future, and skills in problem solving (*Suicide Prevention Resource, www.2.sprc.org and the National Suicide Prevention Strategy at www.samhsa.gov/prevention/suicide*).

In January 2003, the investigative report regarding the suicide death of 12 year old Joseph Daniel was released. Even prior to the release of this report, transformative public policy efforts began with the first iteration of anti-bullying legislation. Further policy changes occurred regarding school truancy, and other safety nets that failed this child (*www.ct.gov/oca*).



The issue of bullying among school children has moved to the forefront of public consciousness following the tragic suicides of some American teenagers after serious bullying incidents came to light. Dr. Ken Rigby refers to this type of bullying as “bullycide” (www.education.unisa.edu.au/bullying). Research indicates that some groups may be at greater risk for being bullied such as children with disabilities, children who are overweight, children experiencing discrimination due to their gender identity, children who are gay, lesbian, bi-sexual, transgendered, or questioning, and children whose culture and heritage may be different than their peers. In Connecticut, Public Act 11-232 passed in 2011 strengthening current anti-bullying laws.

Bullying has been identified as a risk factor for suicide among youth in Connecticut. Over 25% percent of Connecticut high school students reported having been bullied on school property (*Connecticut Youth Behavior Component Executive Summary, 2011*). While this is already a high statistic, it does not include bullying that might have occurred off-campus, including online. Over 900,000 high school students across the country reported having been cyberbullied within one year (*Commission on Children, Anti-Bullying Bill Becomes Law, July 18, 2011*).

Protective factors are critical to keep Connecticut youth safe. Strong and positive connections to others, feeling safe at school or in the community can help prevent teen suicide (*National Center for Child Death Review- Suicide Fact Sheet*). Many Connecticut schools appear to be aligning with these protection factors. An increased focus on school climate, ensuring that students feel safe and accepted at school and with the important new provisions of the anti-bullying law, Connecticut has the ingredients necessary to eradicate the epidemic of bullying behavior (*Connecticut’s Bullying Prevention & School Climate Law: Policy Checklist for Educators, Parents and Students*).

CT Public Act 11-232, School Bullying Laws (July 2011)

The expansion of current anti-bullying laws was signed by Governor Dannel Malloy on July 13, 2011. The strengthened state law speeds school response, expands staff training, makes all public school employees mandated reporters of bullying, addresses cyberbullying and launches statewide school climate assessments.



Recommendations

- * **Continue statewide partnerships with the Connecticut Youth Suicide Advisory Board, the Interagency Suicide Prevention Network, and the Garret Lee Smith initiative, to promote training initiatives, and other primary prevention efforts.**
- * **Work with key community stakeholders to support public education and awareness efforts to reduce the risk of suicide.**
- * **Initiate efforts to capture and analyze suicide attempt data.**
- * **Secure statewide suicide attempt data as a critical component in monitoring for trends in suicide deaths.**

Summary

Trends of child deaths may rise and fall from year to year. While the overall number of suicides have been had an up and down pattern, in a 6- week period between late October and December 2011, Connecticut tragically lost five youth to suicide; this surpasses all suicide deaths in 2010. We need to keep working at all levels and maintain a vigilance in all aspects of child death review; ultimately one preventable death is one too many.

The recommendations included in this report outline a beginning strategy to protect children. In the meantime all Connecticut citizens share an obligation to keep children safe and to work together in partnership to do everything possible to put and keep comprehensive prevention initiatives at the forefront of our conversations about risks to children. After all, they are our future.

It is with deep gratitude that we would like to extend a heartfelt thank you to everyone who contributed to this ten year report.

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