Unintentional Firearm Fatalities

In 2005, ten Missouri children died of unintentional firearm injuries.

Representative Cases:

- **Education should be offered in all communities about gun safety. Parents should monitor children who are handling firearms.**

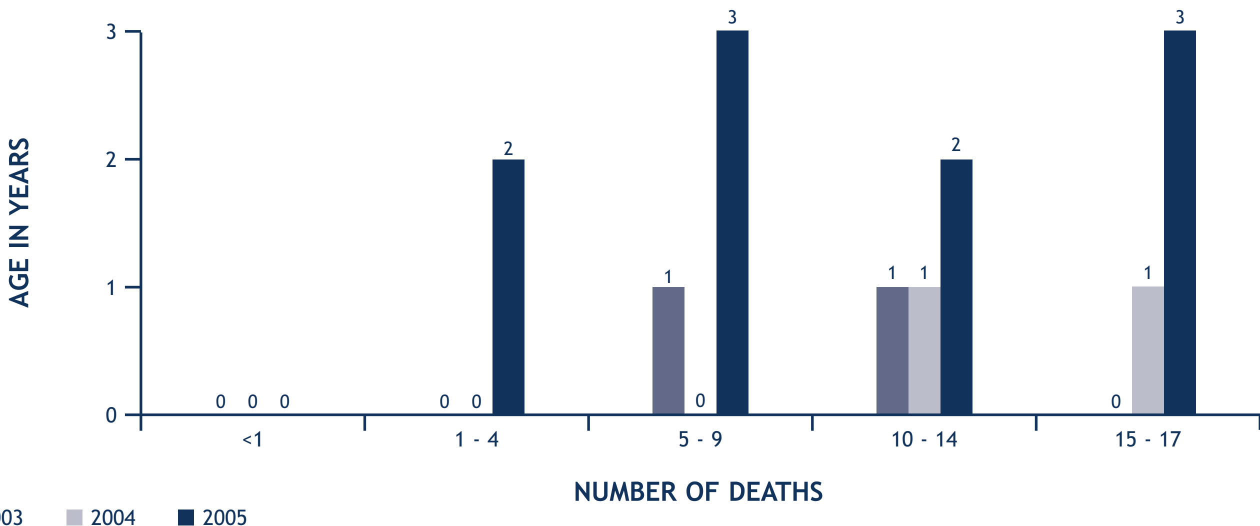
  A sixteen-year-old was shot by a sibling, who was attempting to unload the weapon.

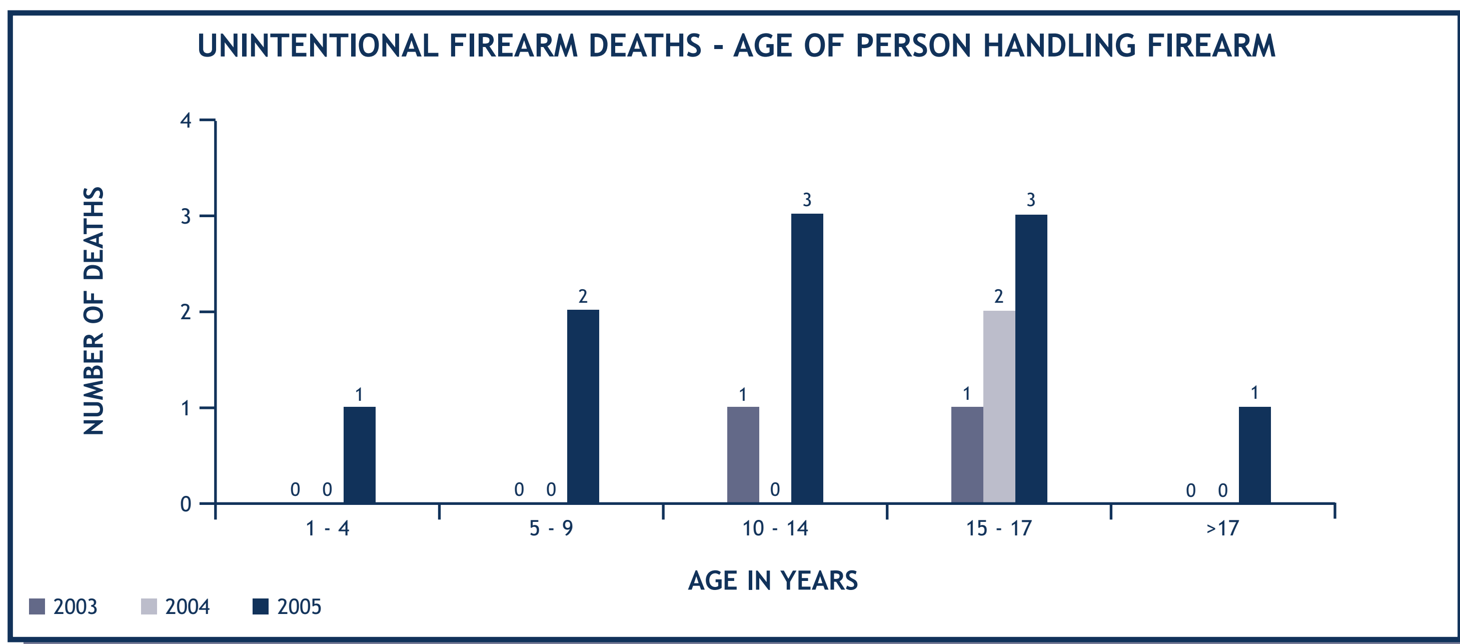
- **Parents who own guns should always store firearms unloaded and locked up, out of children's reach. Use gun locks, load indicators, and other safety devices on all firearms.**

  A three-year-old and his one-year-old brother were playing unsupervised. The older child found his father's gun in a plastic case, which had been left on the floor. While playing with the gun, it discharged and the toddler was shot.

  A six-year-old was playing with his father's gun, which was loaded. She was pretending to shoot her two-year-old brother and pulled the trigger. The gun discharged, shooting the two-year-old in the head and the six-year-old in the foot.

In the United States, about 500 children die each year from unintentional shootings and at least five times as many, are wounded. In 2005, **ten** Missouri children died of unintentional firearm injuries.





Certain groups of children are at higher risk for unintentional firearm-related injuries. In the United States, male children are far more likely to be injured and die from unintentional shootings, than female children. Of those children age 14 and under who are killed by an unintentional shooting, 82% are male. In Missouri in 2005, **8** of the 10 child victims of unintentional shootings were male and **2** were female. Children living in the South and in rural areas have higher rates of unintentional firearm-related deaths, than other areas.

Nationally, more than 70% of unintentional shootings involve handguns. In 2005, **8** of the 10 uninentional firearm deaths among children involved handguns. The other two involved a rifle and a shotgun.

Forty percent of gun owners keep firearms in the home for protection and crime prevention. Guns in the home for protection are more likely to be handguns, found in a home with children, stored loaded and unlocked. Of the **10** unintentional firearm deaths reviewed by CFRP panels in 2005, **7** involved a gun that was owned by a family member and **one** gun was owned by the decedent. **Eight** of the 10 Missouri children who died as a result of unintentional firearm injury in 2005, were killed with a gun that was stored in a location accessible to children, or not locked and secured.

Unintentional Firearm Deaths Among Children

Unrealistic perceptions of children's capabilities and behavioral tendencies with regard to guns are common.

- Most unintentional childhood shooting deaths involve guns kept in the home, that have been left loaded and accessible to children, and occur when children play with loaded guns. **Six** of the 10 Missouri children who died as a result of unintentional firearm injury in 2005, were reported to be playing with the gun.

- Unintentional shootings among children most often occur, when children are unsupervised and out of school.

- Nearly two-thirds of parents with school-age children, who keep a gun in the home, believe that the firearm is safe from their children. However, one study found that when a gun was in the home, 75-80% of first and second graders knew where the gun was kept.

- Generally, before age 8, few children can reliably distinguish between real and toy guns, or fully understand the consequences of their actions.

- Children as young as age three are strong enough to pull the trigger of many of the handguns available in the U.S.

Declines in child firearm and BB-pellet gun-related injury rates during the 1990's, coincided with increased prevention efforts, including legislation and education, aimed at reducing unsupervised access to guns by children.

- It is estimated that two safety devices - gun locks and load indicators - could prevent more than 30% of all unintentional firearm deaths.

- To distinguish them from real guns, toy guns must conform to marking requirements under the U.S. Department of Commerce "Marking of Toy Look Alike and Imitation Firearms" regulation.

- Eighteen states have enacted child access prevention laws, which may hold adults criminally liable for failure to either store loaded firearms in a place inaccessible to children, or use safety devices to lock guns.

- State safe-storage laws intended to prevent child access to guns, have reduced unintentional firearm-related deaths among children ages 14 and under, by an average of 23 percent. *(Safe Kids)*

  One possible strategy to decrease firearm injury and deaths to children, is educational programs. These can be directed at the children themselves, or at parents and adults, to store guns more safely in the home (or out of the home). The National Rifle Association's "Eddie Eagle" program is an example of the former type of educational intervention. Unfortunately, few of these educational interventions have been evaluated. *(National Injury Prevention and Research Center)*

Prevention Recommendations:

For Parents:

- Parents who own guns should always store firearms unloaded and locked up, with ammunition locked in a separate location, out of children's reach, use gun locks, load indicators and other safety devices on all firearms.

- All parents should teach children never to touch a gun and tell an adult, if they find a gun.

For community leaders and policy makers:

- Enforce laws and ordinances that restrict access to and decrease availability of guns.

- Enact and enforce laws requiring new handguns be designed to minimize the likelihood of discharge by children.

- Enact laws outlining owner liability for harm to others, caused by firearms.

For professionals:

- Implement gun safety education. It is important to include public education about the hazards of firearms, as one component of an overall effort to reduce the incidence of firearm injuries and deaths.

