



KEEPING KIDS ALIVE NATIONAL SYMPOSIUM

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May 20, 2009

Statutory Authority

Independent State Agency

- Statutorily created in 1995 to provide oversight to protect the civil, legal, and special rights of children and to advocate for their well-being
- Broad statutory mandate and authority
- Individual case reviews, systemic review and reform, public policy advocacy, legislative initiatives, and legal action
- Authority supported by subpoena power including compelling documents and witness testimony
- Child Fatality Review Panel



Child Fatality Review Panel

- (b) There is established a child fatality review panel composed of thirteen permanent members as follows: The Child Advocate, or a designee; the Commissioners of Children and Families, Public Health and Public Safety, or their designees; the Chief Medical Examiner, or a designee; the Chief State's Attorney, or a designee; a pediatrician, appointed by the Governor; a representative of law enforcement, appointed by the president pro tempore of the Senate; an attorney, appointed by the majority leader of the Senate; a social work professional, appointed by the minority leader of the Senate; a representative of a community service group appointed by the speaker of the House of Representatives; a psychologist, appointed by the majority leader of the House of Representatives; and an injury prevention representative, appointed by the minority leader of the House of Representatives. A majority of the panel may select not more than three additional temporary members with particular expertise or interest to serve on the panel. Such temporary members shall have the same duties and powers as the permanent members of the panel. The chairperson shall be elected from among the panel's permanent members. The panel shall, to the greatest extent possible, reflect the ethnic, cultural and geographic diversity of the state.
- (c) The panel shall review the circumstances of the death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes 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. Members of the panel shall not be compensated for their services, but may be reimbursed for necessary expenses incurred in the performance of their duties.
- (d) On or before January 1, 2000, and annually thereafter, the panel shall issue an annual report which shall include its findings and recommendations to the Governor and the General Assembly on its review of child fatalities for the preceding year.
- (e) Upon request of two-thirds of the members of the panel and within available appropriations, the Governor, the General Assembly or at the Child Advocate's discretion, the Child Advocate shall conduct an in-depth investigation and review and issue a report with recommendations on the death or critical incident of a child. The report shall be submitted to the Governor, the General Assembly and the commissioner of any state agency cited in the report and shall be made available to the general public.
- (f) The Chief Medical Examiner shall provide timely notice to the Child Advocate and to the chairperson of the child fatality review panel of the death of any child that is to be investigated pursuant to section 19a-406.
- (g) Any agency having responsibility for the custody or care of children shall provide timely notice to the Child Advocate and the chairperson of the child fatality review panel of the death of a child or a critical incident involving a child in its custody or care.

Child Fatality Review Panel Membership

EX-EFFICIO MEMBERS

Child Advocate/Chairperson: Jeanne Milstein

Office of the Child Advocate
18-20 Trinity Street, 5th Fl.
Hartford, CT 06106

Office of the Chief State's Attorney : Judith Rossi

300 Corporate Place
Rocky Hill, CT 06067

Medical Examiner: H. Wayne Carver, M.D.

Chief Medical Examiner
11 Shuttle Road
Farmington, CT 06032

Law Enforcement Representative: Honorable John Danaher III

Sgt. David Rosado
Department of Public Safety
1111 Country Club Road
P.O. Box 2794
Middletown, CT 06457

DCF Commissioner: Hon. Susan Hamilton

Ken Mysogland
Area Director-DCF
401 Shippan Avenue
Stamford, CT 06902
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Public Health Commissioner

J. Robert Galvin, M.D. Commissioner
William Gerrish
Department of Public Health
410 Capitol Avenue, MS#13COM
Hartford, CT 06106

APPOINTED MEMBERS:

Pediatrician: (by Governor) Kirsten Bechtel, M.D.

