



# State of Connecticut Office of the Child Advocate

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## ANNUAL REPORT OF THE CHILD ADVOCATE

### 2000 Annual Report of the Office of the Child Advocate

**Jeanne Milstein, Chairperson**, Child Advocate

**John Bailey, Esq.**, Chief State's Attorney

**H. Wayne Carver II, M.D.**, Chief Medical Examiner

**Leticia Lacomba, M.S.W.**, Regional Administrator Department of Children and Families

**Jane Norgren**, Executive Director, Child Care Center of Stamford

**Honorable Arthur Spada**, Commissioner of Public Safety

**Betty S. Spivack, M.D.**, Pediatrician

#### Staff

**Faith Vos Winkel**, Assistant Program Director

#### Contact Information for the Child Advocate

18-20 Trinity Street. Hartford, Ct 06106

Telephone: [860-566-2106](tel:860-566-2106) \* Toll Free: [800-994-0939](tel:800-994-0939) \* Facsimile: [860-566-2251](tel:860-566-2251)

#### Child Fatality Review Panel Annual Report 2000

##### Relevant Statutes

##### Connecticut General Statutes sec. 46a-131 (b) and (c):

(b) There is established a child fatality review panel composed of seven permanent members as follows: A pediatrician, appointed by the Governor; a representative of law enforcement, appointed by the president pro tempore of the Senate; the Child Advocate, or a designee; a public child welfare practitioner, 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 medical examiner, appointed by the minority leader of the House of Representatives; and the Chief State's Attorney, or a designee. A majority of the panel may select not more than two additional temporary members with particular expertise or interest to serve on the review of a specific fatality. 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.

## **Child Fatality Review Panel Annual Report 2000**

### **Mission**

The Child Fatality Review Panel reviews child fatalities so that we may learn how to prevent future tragedy. The panel's purpose is to save lives by learning from lives lost. Thorough review of infant and child deaths is the key to recognizing what types of death are preventable and taking steps to protect children from harm.

### **New Developments**

During the past two years, the legislature and the panel have taken steps that will greatly improve the panel's ability to fulfill its mission. First, the legislature authorized the panel to review all unexpected or unexplained deaths. Until October 1, 1999, the panel could review only the deaths of children who had received state services.

Second, in September 2000, the panel improved the review process by developing a fatality review data form that will capture detailed information about every unexplained or unexpected death. (Appendix A) Although it is painful for family members to provide these details, this information is the key to preventing additional deaths. Only by understanding how and why children die can we prevent death. By tracking and studying this information, we can recognize patterns of risk and recommend ways to save lives.

## **Child Fatality Review Panel Annual Report 2000**

### **Overview**

This report covers the period from October 1, 1999 through September 30, 2000. It examines "untimely or unexplained" deaths that were reported to the Office of the Chief Medical Examiner. Because the panel's 1998 report tracked only the deaths of children who had received state services, it is impossible to compare this report with previous reports.

From October 1, 1999 to September 30, 2000, one hundred and thirty-eight child fatalities were reported to the Child Fatality Review Panel. Motor vehicle accidents were the leading cause of reported fatalities (20%), followed by Sudden Infant Death Syndrome (SIDS) (17%).

Sixty-five children died during the first year of life (47% of all deaths). Twenty-four infants died of SIDS.

The number of reported deaths decreased for children ages two to five (15 deaths) and ages six to twelve (18 deaths). Most of these young children died in motor vehicle accidents or by drowning.

For children in their teenage years (13-18), the number of reported deaths increased significantly. Forty teenagers died; twenty-three died in motor vehicle accidents.

Sixty-two percent of the children who died were male. Teen males committed suicide at a much greater rate than females (87% male versus 13 % female). Likewise, 4 of the 5 homicide victims were male.

## **Child Fatality Review Panel Annual Report 2000**

### **Goals**

Now that the child fatality review data form is in use, the panel will develop a database to record the information. By studying these details, we will identify trends and patterns of risk in order to prevent future deaths.

In the case of SIDS, for example, the form will record where the baby was sleeping, how the baby was positioned for sleep, how the baby was positioned at the time of death, and other details that may help explain why infants die of SIDS.

In the case of a motor vehicle accident, the form will record whether the victim was restrained in a car seat or by a seat belt, the type of vehicle, the age of the driver, where the victim was positioned in the vehicle, the road condition, whether airbags deployed, and other details that will teach us how to reduce the number of motor vehicle deaths.