For Child Fatality Review Panels:

- In all cases of firearm fatalities involving children, ensure that every effort is made to determine the source of the gun and consider the responsibility of the gun owner in the incident.

Resources and Links:

National Safe Kids Campaign . . . . www.safekids.org

Harborview Injury Prevention and Research Center . . . . http://depts.washington.edu/hiprc

National Rifle Association
"The Eddie Eagle GunSafe Program". . . . . www.nrahq.org/safety/eddie

Missouri Department of Conservation Hunter Education Program . . . . www.mdc.mo.gov
"Education" features education resources for teachers, youth groups and organizations, including an educational materials request form, as well as information on Hunter Education class locations, conservation and other outdoor skills education programs. The Hunter Eduction Program features the film, "The Last Shot," which targets older children and teen audiences with an effective gun safety message.

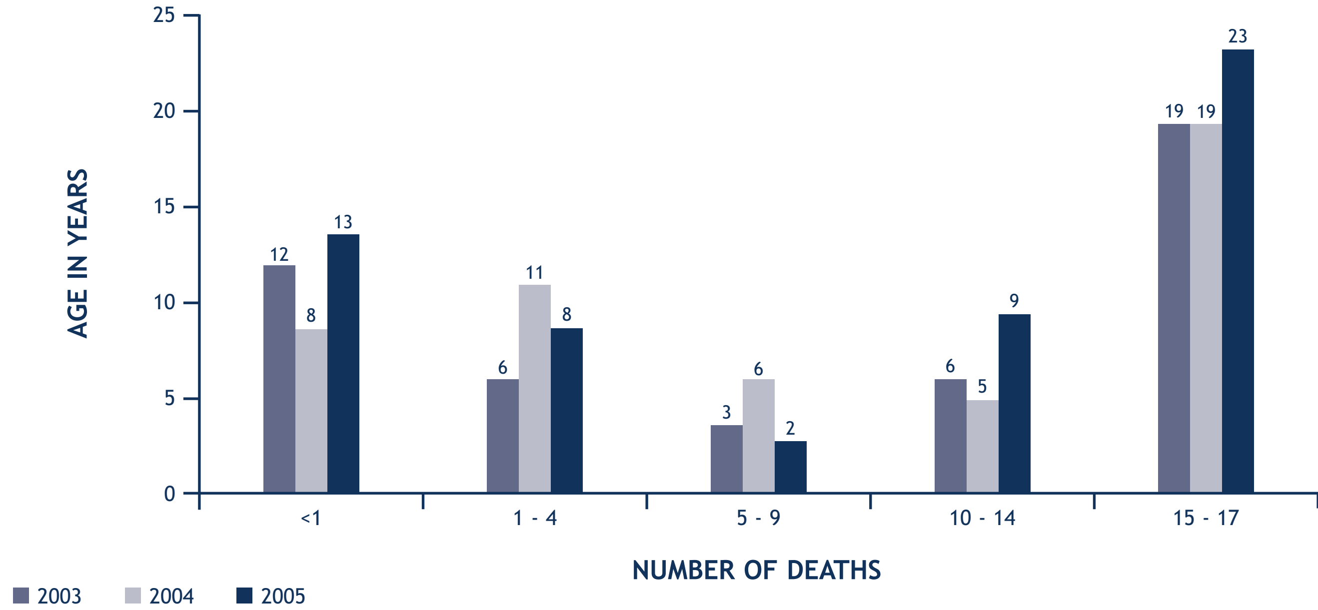
Homicides

In 2005, homicide was listed as the death certificate manner of death for 55 Missouri children.

1. **Fatal Child Abuse and Neglect: Child death resulting directly from inflicted physical injury and/or grossly negligent treatment by a parent or caretaker, regardless of motive or intent.** This includes, but is not limited to, children whose deaths were reported as *homicide* by death certificate. In 2005, a total of **78** Missouri children were identified by CFRP panels, as victims of Fatal Child Abuse and/or Neglect; of those, **22** Fatal Child Abuse-Inflicted Injury were reported by death certificate as Homicide.

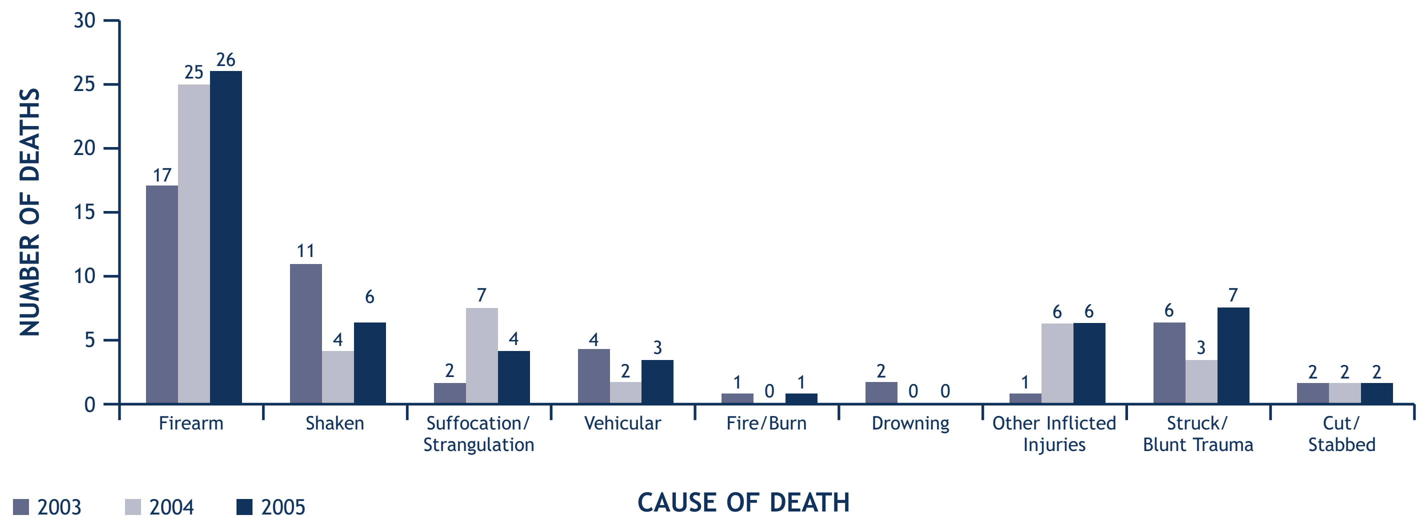
2. **Death of a child in which the perpetrator was not in charge of the child.** This most often includes youth homicides, such as gang-related or drug-related shootings and child abductions that culminate in murder. There were **30** such fatalities among Missouri children in 2005. Of those, CFRP panels identified **four** child deaths in which parental negligence was a contributing factor.

3. **Deaths of children in which the perpetrator, not in charge of the child, was engaged in criminal or negligent behavior, and the child was not an intended victim.** Examples often involve firearms or motor vehicles and drugs or alcohol. In 2005, there were **three** such deaths of this type among Missouri children. Of those, CRFP panels identified **one** child death in which parental negligence



HOMICIDES BY SEX AND RACE

SEX	2003	2004	2005	RACE	2003	2004	2005
FEMALE	13	19	17	WHITE	25	20	29
MALE	33	30	38	BLACK	21	29	26
	46	49	55		46	49	55



"In the little world in which children have their existence, whosoever brings them up, there is nothing so finely preserved and so finely felt as injustice."
-Charles Dickens, from Great Expectations.

Fatal Child Abuse and Neglect

In 2005, 78 Missouri children were victims of Fatal Child Abuse and Neglect. Of those, 27 were reported as homicide by death certificate.

Representative Cases:

- **Young children are more likely to die from abuse and neglect.**

  An infant with a history of asthma, was suffering from pneumonia. She was put to bed, wrapped in a blanket, in a very hot room that was the only non-air-conditioned area of the house. When she was found unresponsive, the parents drove her to the hospital, where she was pronounced dead.

  A toddler was left in the care of his mother's boyfriend, while she was at work. While returning to the apartment with the child, the boyfriend kicked him in the stomach, when he was too slow in climbing the stairs. He died of blunt trauma to the abdomen.

- **Multidisciplinary teams should be developed, supported and trained on the local level to investigate serious offenses against children.**

  An sixteen-week-old baby was lying in his father's arms, while the father slept in a recliner. The father claimed that when he awoke, the baby was limp and unresponsive. When autopsy revealed fresh and healing posterior rib fractures, the father confessed to squeezing the infant on multiple occasions, to stop him from crying. Cause of death was chest compression. Both parents had a child abuse and neglect history.

- **Parents and caretakers must be educated about the dangers of shaking and ways to cope with crying infants.**

  The mother of a six-month-old became frustrated with the infant's crying. She placed her face down on an adult pillow, on a mattress on the floor, covered her with blankets, and left the room. The baby was found unresponsive an hour and a half later.

