THE OFFICE OF THE CHILD ADVOCATE AND THE CONNECTICUT CHILD FATALITY REVIEW PANEL

ALERT: UNSAFE SLEEP-RELATED DEATHS ARE THE LEADING CAUSE OF PREVENTABLE DEATHS OF INFANTS IN CONNECTICUT

The number of Connecticut infants who died between 2001 and 2013 where unsafe sleep conditions were present was almost three times the number of infants who died from child abuse.

Each year infants die unnecessarily in Connecticut. This Public Health Alert outlines the tragedy of infant fatalities associated with unsafe sleep conditions and makes recommendations for prevention.

Infant Fatality Risk Factors

- Sleeping in adult beds with adults and other children
- Sleeping in beds with comforters, blankets and duvets
- Sleeping on couches or chairs when caregivers sleep holding them
- Sleeping in cribs with stuffed animals, blankets, toys and other items
- Overdressing/overheating baby
- Propping bottles

Research also confirms additional risk factors associated with sudden infant death.

- Mental health challenges, including depression
- Substance use, including alcohol or drugs
- Smoking
- Obesity
- Parental isolation

What is an "unsafe sleep-related" infant fatality?

Unsafe sleep-related causes of infant death are linked to how or where a baby sleeps. Deaths may be due to blockages of the nose/mouth; entrapment/chest compression (when an infant gets trapped between two objects, such as a mattress and wall, and cannot breathe or overlying); or suffocation from a low oxygen/high carbon dioxide environment (under a blanket).

How often do infants in Connecticut die from unsafe sleeping conditions?

Infants in Connecticut are more likely to die from unsafe sleeping conditions than from child abuse, car accidents, choking, drowning, falls, or any other source of accidental injury.

2013 Infant Fatality by the Numbers

In 2013, there were 23 infants who died where the causes of death were Sudden Unexplained Infant Death (SUID), Sudden Infant Death Syndrome (SIDS), or "Undetermined." Of these 23 unexpected, unexplained deaths, 18 infants had one or more risk factors associated with their sleep environment.

- **17 Boys**
- **6 Girls**
- **Average age of infants: 3 months**
- **In at least seven cases, the parent(s) had documented histories of substance abuse.**

2011 and 2012 Infant Fatality by the Numbers

In 2011 and 2012 there were 43 infants who died where the causes of death were SUID, SIDS, or "Undetermined." **Of these 43 unexpected, unexplained infant deaths, 31 infants had risk factors associated with their sleep environment.**

Most common unsafe sleep environments in Connecticut fatality cases

- Co-sleeping in an adult bed with parents or siblings
- Car seat
- In a crib with blanket, pillows, or placed on their stomachs
- Put to sleep with a bottle in an adult bed

For Additional Information and Materials Visit:

http://www.nichd.nih.gov/SIDS

The Eunice Kennedy Shriver National Institute of Child Health and Human Development

RECOMMENDATIONS TO PREVENT UNSAFE SLEEP-RELATED INFANT DEATHS

FOR LAWMAKERS

- Conduct an annual child fatality report and legislative hearing to review child deaths and prevention strategies.
- Mandate "safe sleep" counseling by health care providers.
- Increase screening for maternal depression.
- Expansion of evidence-based home visiting programs for parents and children that increase parental capacity and improve child well-being.
- Ensure uniform law enforcement, first responder and medical examiner protocols for sudden unexplained infant death investigations.
- Regulate sale of unsafe infant bedding and positioners.

FOR DCF, IN-HOME SERVICE PROVIDERS, AND CHILDCARE PROVIDERS

- Important 2014 DCF policy change regarding safe case planning and sleep practices must lead to rigorous training and compliance measures.
- Information drives using existing state and national materials: *www.ct.gov/dph/safetosleep* & *http://www.nichd.nih.gov/sids and 1-800-505-2742*
- Collaboration with best practice centers like the Sudden Infant and Child Death Resource Centers.
- Monitoring sleep conditions in home and institutional settings.

FOR HEALTH CARE PROVIDERS

- Engage and educate caregivers about safe sleep/address misperceptions.
- Increase screening to identify high need or at-risk caregivers and connect caregivers to community supports.
- Address unsafe bedding and positioners directly.
- Modeling best practices, and provide anticipatory guidance.
- Encourage breastfeeding *and* safe sleep practices.