Yale-New Haven Children's Hospital
20 York Street, WP 143
New Haven, CT 06504

Public Child Welfare Practitioner: Mr. Richard Dallavalle (by Senate Minority Leader) Community Service Coordinator

Torrington AIC
2691 Newfield Road
Torrington, CT 06790

Community Service Representative: Jane Norgren (by Speaker of the House) 26 Penfield Place

Bridgeport, CT 06605
Cell: (203) 540-7446

Physician Brian D. Karsif, MD, MPH, FACOG, CIP (by Child Fatality Review Panel) 149 Cleveland Road

New Haven, CT 06515

Domestic Violence: Tonya T. Johnson (by Child Fatality Review Panel) Director of Program Operations

CT Coalition Against Domestic Violence
90 Pitkin Street
East Hartford, CT 06108

Injury Prevention: Judge Russell A. Kimes, Jr., EMT (by House Minority Leader) New Canaan Probate District (090)

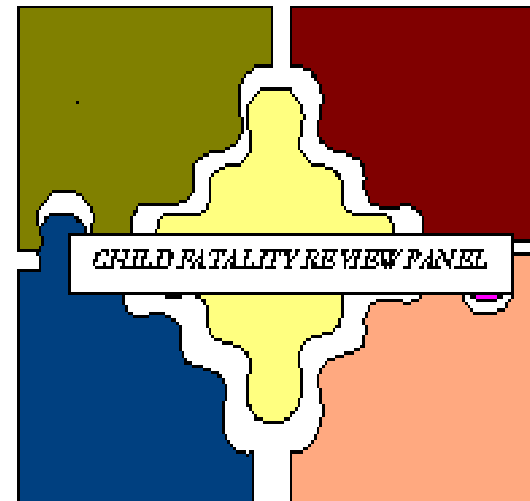
77 Main Street
New Canaan, CT 06840

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

559 Hartford Pike Suite 207
Dayville, CT 06241

CFRP Meetings

- ❑ Monthly Meetings
- ❑ 10-15 Cases a month
- ❑ Meetings held at the OCME past 2 years
- ❑ Multi-agency/multi-disciplinary
- ❑ Executive Session for case specific discussion



The Child Fatality Review Panel

Reviewed 146 Child Deaths

July 1, 2007 and June 30, 2008

Annual Report Data

ACCIDENTAL DEATHS

32 Motor vehicle
related
9 Drowning
4 Accidental asphyxia
3 Drug Overdoes
2 Fire
5 Other

HOMICIDES

7 Blunt force trauma
3 Gunshot wounds
2 Smoke Inhalation
2 Drowning/Stabbing
1 Abusive head trauma

Natural= 76
Accidental= 55
Homicides= 14
Undetermined=21
Suicides=6

- **UNDETERMINED**
- 12 Sudden Unexplained Infant Death (SUID)
- 2 Drowning/GSW
- 7 Undetermined

- **SUICIDES**
- 6 Hanging

- **NATURAL DEATHS**
- 5 SIDS
- 4 Sudden Infant Death

Eighty-Eight Youth Homicides

January 1, 2001 to December 31, 2008

- Boys= 67
- Girls=21
- Birth though One= 31
- Ten were 2yo-5yo
- Three were 6yo-10yo
- Seven were-11yo-14yo
- Thirty-seven were 15yo-17 yo
- Black=41
- White=29
- Hispanic=15
- Other=3
- Blunt force=36
- GSW=35
- Stabbed=6
- Fire=4
- Strangulation=2
- Drowning=2
- Other=3

Snap-Shot of Child Homicide

- ❑ Two categories:
 - Teens and infants/toddlers
- ❑ Teens: Black Males/GSW
- ❑ Infant/Toddler: Known perpetrator abusive head trauma
- ❑ Similar number of teens/young child deaths
- ❑ Boys are the dominant factor is both teen and infant death
- ❑ High Profile Cases
- ❑ Conducting a five-years overview of teen homicides.

Sixty Five Suicides

The face of youth suicide in Connecticut

- There were a total of 65 suicide deaths of youth under the age of 18 years old between October 1, 2000 and March 20, 2008.