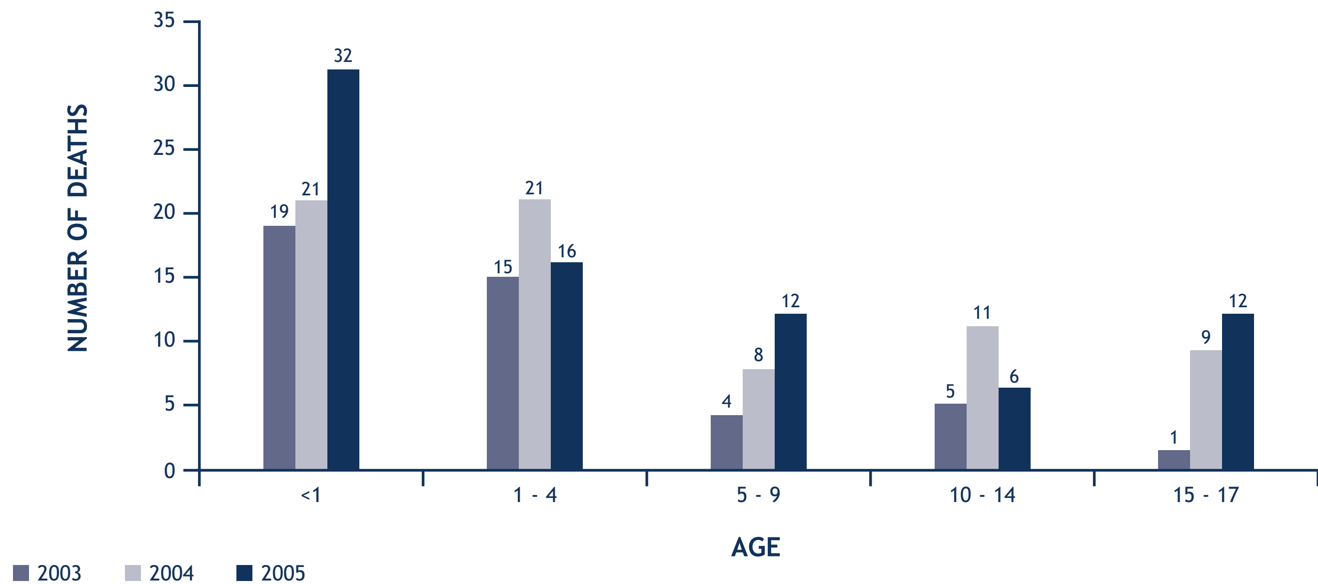
  A two-year-old was crying unconsolably. The mother slapped her in the face, which resulted in bruising. When the child continued to cry, the mother forcibly held a pillow over the child's face, until she stopped breathing.

  A four-month-old was in the care of his father, while the mother was at work. The father worked during the day and the mother worked nights. The father was trying to sleep when the baby began crying. He called the mother to tell her to come home. When she arrived, she found the baby unresponsive. The father later admitted that he had shaken the baby, to make him stop crying. He also admitted that this was not the first time he had shaken him.

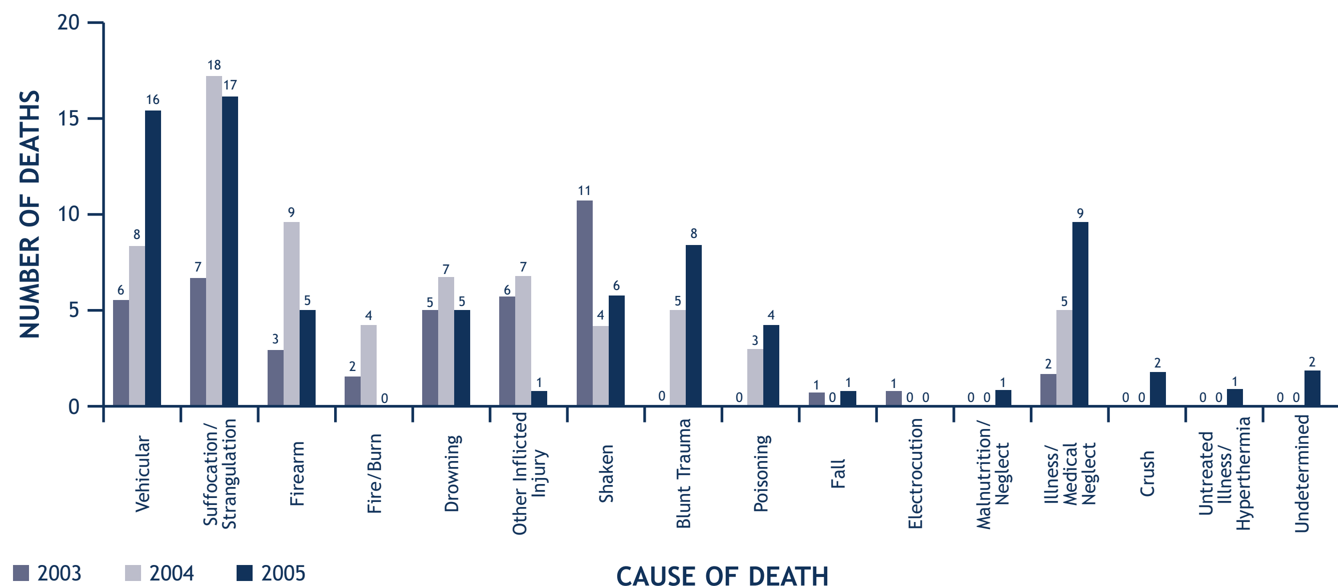
CHILD ABUSE AND NEGLECT FATALITIES BY SEX AND RACE

SEX	2003	2004	2005	RACE	2003	2004	2005
FEMALE	16	32	35	WHITE	32	48	63
MALE	28	38	43	BLACK	12	22	15
	44	70	78		44	70	78

CHILD ABUSE AND NEGLECT FATALITIES BY AGE



CHILD ABUSE AND NEGLECT DEATHS BY CAUSE



Child fatalities are the most tragic consequence of child abuse and neglect. In the United States, approximately 1,200 children die of abuse or neglect each year, according to vital records (NCAN-DS). However, it is well documented that child abuse and neglect fatalities are under-reported and that, nationally, at least 2,000 children die each year at the hands of their parents or caretakers. Some estimates are as high as 3-5,000. (Ewigman et al., 1993; Herman-Giddens et al., 1999) There are a number of reasons for the discrepancies and some of the fundamental problems are highlighted in this section. The Centers for Disease Control has funded an effort to develop a standardized national surveillance system capable of accurately reported child abuse and neglect families. On a state level, properly organized and functioning child fatality review systems have improved the accuracy of child death reporting.

In Missouri, there are three entities within state government responsible for child fatality information: **Department of Health and Senior Services' Bureau of Vital Statistics, Department of Social Services, Children's Division** and **Child Fatality Review Program.** All three exchange and match child fatality data in order to ensure accuracy throughout the system. However, the Bureau of Vital Statistics, Children's Division and the Child Fatality Review Program serve very different functions and, therefore, different classifications and timing periods apply, when child fatality data is reported.

Vital Statistics and Death Certificate Information

The death certificate is issued for two major purposes. One is to serve as legal documentation that a specific individual has died. In general, the death certificate serves as legal proof that death has occurred, but not as legal proof of the cause of death. The second major purpose of the death certificate is to provide information for mortality statistics that may be used to assess the nation's health, causes of morbidity and mortality, and developing priorities for funding and programs that involve public health and safety issues.

Death certificate information is widely recognized as inadequate as a single source for identification of child abuse and neglect deaths. Misidentification of deaths may occur, because of inadequate scene investigation or autopsy procedure, inadequate investigation by law enforcement or child protection, or misdiagnosis by a physician or coroner. Child abuse and neglect fatalities often mimic illness and accidents. Neglect deaths are particularly difficult to identify, because negligent treatment often results in illness and infection that can be attributed to natural causes.

Children's Division: Child Abuse/Neglect Fatalities

The Missouri Department of Social Services, Children's Division is the hub of the child protection community. Children's Division provides a unique, multiple-response system for responding to each report of child abuse and neglect received by the Child Abuse/Neglect Hotline Unit (CANHU). Children's Division's responsibilities are limited to those reports that meet the legal definition of child abuse and neglect, stipulated in 210.110, RSMo, for children under the age of 18, from whom the perpetrator has care, custody and control.

Since August 2000, all child deaths are reported to the Children's Division Central Registry. Any child not dying from natural causes, while under medical care for an established natural disease, is brought to the attention of the division by the coroner or medical examiner. A fatality report is taken and,

when appropriate, the report is accepted for investigation of child abuse and neglect by the division. The Child Fatality Review Program is immediately notified of all fatality reports. The division is also responsible, if ordered by a judge, for protecting any other children in the household, until the investigation is complete and their safety can be assured.

After a report of child abuse or neglect has been made, investigations that return sufficient evidence supporting the report are classified as *probable cause child abuse and neglect*. When there is probable cause to believe that a child who has died was abused or neglected, or when this finding is court-adjudicated, that death is considered by the division to be a *probable cause child abuse and neglect fatality.* Thus, reports classified by the division as *probable cause child abuse and neglect fatalities* include deceased children whose deaths may or may not have been a direct result of the abuse or neglect. An example would be an unsupervised toddler who was run over in the driveway of her home. That death would be included as a pedestrian fatality in this CFRP Annual Report, with Inadequate Care as a contributing factor. In a case such as this, Children's Division would determine that there was *probable cause* to believe that this child was a victim of *neglect*, specifically, lack of supervision.