TIPS FOR PARENTS AND CAREGIVERS

Please share these tips with all who care for me

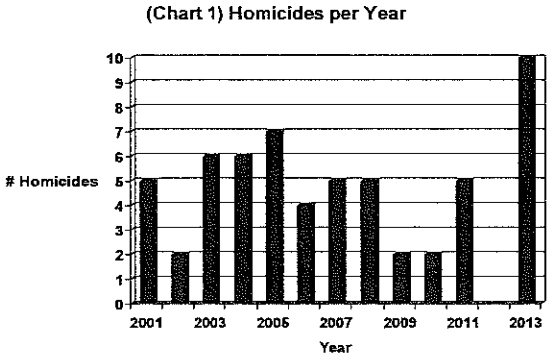
Every night—Every Nap—Every Caregiver

- ***Put me on my back to sleep, even for naps. When I'm awake, put me on my stomach for "tummy time."***
- ***Keep my home and car smoke-free. Babies who breathe smoke or sleep with those who smoke have a greater risk of unexpected death.***
- ***Be sure my crib is safety approved and it has a firm, tight fitting mattress. Do not let me sleep on surfaces like adult beds, water beds, couches, and recliners. These have space that can trap my face and block my breathing.***
- ***Pillows, stuffed toys, futons, and comforters are a danger in my sleep area. Do not let me sleep on soft bedding. I need a firm sleeping surface that is free from soft items that could block my breathing.***
- ***Sleep in the room with me, but not in the same bed. You can breastfeed me in your bed, but when I'm ready to sleep, put me back in my crib: Sleeping with other people, ever parents, sister and brothers, puts me at risk for being rolled on and smothered.***
- ***Put me in clothes that will not make me feel too warm when I sleep. Getting too warm puts me at greater risk of unexpected death.***

Office of the Child Advocate
Connecticut Child Fatality Review Panel
Public Heath Alert
Infant and Toddler Homicides

In 2013 Connecticut experienced an unprecedented number of infant and toddler homicides. Ten infants and toddlers were killed by people who knew them, and most of the alleged perpetrators were in a caregiving role.

Fatal child abuse or neglect is the physical injury or negligent treatment of a child by a person who is responsible for the child's well-being. More than 2,000 children die each year from child abuse and neglect in the United States. Most deaths result from fatal head trauma such as when an infant's head is violently shaken, slammed against a surface, or struck by a caregiver, or from fatal abdominal injury, when a child's abdomen is struck, leading to internal bleeding. Connecticut, similar to the rest of the country, sees a higher incidence of child maltreatment fatalities in boys. Biological parents account for up to 63% of perpetrators of fatal child abuse and neglect. Men (usually mother's boyfriends or fathers) are the most common perpetrators of fatal abuse and, therefore, need to be especially targeted in prevention efforts. Strangers are responsible only for a small fraction of child homicides.



Child Homicide in Connecticut

Between January 1, 2001 and December 31, 2013 there were fifty-seven homicides of children from birth through three years of age. Thirty-eight (67%) were boys and nineteen (33%) were girls. Over 75% of these young children sustained fatal child abuse associated with head and/or abdominal trauma. Forty-six (81%) of the children were under two years old. Connecticut experienced an unprecedented number of child homicides for young children in 2013. There were no homicides of infants and young children three years old and under in 2012.

In 2013, the suspected perpetrators in all ten infant and children homicides were known to the children. Four were fathers, four were mother's boyfriends, and two brothers were killed by their grandmother. Two of these homicides had an open case with the Department of Children and Families (DCF) at the time of death, and three other cases had a history with DCF. DCF has developed several initiatives with Pediatric Child Abuse Specialists that focus on multidisciplinary education, training, case consultation and real time assessment and intervention.

In the United States, deaths due to child abuse and neglect may be vastly underreported due to inadequate investigations, lack of information-sharing between medical personnel (first responders and emergency department personnel), police investigators, child protective service agencies, the medical examiner's office, and reporting systems that fail to capture the contribution of maltreatment as a cause of death. The use of statewide child fatality review teams that perform child fatality surveillance may address this issue as Child Fatality Review Teams (CFRTs) may be able to more accurately determine the cause and manner of death.

To examine the global issues related to child abuse deaths, a federal commission has been charged with making recommendations to the President and Congress. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), is a federal advisory committee established by the Protect Our Kids Act of 2012, Public Law 112-275. According to the enabling legislation, the commission's work includes an examination of best practices in preventing child and youth fatalities that are caused due to negligence,

neglect, or a failure to exercise proper care; the effectiveness of federal, state, and local policies and systems aimed at collecting accurate and uniform data on child fatalities; the current barriers to preventing fatalities from child abuse and neglect, how to improve child welfare outcomes; trends in demographic and other risk factors that are predictive of or correlated with child maltreatment, such as age of the child, child behavior, family structure, parental stress, and poverty; methods of prioritizing child abuse and neglect; and methods of improving data collection and utilization, such as increasing interoperability among state and local and other data systems.

Perpetrators

Male caregivers are more likely to be the perpetrators of fatal injuries to young children. Some of these men reported that they fatally injured the infant or child because they lost patience when the child would not stop crying. Male caregivers are less likely to accompany mothers and their children to well-child care appointments and therefore may be missing important information about child development. Fatherhood initiatives are key to ensuring that male caregivers have critical information about early childhood developmental milestones.