In addition, the panel will develop a protocol to ensure that local hospitals and medical examiners report all unexplained or unexpected deaths to the Office of the Chief Medical Examiner. Without criteria to define the terms "unexpected" and "unexplained," some child fatalities may escape review.

Many childhood deaths are preventable, but only if we understand how and why children die. More detailed information and complete reporting will help the panel to develop a greater understanding of child fatalities in order to develop appropriate prevention strategies.

## **Child Fatality Review Panel Annual Report 2000**

### **Child Fatality Data**

The remainder of this report focuses on the child fatalities that were reported to the Office of the Chief Medical examiner and reviewed by the panel between October 1, 1999 and September 30, 2000.

#### **Natural Deaths**

Fifty-four children (39% of total fatalities) died of natural causes. Forty-four of the children were infants (age 0-1) who died of SIDS, problems during the birth process, or prematurity. Older children died of heart disease, asthma or sleep apnea, and other medical conditions.

#### **Sudden Infant Death Syndrome**

SIDS was the leading cause of natural deaths and the leading cause of death among infants (37% of reported infant deaths are attributed to SIDS). Twenty-four babies died of SIDS, which is defined as "the sudden death of a healthy infant under one year of age that remains unexplained after the performance of a complete post mortem investigation, including an autopsy, an examination of the scene of death, and review of the case history." National Institute of Child Health and Human Development (1990).

Most of the infants who died of SIDS were between two and four months of age. Ten infants died of SIDS during their second month of life. Seven babies who died of SIDS were in their third and four months. The infants ranged in age from four weeks to seven months.

## **Child Fatality Review Panel Annual Report 2000**

### **Natural Deaths other than SIDS**

Twenty infants died of natural causes other than SIDS. Most of the babies died during the birthing process or shortly after birth because of prematurity or congenital problems.

Natural deaths decreased once children reached the age of two (three children ages 2-12 died of natural causes), but rose again during the teen years (age 13-18). Seven teenagers died of natural causes, including heart problems, asthma, and seizure disorder. Five teenagers died of heart related problems – all were male.

#### **Accidental Deaths**

Fifty-two children (37% of total fatalities) died of accidental causes, including motor vehicle accidents, drowning, and asphyxiation. Suffocation was the leading cause of accidental death among infants. Four of the five infants who died of asphyxiation were two months old or younger.

Once children reached their first birthday, they were killed by motor vehicle accidents more than any other cause. Older children also died of drowning and asphyxiation. Two young men, ages sixteen and seventeen, died in industrial accidents while working with their fathers.

## **Child Fatality Review Panel Annual Report 2000**

### **Motor Vehicle Accidents**

Twenty percent of the reported child fatalities were caused by motor vehicle accidents. For children over one year of age, motor vehicle accidents were the leading cause of death. Nearly fifty percent of the teenagers whose deaths were reported died in motor vehicle accidents. Seventy-nine percent of the teenagers who died in motor vehicle accidents were male.

Nine teenagers were driving an automobile when they died. One child died driving an all-terrain vehicle. Another child, riding his bicycle, died in a collision with a motor vehicle.

Eleven children were passengers in automobiles. Five pedestrians were killed – three of the children were two and three years old. A sixth pedestrian was killed by a train.

#### **Drowning**

When children reached the age of five, the number of deaths by drowning increased dramatically. Eight children (6% of reported deaths) drowned. The danger for five and six year olds is particularly acute: three children were five years old; two children were six years old. The older children were ten, twelve, and thirteen years old.

#### **Suicide and Homicide**



Eight children (6%), all teenagers with the exception of one eleven year old, ended their own lives. Seven children were males. Four children died from hanging; two children shot themselves.

Four of the five homicide victims were males, as well. Homicides accounted for four percent of the reported child fatalities. The children were of all ages. Three of the victims were shot; one infant died of a traumatic head injury.

#### **Child Fatality Review Panel Annual Report 2000**

##### **Conclusion**

Child fatality reviews are important because they "have the potential to accelerate progress in the understanding of SIDS, reduce the number of fatal cases of child abuse and neglect that are missed, increase the awareness of familial genetic diseases, focus attention on public health threats, and detect and remediate inadequate medical care." (American Academy of Pediatrics, "Investigation and Review of Unexpected Infant and Child Deaths." Pediatrics Vol. 104 No. 5 November 1999.)

By recording and analyzing the details of child fatalities, we can identify children at risk and act to protect them.

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