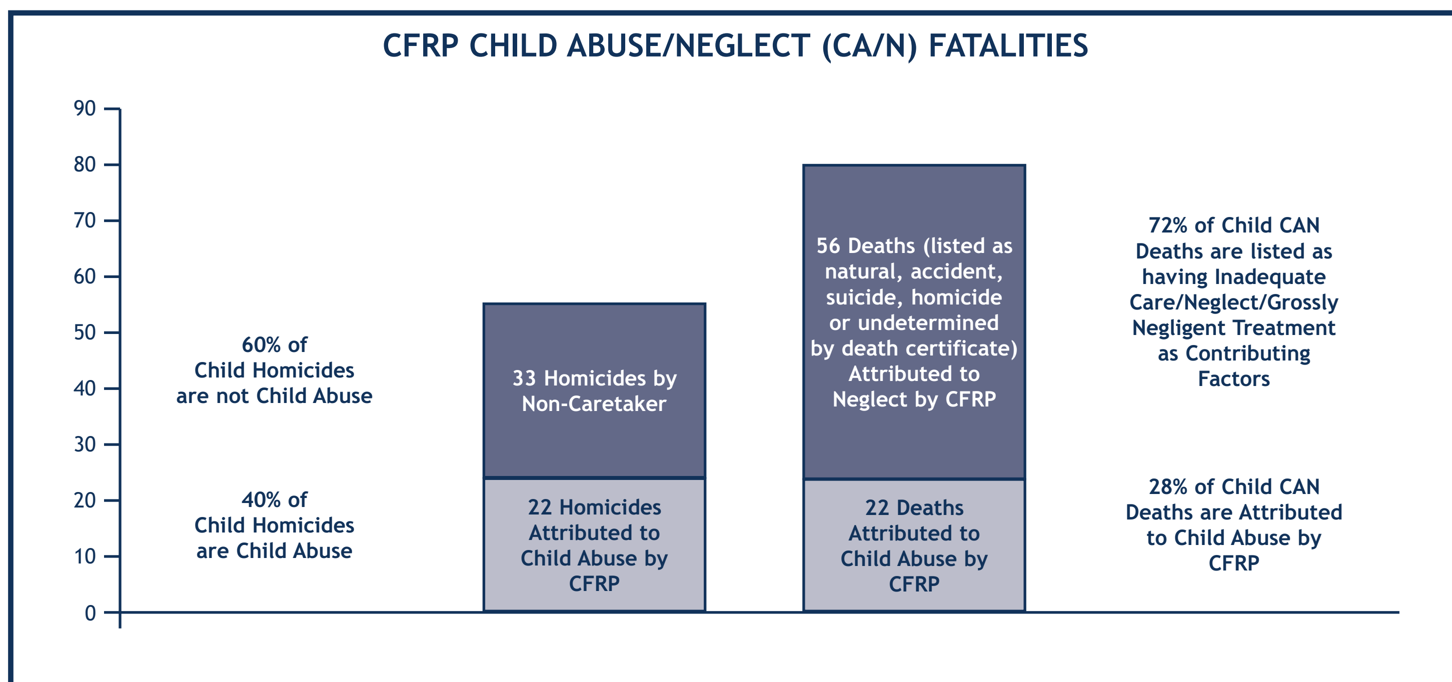
The Missouri Child Fatality Review Program: Fatal Child Abuse and Neglect

Child fatalities represent the extreme of all issues that have a negative impact on children. Despite an increasing awareness of severe violence against children, very little was known in the past about fatal child abuse and neglect. In the late-1980's, Missouri researchers discovered that many fatal child injury cases were inadequately investigated and that many children were dying from common household hazards with inadequate supervision. Many cases of fatal abuse and neglect went undetected, misclassified as natural deaths, accidents or suicides. The information necessary for a thorough investigation of a child death was distributed among agencies, which could not share records. In 1992, Missouri initiated a comprehensive, statewide child fatality review system. The CFRP review process has resulted in better investigations, more timely communication, improved training and technical assistance, and standardized data collection that allows us to understand much more about how our children die, the circumstances in which they die and who may be responsible.

Beginning in 1999, the Child Fatality Review Program Annual Reports refined the reporting and analysis of CFRP data in many ways, including an examination of data concerning "Fatal Child Abuse and Neglect", as defined by local panels. Those numbers represented a subset of child fatalities reported as *homicide* by death certificate. These changes allowed us to begin to understand much more about how Missouri children die, the circumstances in which they die and who may be responsible.

The Child Fatality Review Program defines *Fatal Child Abuse and Neglect* as child deaths resulting directly from inflicted physical injury and/or grossly negligent treatment by a parent or caretaker, regardless of motive or intent. This number includes, but is no longer limited to, children whose deaths were reported as homicide by death certificate; their death certificate manners of death may include natural, accident or undetermined. See Appendices 6 and 7 for additional information.

"Murder is no less a crime because a child, rather than an adult, is the victim."
-Unknown



Fatal Child Abuse: Inflicted Injury

In 2005, 22 Missouri children died from inflicted injury at the hands of a parent or caretaker.

In the United States, it is estimated that 2,000 children are murdered each year. Homicide at the hands of a parent or caretaker is the leading cause of injury-related death in infants under one year of age. Infants and young children under the age of four years are at greatest risk of severe injury and death, due to physical abuse. In 2005, **20** of the **22** (91%) who died from inflicted injuries at the hands of a parent or caretaker, were four years of age or younger. Of those, **13** (65%), were infants under the age of one year.

In 2005, **seven** Missouri children died of blunt trauma injuries to the abdomen or head, when they were struck, punched, kicked or thrown. Infants and young children are especially vulnerable because vital organs are in close proximity to each other; the ribs are small and cannot protect vital internal organs. Blunt trauma to the chest and abdomen can result in massive internal injuries and bleeding.

In the United States, Shaken Baby Syndrome is the second most common cause of death due to trauma in children and the cause of more than 95% of serious head injuries in infants less than one year of age. In 2005, **six** Missouri children were victims of fatal abusive head trauma, commonly known as Shaken Baby Syndrome (SBS).

Another common type of physical abuse among young children, but often more difficult to detect, is suffocation/strangulation. These injuries occur when hands or materials are used to block or cover external airways (suffocation) or used to exert pressure on the neck and interfere with breathing (strangulation), or pressure is exerted on the chest in order to interefere with breathing. In 2005, **five** Missouri children died of suffocation/strangulation injuries at the hands of a parent or caretaker.

Fatal Abuse: Inflicted Injury

FATAL ABUSE INFLICTED INJURIES BY AGE	
<1 year	13
1-4 years	7
5-9 years	1
10-14 years	1
15-17 years	0

FATAL ABUSE INFLICTED INJURIES BY SEX	
Females	8
Males	14

FATAL ABUSE INFLICTED INJURIES BY RACE	
White	17
Black	5

FATAL ABUSE INFLICTED INJURIES BY CAUSE			
Shaken Baby Syndrome	6	Other - Poisoning	1
Blunt Trauma	7	Malnutrition/Neglect	2
Suffocation/Strangulation	5	Other Inflicted Injuries	1

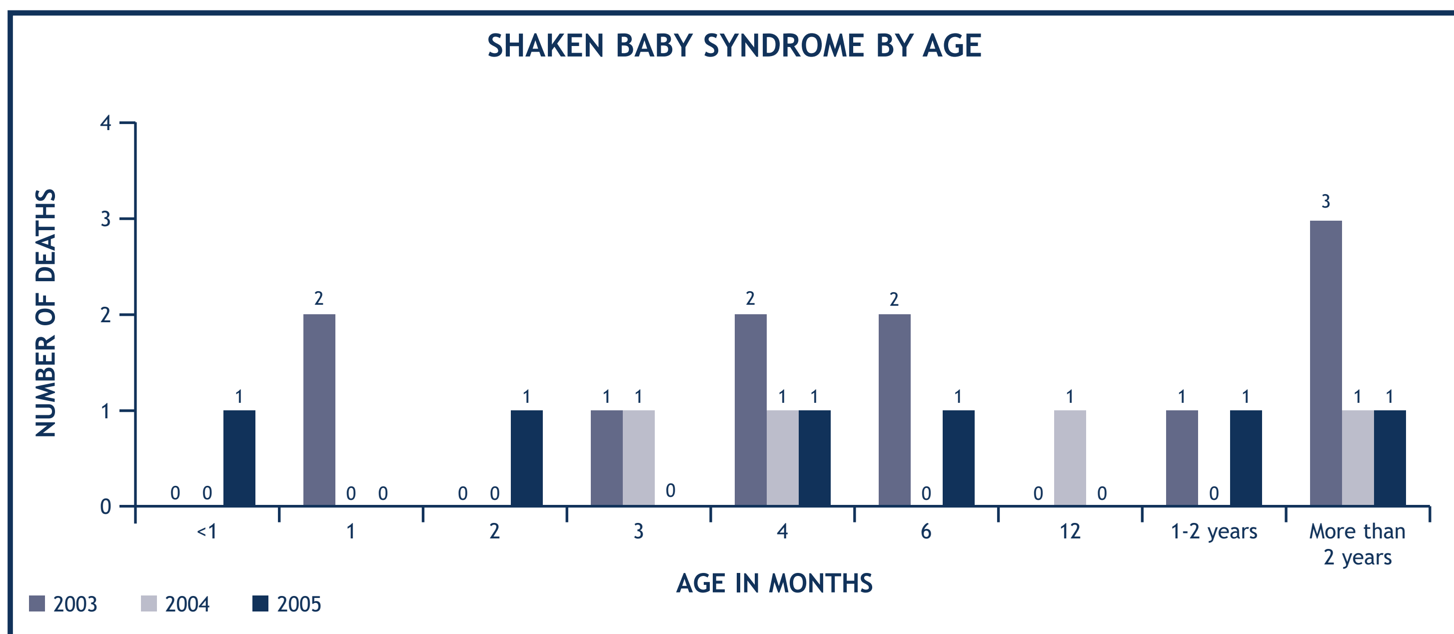
Shaken Baby Syndrome

Of the **22** Missouri children who died from inflicted injury at the hands of a parent or caretaker in 2005, **six** (27%) were victims of abusive head trauma (or inflicted traumatic brain injury), commonly known as Shaken Baby Syndrome. Shaken Baby Syndrome (SBS) is the second most common cause of death due to trauma in children and the cause of >95% of serious head injuries in children less than one year of age.

Shaken Baby Syndrome involves the violent shaking or shaking and impacting of the head of an infant or young child, usually under the age of four years. Signs and symptoms range from minor (irritability, lethargy, tremors, vomiting) to major (seizures, coma, stupor, death). These neurological changes are due to destruction of brain cells, and swelling of the brain. Extensive retinal hemorrhages in one or both eyes are found in the vast majority of cases. Fractures of long bones and/or ribs may also be seen in some cases. *(National Center on Shaken Baby Syndrome)*

Shaken Baby Syndrome is so lethal that approximately 30% of victims require hospitalization and 20% of victims die in the first few days after injury. Approximately 50% of survivors suffer permanent neurologic disabilities ranging from mild (learning disorders, behavioral changes) to moderate and severe, such as profound mental and developmental retardation, paralysis, blindness, inability to eat or exist in permanent vegetative state. Many survivors initially thought to be normal have subsequent learning disabilities or other psychomotor delays that are not diagnosed until they reach school age.