GUIDELINES FOR PARENTS AND CAREGIVERS

- ✓ Talk to *your* child's pediatrician about crying and things you might do to soothe your baby.
- ✓ Ensure that every caregiver of your child understands that:
- ✓ Infant crying is a normal part of development.
- ✓ Crying can be *a way* for *the* baby to communicate (they are hungry, need a diaper change, or want to be held).
- ✓ Sometimes children cry for no reason.
- ✓ Babies can cry often and for long periods of time.
- ✓ Sometimes it is hard to console a crying a baby.
- ✓ Crying is not a reflection of your parenting skills.
- ✓ Crying will not hurt the child.
- ✓ Listening to a baby cry can be very challenging.
- ✓ If a caregiver gets frustrated, *they should* put the baby in a safe place (crib, bassinette, pack and play), take a break and call someone for help.
- ✓ Shaking a baby can cause brain damage resulting in serious mental and physical disabilities, and even death.
- ✓ ***NEVER SHAKE A BABY***

GUIDELINES FOR PEDIATRICIANS AND HOSPITALS, CASEWORKERS, IN-HOME SERVICE PROVIDERS, AND CHILDCARE PROVIDERS

1. Medical providers, child care workers, case workers, and in-home service providers should provide guidance for caregivers regarding the role of crying in infants as part of normal development. These facts about normal infant crying include infants can be difficult to console even in the absence of illness, that crying is not harmful to infants, that shaking an infant can cause brain damage resulting in serious mental and physical disabilities or even death (6) and a safety plan for when caregivers get frustrated with infant crying (take a break, put the baby down on his/her back in a safe place, call someone for help).
2. Hospitals should institute practice policies that encourage guidance in planning for the child's safety when intractable crying becomes an issue during encounters within the hospital or health care system (e.g. well infant visits, sick visits, Emergency Department visits, subspecialty care visits).
3. This guidance should be provided to ALL CAREGIVERS of the infant or child.

RECOMMENDATIONS FOR LAW ENFORCEMENT

1. Request that the Governor's Task Force on Justice for Abused Children establish dedicated funding for child death review training.

RECOMMENDATIONS FOR POLICYMAKERS

1. Devise legislation to encourage or require reimbursement to primary care providers for the time spent counseling families regarding infant and child crying and a safety plan for crying similar to what has been done successfully in other states such as Washington for oral primary care (*www.innovations.ahrq.gov).*
2. Devise legislation that mandates parent training on the dangers of shaking infants and alternatives for maintaining their baby's safety during episodes of prolonged crying is delivered by health care providers at discharge from the newborn hospital (similar to what is done in states like New York about Shaken Baby Syndrome *(www.ncsl.org/research/human-services/shaken-baby-syndrome-prevention-legislation.aspx)*
3. Devise legislation that provides support for evidence based fatherhood programs that teach fathers and other male caregivers to become capable caregivers of infants and children.
4. Support efforts by the Office of the Child Advocate and the Child Fatality Review Panel to report annual to the Connecticut General Assembly the number of infant and toddler homicides.
5. Connect home visitation and clinical home-based services to pediatrics. Home visitation programs provide essential supports and education to new parents.

RESOURCES

- ✓ National Center on Shaken Baby Syndrome (Enjoy Your Baby), (3 Things Every Dad Should Know), www.dontshake.org
- ✓ Enjoy Your Baby: www.parenting.com
- ✓ Prevent Child Abuse: www.preventchildabuse.org
- ✓ Connecticut Parenting: www.ctparenting.com

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SUICIDE DEATHS OF CHILDREN IN CONNECTICUT

January 1, 2001 to December 31, 2013

There were ***108*** youth suicides over this 13 year time frame.

Gender

- 71 are boys (66%)
- 37 are girls (34%)

Race

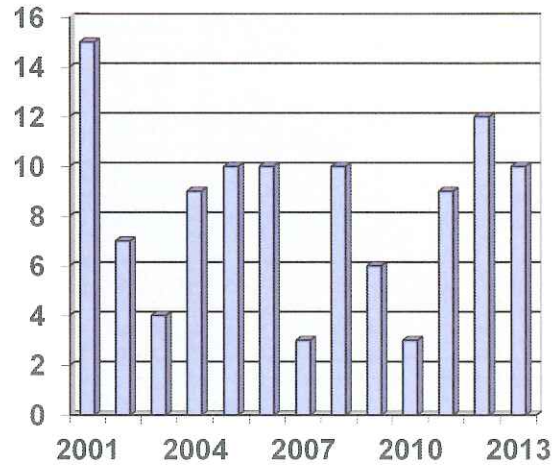
- 84 were White (78%)
- 14 were Black (13%)
- 7 Hispanic/White (6%)
- 3 Asian (3%)

Ages

- 2 were 10 years old
- 2 were 11 years old
- 3 were 12 years old
- 10 were 13 years old
- 12 were 14 years old
- 14 were 15 years old
- 35 were 16 years old
- 30 were 17 years old

Method

- 79 children died by hanging (73%)
- 17 from gunshot wounds (16%)
- 6 drug overdose (5%)
- 4 asphyxia (4%)
- 2 other trauma (2%)



Suicides 2001-2013

Comments: Since 2010, suicide in youth has increased. In the past 2 years, 11 girls died by suicide which accounted for nearly 30% of the female suicides over the past 13 years. The Office of the Child Advocate is currently working on a Public Health Alert regarding youth suicide.