Gender

- Female = 15 (23%)
- Male = 50 (77%)

Age

- 10yo = 1
- 11yo = 2
- 12yo = 2
- 13yo = 5
- 14yo = 5
- 15yo = 6
- 16yo = 20
- 17yo = 24 (37%)

Method

- Hanging = 48 (74%)
- GSW = 9 (14%)
- OD = 5 (8%)
- Other = 3 (4%)

Race of Youth

- White = 51 (78%)
- Black = 9 (14%)
- White/Hispanic = 3
- Asian = 2

Snap-shot of Youth Suicide

- Teenagers
- Boys
- Hanging
- Race
- Suicide Prevention Initiatives
- YSAB
- ISPN
- ADAPSA

Accidental Deaths

- ❑ Most are motor vehicle related deaths
- ❑ Teen drivers
- ❑ Compliance with graduated drivers license
- ❑ Alcohol
- ❑ Speed
- ❑ Inexperience
- ❑ Boys v. Girls

Infant Deaths

- ❑ SIDS
- ❑ SUID/SUDI
- ❑ Co-Sleeping
- ❑ Death Scene Investigation
- ❑ Reenactment
- ❑ Targeted Prevention
- ❑ Public Policy v. Agency Policy



Undetermined

- Primarily infant deaths
- No gross findings on autopsy
- More SUID: Cause, Manner: Undetermined

Partnerships

- ❑ Youth Suicide Advisory Board
- ❑ Inter-agency Suicide Prevention Network
- ❑ Domestic Violence Fatality Coalition
- ❑ State Poverty and Prevention Council
- ❑ Adolescent Depression and Suicide Prevention Assessment Work Group.
- ❑ Garrett Lee Smith Grant Advisory Committee
- ❑ Statewide Injury Task Force
- ❑ Private Agencies and community providers
- ❑ Hospitals
- ❑ Safe Kids Coalitions
- ❑ Other state agencies
- ❑ DCF/DOC//DMHAS/DPH/
- ❑ Shaken Baby Prevention
- ❑ Safe Sleep Initiative
- ❑ Inhalant Task Force
- ❑ Institute on Violence Prevention and Reduction
- ❑ Schools
- ❑ Anti-bullying Initiatives



Prevention

- Using our data to shape initiatives
- Develop partnerships
- Think out-of-the-box for some of those partners
- Global issues confronting kids, access to rapid information
- Bullying
- Teen Dating Violence
- Underage Drinking
- Sexual Harassment



Case Study Baby Michael

- ❑ On May 19, 2008, Michael B. sustained a severe head injury and died at the hospital hours later. The seven-month-old was fatally injured in his second foster home placement of just one week in the custody of the Department of Children and Families (DCF).
- ❑ The Office of the Child Advocate (OCA) was notified of Michael's death and, according to routine practice, immediately began reviewing the circumstances of Michael's life, specifically his and his family's involvement with the DCF.
- ❑ Approximately two months after Michael's death his foster mother was arrested and charged with manslaughter in the first degree. Her case is pending in the criminal court. The foster mother was also a professional employee of the Department of Children and Families
- ❑

Process of Special Review

- The Michael B. fatality review was unique in that the OCA participated as an integral member of a Special Review Team (SRT) made up of the CWLA, the OCA and representation from the DCF.
- Participants in the joint venture had parallel purposes to examine system functions and identify opportunities for improvements in child welfare practices that may prevent deaths.
- Special Review reports are provided to all DCF staff on the DCF-Intranet; incorporated within the interdisciplinary curriculum at the DCF Training Academy; and ideally integrated in daily practice at DCF system.
- The goal of all Special Reviews is to conduct investigations in a respectful manner that encourages open dialogue, with an emphasis on an effective transfer of learning to practice in the field.

Best Practice Efforts

- ❑ Routinely provide information to families at the beginning of the investigation on SBS prevention.
- ❑ Recognized secondary trauma after the death and support teams were assembled.
- ❑ Provided a coordinated systemic response in the area office to questions and concerns, tried to keep folks in the loop.
- ❑ Hotline provided extraordinary support to biological family.

Fourteen Findings and Recommendations

Foster Parent Training	Home Study	Multiple Placement of an Infant	Child Welfare Employees as Foster Parents
Family Centered Practice and Assessment	Risk and Safety Assessment	Substance Abuse	Mental Health Services
Forensic Interviewing of Children	Organization Response to critical incidents	Hotline	Special Investigations
Human Resources Division	SACWIS Compliance		



THANKS

Thanks for all you do to keep kids
safe!

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