The vast majority of SBS victims are indeed, “babies” or infants, less than one year of age, but victims can range in age from <1 month to eight years; the median age is 4-6 months. Infants are particularly vulnerable to shaking injuries, because of their unique physical and behavioral characteristics. Infants’ heads are large and heavy in proportion to their total body weight and their neck muscles are too weak to support such a disportionately large head. Because an infant’s brain is immature, it is more easily injured. When an infant or young child is violently shaken, the head rotates wildly on the axis of the neck, resulting in rotation of the brain within the skull.



SHAKEN BABY SYNDROME DEATHS BY SEX AND RACE

SEX	2003	2004	2005	RACE	2003	2004	2005
FEMALE	1	3	1	WHITE	9	2	5
MALE	10	1	5	BLACK	2	2	1
	11	4	6		11	4	6

Young parents, unstable family conditions, low socioeconomic status and disability or prematurity of the child make an infant particularly vulnerable. The triggering event for the shaking is almost always the baby's uncontrollable crying and loss of control by the caregiver. Crying peaks between six weeks and four months. Infant crying was known to be the apparent triggering event in **four** of the six SBS abuse fatalities among Missouri children in 2005.

Research has established that 60-70% of perpetrators of SBS are male. Birth fathers account for the majority, followed by the mother's boyfriend, female babysitters, and mother. In 2005, perpetrators of SBS abuse fatalities included **three** birth fathers, **one** mother's boyfriend, **one** babysitter and **one** unknown.

"I shook her and her eyes half closed and they never moved."

Fatal Child Neglect: Inadequate Care and Grossly Negligent Treatment

The majority of unintentional fatalities and serious injuries among young children are the result of a temporary lack of supervision or inattention at a critical moment. This is often the case when infants and toddlers drown in bathtubs and swimming pools, or young children dart in front of moving vehicles. Parent and other caretakers often underestimate the degree of supervision required by young children. This is complicated by the mistaken idea that young children have some sort of innate fear of dangerous situations.

Negligent treatment of a child is an act of omission, which is often fatal when due to grossly inadequate physical protection, withholding nutrition or health care necessary to preserve life. Child deaths resulting from grossly negligent treatment are frequently difficult to identify, because neglect often results in illnesses and infections that can be attributed to natural causes, or exposure to hostile environments or circumstances that result in fatal "accidents."

Definitions of negligent treatment vary depending on whether one takes a legal, medical, psychological, social service or lay perspective. There are broad, widely recognized categories of neglect that include: *physical neglect, emotional neglect, medical neglect, neglect of mental health, and educational neglect*. Within those definitions, there are subsets, as well as variations in severity that often include *severe* or *"nearly-fatal"* and *fatal*. Negligent treatment may or may not be intentional; however, the end result for the child is the same whether the parent is willingly neglectful (e.g., out of hostility) or neglectful due to factors such as ignorance, depression or overwhelming stress and inadequate support.

Grossly negligent treatment by a parent or caretaker generally involves failure to protect from harm and withholding or otherwise failing to provide food, shelter, or medical care necessary to meet the child's basic needs. This level of negligence is egregious and surpasses momentary inattention or a temporary condition; it is often part of a pattern of negligent treatment. Child deaths often result when a parent or caretaker fails to adequately supervise the child, usually for extended periods of time.

In some cases, "failure to protect from harm" or failure to meet basic needs, involves exposure to a hostile environment or a hazardous situation with potential for serious injury or death. An example would be a three-year-old who was riding unrestrained, while his intoxicated parents were "playing chicken" with another vehicle. The child was ejected in the crash and died instantly. Another example is a toddler, put outside to play alone, who wandered out of the yard and drowned in a pond.

Medical neglect, as a form of grossly negligent treatment, refers to failure to provide prescribed medical treatment or emergency medical care for a known illness or injury with potential for a serious or fatal outcome. Examples include untreated diabetes or asthma.

As part of the review process, CFRP panels are asked to consider and designate all child fatalities in which Inadequate Care and/or Grossly Negligent Treatment contributed to the death of the child. In 2005, CFRP panels found Grossly Negligent Treatment had contributed to the deaths of **56** Missouri children; of those **five** were designated as Homicide by death certificate. For data purpose, all 56 deaths are included in the appropriate data section, Illness/Natural Cause, Unintentional Injury, Homicide or Suicide.

Total Child Deaths	Cause of Death	*Circumstances of Gross Negligent Treatment that Contributed to the Death						Examples
		Lack of Supervision	Malnutrition/ Starvation	Medical Neglect	Exposure to Hostile Environment or Hazardous Situation	Unrestrained Children	Other	
8	Illness/ Natural Cause	1	1	5	3	0	3	Two newborn infant deaths resulted from complications of prematurity due to maternal substance abuse. Four child deaths resulted from withholding medical care for known or apparent illness or condition, including seizure; one of those children was also suffering from malnutrition at the time of death.
16	Vehicular	3	0	0	1	4	8	Four children, age 4 and under, riding unrestrained. Two children in separate incidents were riding on farm tractors, when they were thrown off or fell off. In two cases, very young children were left unattended near busy roads and struck by passing vehicles. One young child died when he was thrown from an ATV and crushed by the vehicle. Four young children died in two separate crashes caused by careless and wreckless driving, speeding, or intoxication of the adult driver.
12	Infant Suffocation	4	0	0	2	0	5	Seven infants died while bedsharing with adults. Two were overlayed by adults; one was exposed to soft bedding and foam mattress; in three cases, adults were intoxicated and in one case adults had been using meth. Four infants suffered positional asphyxia when left unattended for long periods of time in swings, infant carriers and bouncy seats. One infant slipped from a mother's bed into a head-down position in a diaper bag.
3	Poisoning	1	0	0	2	0	1	Two young children died of overdoses of adult prescription medications, including Fentanyl and Methadone, left in reach in containers that were accessible and not child-proof.
5	Firearm	2	0	0	4	0	2	Two children were accidentally shot by their siblings, who were playing with guns, left unlocked and accessible. One child was murdered by her former step-father, who then killed himself. A five-year-old apparently discovered a handgun and shot himself accidentally. Another young child was taken by her father to some type of drug transaction, which resulted in an altercation, during which the child was shot in the head.
5	Drowning	4	0	0	0	0	1	All seven drownings in young children age four and under involved at least a momentary lack of supervision. However, five of those were found to involve grossly negligent treatment, because they were left unattended in and around open water or swimming pools and drowned when adults left the area.
7	Other	0	0	2	2	0	4	There were 7 other child deaths due to various causes, designated by CFRP panels as grossly negligent treatment. One child received no medical care following a head injury, despite obvious signs of distress and diminishing consciousness, until she died. Another young child died in a daycare setting, when an unsecured room divider fell on him. Another child was exposed to a hazardous situation, when he became entangled in a power driven post-hole digger.
Total		15	1	7	14	4	24	

*In some cases, more than one neglect category was applied to a single child death.

Investigation and Prosecution of Physical Child Abuse and Homicide

Most serious child abuse occurs in the privacy of the home, and seldom in the view of family or other witnesses. If evidence exists, it is often concealed or destroyed. Perpetrators rarely fit the image of a criminal, and most jurors and judges find it hard to accept that any parent or caretaker would intentionally harm a child. There may be no outward signs of trauma, as in most cases of abusive head trauma (Shaken Baby Syndrome). Cases of physical child abuse and homicide are complex and technical; proof hinges on the expertise with which the investigation is conducted and the clarity with which details of the medical evidence are presented to the jury. The legal and medical issues are often daunting, but there are resources designed to assist criminal investigators and prosecutors in identifying perpetrators and holding them accountable.

The State Technical Assistance Team (STAT), a commissioned law enforcement unit with the Department of Social Services, *is available 24 hours a day to respond to requests for assistance in the complex and highly technical field of child abuse, neglect and exploitation. Besides managing the Child Fatality Review Program, STAT also provides hands-on assistance, training, and expertise.*
1-800-487-1626
www.dss.mo.gov/stat

National Center for the Prosecution of Child Abuse, a program of the American Prosecutors' Research Institute APRI . . . . www.ndaa.org/apri/programs/ncpca/ncpca_home.html
Provides training and technical assistance. A clearinghouse on child abuse case, law, statutory initiatives, court reforms, information on expert witnesses, and trial strategies and research.

National Center on Shaken Baby Syndrome . . . . www.dontshake.com
Provides technical assistance, research, expertise to investigation professionals, including scene investigation and suspected incidents, legal professionals, including visual presentation of medical evidence, and medical professionals, including recognizing abusive head trauma.

Missouri Attorney General's Office. . . . . www.ago.mo.gov
Special prosecutions and assistance, when requested by the local prosecutor.

"Child Abuse casts a shadow the length of a lifetime."

Something We Can Do: Preventing Shaken Baby Syndrome

The majority of fatal inflicted injury deaths among children involve abusive head trauma, commonly known as Shaken Baby Syndrome (SBS). Research has demonstrated that prevention programs targeting all new parents and caregivers with education about the dangers of shaking and ways to cope with crying infants, results in a measurable reduction in the number of serious and fatal injuries.

Children's Trust Fund, Missouri's Foundation for Child Abuse Prevention, provides SBS Prevention materials, including brochures and "Preventing Shaken Baby Syndrome" videotapes for parent and for child care providers.

For additional information, or to order education materials, contact CTF at 573-751-5147 or visit the website at www.ctfkids.org.

Prevention Recommendations:

For parents:

- Report child abuse and neglect.
- Seek crisis help through the Parent Helpline (800-367-2543) or ParentLink (800-552-8522).

For community leaders and policy makers:

- *Support and fund home-visitation child abuse prevention programs that assist parents.*
- *Enact and enforce laws that punish those who harm children.*

For professionals:

- Support and facilitate public education programs that target male caretakers and child care provider.
- Expand training on recognition and reporting of child abuse and neglect.
- Support development and training for multidisciplinary teams to investigate child abuse.

For Child Fatality Review Panels:

- The role of CFRP panel is critical in identifying fatal child abuse, protecting surviving children, and ensuring that the family receives appropriate services. CFRP panels provide important data that enhances our ability to identify those children who are most likely to be abused and intervene before they are harmed.

Resources and Links:

The National Center on Shaken Baby Syndrome . . . . www.dontshake.com

U.S. Department of Justice
Office of Juvenile Justice and Delinquency Prevention. . . . . www.ojjdp.ncjrs.org

ChildAbuse.com . . . . .www.childabuse.com

Missouri Department of Social Services, Children's Division . . . . www.dss.mo.gov/cd

Missouri Child Abuse Hotline. 1-800-392-3738

National Center for Missing and Exploited Children . . . . www.missingkids.com

Missouri Office of Child Advocate for Children's Protection and Services . . . . www.oca.mo.gov

OTHER HOMICIDES

Of the 55 child homicides in Missouri in 2005, 33 involved perpetrators who were not in charge of the child; of those, 26 (79%) involved firearms.

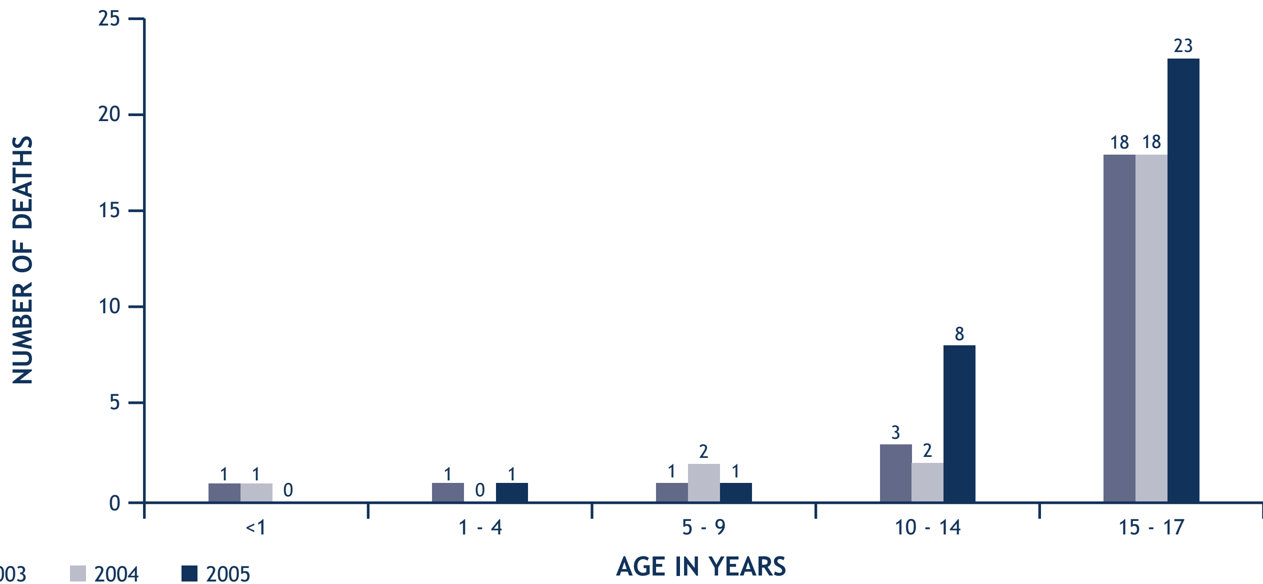
Representative Cases:

- **The increased availability of guns and drugs contributes to violence.**

  A 16-year-old male, formerly in DYS custody because of delinquent behavior, became involved in a gang fight and was shot.

  A 16-year-old male was shot while driving a car, apparently in revenge for a shooting that had occurred two weeks earlier.

  A 14-year-old male was standing with a group of older teens and became an unintended victim, when an 18-year-old member of a rival gang began shooting.



OTHER HOMICIDE FATALITIES BY SEX AND RACE

SEX	2003	2004	2005	RACE	2003	2004	2005
FEMALE	4	6	10	WHITE	9	7	12
MALE	20	17	23	BLACK	15	16	21
	24	23	33		24	23	33

In 2005, **33** Missouri children were murdered by non-caretakers. Of those, **16** were youth homicides, child deaths in which the perpetrator was another child. Most youth homicides involve juvenile crime and violence, or abductions by adults or other adolescents, that culminated in murder.

Of the **33** Missouri children murdered by non-caretakers, **three** involved a perpetrator who was not in charge of the child, was engaged in criminal or negligent behavior, and the child was not an intended victim: (1) The murder of a mother by arson, also resulted in the death of her infant, who was sleeping with her. (2) A father took his nine-year-old son with him to buy drugs; when a fight erupted, and the boy was shot. (3) A 14-year-old male, standing with a group of older teens, became an unintended victim when a member of a rival gang began shooting.

Youth homicide:

The most common mechanism of juvenile homicide is firearms. **Twenty-six** Missouri children died of intentional firearm injuries in 2005. Youth homicides are a serious problem in large urban areas, especially among black males. The majority of gun homicides among Missouri adolescents has risen sharply in the last three years, particularly when drug and gang activity is a factor.

OTHER HOMICIDES BY MECHANISM	
Firearm	10
Fire/Burn	1
Other Inflicted Injury	3
Vehicular	3
YOUTH HOMICIDES BY MECHANISM	
Firearm	16

Nationally, the rate of juvenile arrest for violent crime has risen sharply since the mid-1980's, and juvenile arrests for murder, robbery, motor vehicle theft and weapons violations far surpassed the growth in adult arrests, for these crimes. The growth in juvenile homicides has been particularly disturbing. The rapid rise of gun homicides of youth, coincided with the growth of crack cocaine markets in the inner city. The increased availability of guns to youth has been matched by an increased willingness to use violence to achieve one's goals. Violent confrontations are common in adolescence. If both parties are armed, the one who acts first usually gains a decided advantage. The realization that many youth on the street are carrying a weapon, increases the potential for an immediate and exaggerated response to real or perceived threats. Young males commit the majority of juvenile crime and violence. With the exception of rape and domestic violence, males are also more likely to be victims of violence than females. By age 17, the risk of homicide among males is five times that of females. *(Harborview Injury Prevention and Research Center)*

Research on youth violence has increased our understanding of factors that make some populations more vulnerable to victimization and perpetration. Many risk factors are the same, in part, because of the overlap among victims and perpetrators of violence. Risk factors are not direct causes of youth violence; instead, risk factors contribute to youth violence by increasing the likelihood that a young person will become violent. For example, in Missouri in 2005, 19% of high school participants in the Youth Risk Behavior Survey indicated that they had carried a weapon during the past month and 30% had been in a physical fight during the previous year. These behaviors are known to contribute to youth violence and homicide.

Research associates the following risk factors with perpetration of youth violence:

Individual Risk Factors

- History of violent victimization or involvement

- Attention deficits, hyperactivity, or learning disorder
- History of early aggressive behavior
- Involvement with drugs, alcohol, or tobacco
- Low IQ
- Poor behavioral control
- Deficits in social cognitive or information-processing abilities
- High emotional distress
- History of treatment for emotional problems
- Antisocial beliefs and attitudes
- Exposure to violence and conflict in the family

Family Risk Factors
- Authoritarian childrearing attitudes
- Harsh, lax, or inconsistent disciplinary practices
- Low parental involvement
- Low emotional attachment to parents or caregivers
- Low parental education and income
- Parental substance abuse or criminality
- Poor family functioning
- Poor monitoring and supervision of children

Peer/School Risk Factors
- Association with delinquent peers
- Involvement in gangs
- Social rejection by peers
- Lack of involvement in conventional activities
- Poor academic performance
- Low commitment to school and school failure

Community Risk Factors
- Diminished economic opportunities
- High concentrations of poor residents
- High level of transiency
- High level of family disruption
- Low levels of community participation
- Socially disorganized neighborhoods

Protective factors buffer young people from risks of becoming violent. These factors exist at various levels. Protective factors have not been studied as extensively or rigorously as risk factors and most research is preliminary.

Individual Protective Factors
- Intolerant attitude toward deviance
- High IQ or high grade point average
- Positive social orientation
- Religiosity

Family Protective Factors
- Connectedness to family or adults outside of the family
- Ability to discuss problems with parents
- Perceived parental expectations about school performance are high
- Frequent shared activities with parents

- Consistent presence of parent during at least one of the following: when awakening, when arriving home from school, at evening mealtime, and when going to bed
- Involvement in social activities

Peer/School Protective Factors
- Commitment to school
- Involvement in school activities
  (National Center for Injury Prevention and Control)

Violence Prevention Recommendations:

For parents:

- Provide supervision, support and constructive activity for children and adolescents in your household.
- Access family therapy and parenting assistance, as necessary, for help with anger management skills, self-esteem and school problems.

For community leaders and policy makers:

- Support the implementation of violence prevention initiatives.
- Encourage programs that provide support, education and activities for youth.
- Support legislation that restricts access to guns by children and adolescents.

For professionals:

- Support and implement crisis interventions and conflict resolution programs within the schools.

For Child Fatality Review Panels:

- Ensure that support for victims and survivors of youth violence is available.
- Support proactive approaches to crime control, especially those programs that include efforts to confiscate illegally carried firearms.

Resources and Links:

National Center for Injury Prevention and Control . . . . .www.cdc.gov/ncipc
Best Practices of Youth Violence Prevention:
A Sourcebook for Community Action. . . . . www.cdc.gov/ncipc/dvp/bestpractices.htm
Harborview Injury Prevention and Research Center . . . . http://depts.washington.edu/hiprc
US Department of Justice
Office of Juvenile Justice and Delinquency Prevention. . . . . www.ojjdp.ncjrs.org
The National Youth Violence Prevention Resource Center . . . . www.safeyouth.org
Missouri Juvenile Justice Association . . . . www.mjja.org
2005 Youth Risk Behavior Survey . . . . .www.cdc.gov/yrbss

SUICIDES

"Suicide is not chosen; it happens when pain exceeds resources for coping with pain."

Suicide was the manner of death of 21 Missouri children in 2005.

Representative Cases:

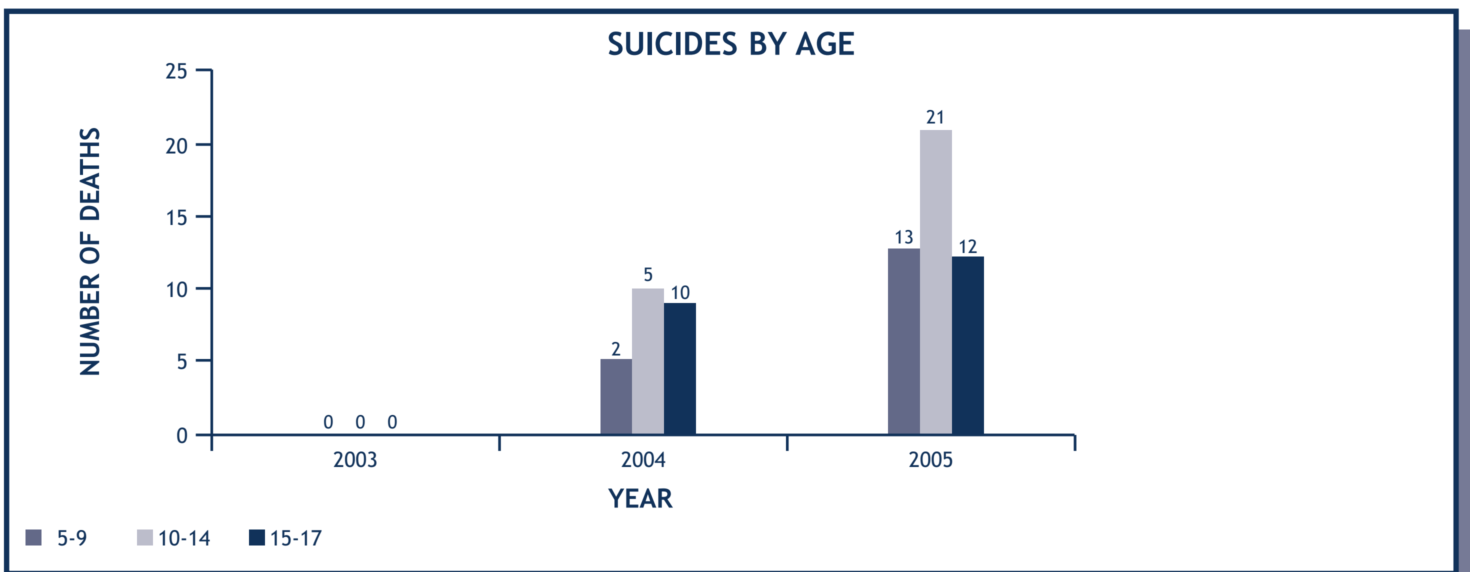
- **Parents and professionals are responsible for children must be educated to recognize and respond to risk factors for suicide.**

  A 13-year-old male had argued with his father earlier in the day and talked of killing himself. Later in the day, he was in the house alone, while his father and brother went outside. He used his father's pistol to shoot himself in the head.

  A 12-year-old girl had been depressed and talking of wanting to die for several days, after learning of the impending death of a family member. A counselor had talked her out of it and attempted to get her into a hospital, but there were no beds. She found a handgun in the home and shot herself.

  A 14-year-old had been confined to a juvenile facility for criminal actions. He was observed to be upset, crying and banging his head on the walls, wanting out. Staff was checking on him every 15 minutes and found him hanging in his room.

In Missouri and the United States, suicide is the third leading cause of injury-related deaths for young people following unintentional injuries and homicides. The suicide rate among young teens and young adults increased by more than 300% in the last three decades and rates continue to remain high. In Missouri in 2005, **21** children died of self-inflicted injury; **12** were age 15-17; the remaining **9** were children age 10-14.

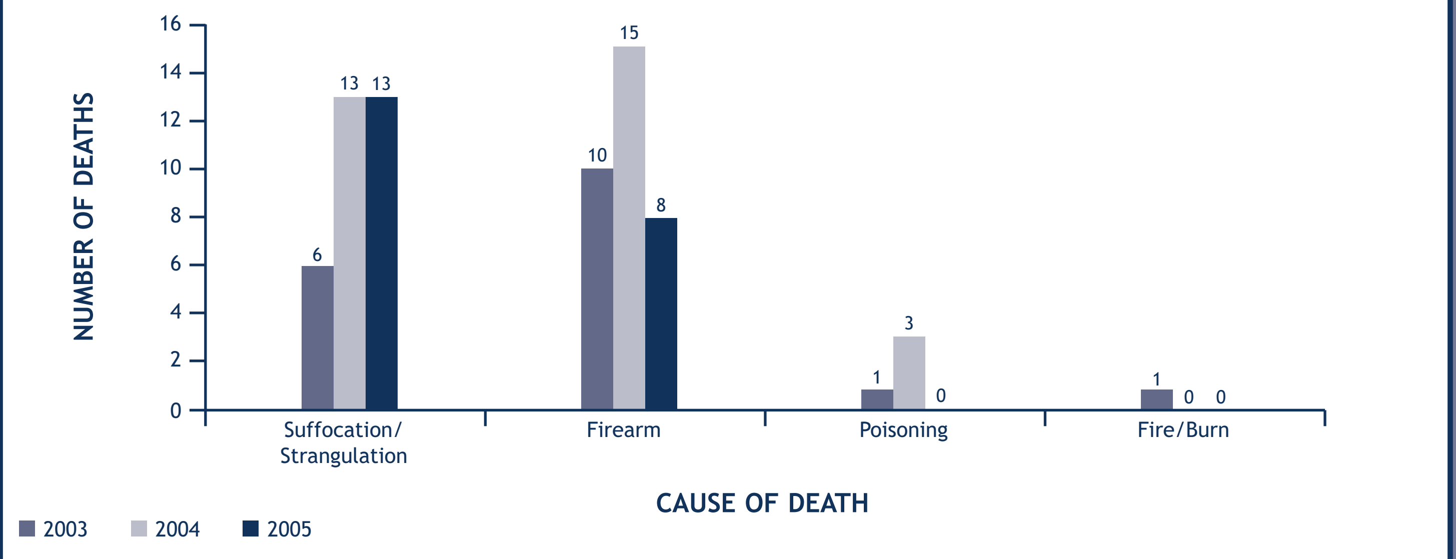


White males comprise the majority of adolescent suicide victims in Missouri. Although more females attempt suicide than males, males are approximately three times more likely to die from suicide.

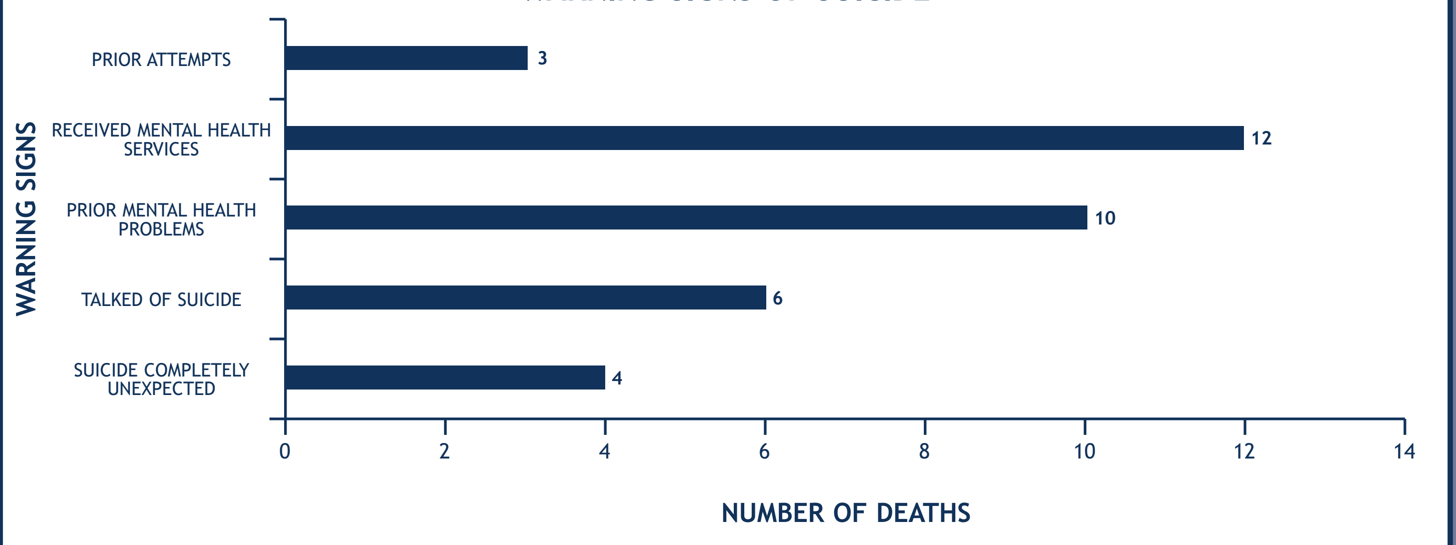
SUICIDES BY SEX AND RACE

SEX	2003	2004	2005	RACE	2003	2004	2005
FEMALE	4	9	6	WHITE	15	28	13
MALE	14	22	15	BLACK	3	1	7
				OTHER		2	1
	18	31	21		18	31	21

Suffocation/strangulation and firearms are the most common mechanism of suicide among Missouri children.



Of the **21** suicide victims age 17 and under in 2005, **16** (76%) had displayed one or more warning signs.



"The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion of devastation that is, for the most part, beyond description."

-Kay Redfield Jamison

Risk and Protective Factors For Youth Suicide:

Suicide is a reaction to intense feelings of loneliness, worthlessness, hopelessness, or depression. Suicidal behaviors in young people are usually the result of a process that involves multiple, social, economic, familial, and individual risk factors, with mental health problems playing an important part in its development. Risk factors compiled from the National Strategy for Suicide Prevention fall into three general categories:

Biopsychosocial:
- Mental health disorders, particularly depression, anxiety and related mood disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illness
- Previous suicide attempt
- Family history of suicide

Environmental:
- Academic, job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Sociocultural
- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)

Protective factors reduce the likelihood of suicide; they enhance resilience and may serve to counterbalance risk factors. Both parent-family connectedness and perceived school connectedness have been shown to be protective against suicidal behavior.

Key protective factors for suicide include:
- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support of help-seeking
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Only a few studies have examined protective factors among youth for suicidal behavior.

The Missouri Suicide Prevention Plan:

In 1999, the U.S. Surgeon General, Dr. David Satcher, issued a "Call to Action to Prevent Suicide," introducing an initial blueprint for reducing suicide in the United States, summarized as "AIM," awareness, intervention and methodology. In response to the national recognition of suicide as a worldwide public health problem, collaborative planning efforts began in Missouri that resulted in the passage of legislation in 2003, that mandates the development of a statewide suicide prevention plan.

The "Missouri Suicide Prevention Plan, 2005-2010" includes research, data, specific strategies for reducing suicide and suicidal behaviors, and links to suicide prevention resources. The state plan is available online at the Missouri Department of Mental Health website: www.dmh.mo.gov/cps/issues/suicide.htm. The writers point out that suicide is a huge and complex problem and Missouri's communities are too diverse in their members and needs for a single intervention to be adequate. Thus, a diverse array of interventions will be required to meet the particular local needs of the many unique communities in Missouri. Collaboration is essential if recommendations are to be effective. Communities should use the plan as a guide to develop and implement their own local plan.

Prevention Recommendations:

For parents:

- Seek early treatment for children with behavioral problems, possible mental disorders (particularly depression and impulse-control disorders) and substance abuse problems.
- Limit young people's access to lethal means of suicide, particularly firearms.

For community leaders and policy makers:

- Encourage health insurance plans to cover mental health and substance abuse on the level physical illnesses are covered.
- Support and implement school and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse and aggressive behaviors.
- Enact and enforce laws and policies that limit young people's access to firearms and encourages responsible firearm ownership.

For professionals:

- Children who have attempted suicide or displayed other warning signs should receive aggressive treatment attention.

For Child Fatality Review Panels:

- Support or facilitate evidence-based suicide prevention programs in your community.

- In reviewing a possible suicide, consider carefully the warning signs and history of the victim. Consider, also, points of early intervention that can be enhanced in your community to prevent other suicides and suicidal behaviors.

Resources and Links:

Missouri Department of Mental Health, Division of
Comprehensive Psychiatric Services . . . . www.dmh.mo.gov/cps/issues/suicide.htm
The Missouri Suicide Prevention Plan, mental health resources, suicide prevention resources, data, fact sheets, support groups and organizations and other links

KUTO (Kids Under Twenty-One) . . . . www.kuto.org
Offers a youth crisis Helpline, staffed entirely by trained youth volunteers.
1-888-644-5886

Missouri Department of Elementary and
Secondary Education . . . . http://dese.mo.gov/divcareered/guide_crisis_counseling.htm
Offers suicide prevention training to school personnel.

National Youth Violence Prevention Resource Center. . . www.safeyouth.org/scripts/topics/suicide.asp

Yellow Ribbon Suicide Prevention Program . . . . www.yellowribbon.org

National Center for Injury Prevention and Control . . . . .www.cdc.gov/ncipc

Youth Suicide Prevention Programs: A Resource Guide . . www.cdc.gov/ncipc/pub-res/youthsui.htm

Suicide Prevention Resource Center. . . . . www.sprc.org

Suicide Prevention Advocacy Network . . . . .www.span.org

American Association of Suicidology . . . . .www.suicidology.org

National Suicide Prevention Lifeline: 1-800-SUICIDE (784-2433)

Missouri Department of Mental Health,
Access Crisis Intervention (ACI) Hotlines . . . . www.dmh.mo.gov/cps/ACImap.htm

Life Crisis Services (St. Louis area): 314-647-HELP (4357)

Mid-Missouri Crisis Line: 1-888-761-HELP (4357)

"Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives."
-National Strategy for Suicide Prevention

The Practical Application of Child Death Review: Prevention of Child Fatalities

The death of a child is a sentinel event that captures the attention of the public and creates a sense of urgency that deserves a well-planned and coordinated prevention response. Generally, successful prevention initiatives are realistic in scope and approach, clear and simple in their message, and based on evidence that they work!

Local and regional teams are remarkably dedicated and enthusiastic in initiating timely prevention activities that serve to raise awareness, educate parents and caretakers, influence public policy and involve the community in prevention initiatives. In Missouri, local CDR team members organized a coalition focused on child fatality prevention after two residential fires killed three children in less than a month. The coalition collaborated with two area fire departments to canvass the neighborhoods where the deaths occurred, installed smoke detectors and batteries where they were needed and raised public awareness through the media. A decade later, the Annual Neighborhood Fire Prevention Awareness Day continues in multiple locations throughout the region.

At the state and national level, the sum of collected data is used to identify trends and patterns that require systemic solutions. Researchers in St. Louis utilized Missouri CDR data to gain new insights into sudden, unexpected infant deaths and concluded that certain unsafe sleep arrangements occurred in the large majority of cases of sudden infant deaths diagnosed as SIDS, unintentional suffocation and cause undetermined. Research had demonstrated what CDR team members had suspected: Infant deaths caused by unsafe sleep conditions were preventable. In Missouri, Iowa, Wisconsin, Minnesota and other states, safe sleep campaigns, developed and implemented by a variety of public and private entities, include parent education and provide a safe crib to families in need. The Consumer Product Safety Commission and the American Academy of Pediatrics revised their safe sleep recommendations to reflect this new information.

Basic principles

It is widely accepted among professionals in the field of injury prevention that the public health tools and methods used effectively against infectious and other diseases and occupational hazards, can also be applied to injury prevention. As a result, attention is given to the environment and to products used by the public, as well as individual behavior. An epidemiologic approach to child fatalities and near-fatalities offers tools that can effectively organize prevention interventions and draws on expertise in surveillance, data analysis, research, public education and intervention. There are four steps that are interrelated:

- ***An ongoing surveillance of child fatalities provides comparable data, documentation and monitoring over time. (What's the problem?)*** Current efforts to create a standardized case report tool and data system on the national level are keys to improving and protecting the lives of all children and adolescents. Even a small subset of uniform data would give us the opportunity to identify valuable national trends and patterns. The National Maternal Child Health Center for Child Death Review provides technical assistance and training, support resources and tools to states with the goal of expanding reviews to all preventable deaths, and using the information from CDR to improve and protect the lives of children.

- ***Risk factor research identifies or confirm what is known about risk and protective factors that may have relevance for public policies and prevention programs. (What's the cause?)*** In Western New York, a hospital-based program was developed to educate all new parents about the dangers of shaking an infant. This initiative has effectively reduced the incidence of Shaken Baby Syndrome in that region every year since it was implemented. This program has been replicated throughout the country and proven equally successful. Several states have passed legislation requiring this program in all hospitals. Other states have included SBS education as part of the licensing process for child care providers. In this way, prevention of Shaken Baby Syndrome is being integrated in state and community systems that provide services and support to children and families.

- ***Identification of evidence-based strategies that have proven effective or have high potential to be effective. (What works?)*** Assessing effectiveness of a prevention strategy as it is implemented is difficult, because of limited resources and limited reliability of existing assessment tools. However, resources are available to assist in evaluating various strategies during the early stages of planning. The benefits in terms of funding and long-term cost are obvious. The safe sleep and SBS initiative described above were based on research. University-based research groups, such as Harborview Injury Prevention and Research Center and the Childhood Injury Research Group at the University of Missouri provide evaluations of various injury prevention strategies. National organizations and governmental agencies, such as the National Safe Kids campaign and the National Center for Injury Prevention at CDC and the American Academy of Pediatrics provide research and prevention information.

- ***Implementation of strategies where they currently do not exist. (How do you do it?)*** Outcomes for prevention initiatives are generally functions of structure and duration. Short-term, emergency and educational programs are effective in the short-term; unfortunately, such programs are usually based on the effort and enthusiasm of a few individuals and a limited funding source. Prevention initiatives that are integrated into community and state systems are sustainable and effective in the long term. Examples include state laws that require proper restraint for child passengers in motor vehicles and helmets for children riding bicycles. In many areas, schools include safety education for children and health care providers, who are in a unique position to assist in the prevention of child maltreatment, actively promote health and safety for children. Many state and local entities responsible for licensing child care providers are mandating education on safe sleep for infants and toddlers and prevention of child abuse, including Shaken Baby Syndrome, as part of their curricula.

Resources:

American Academy of Pediatrics . . . . www.aap.org

Children's Safety Network . . . . http://research.marshfieldclinic.org

Consumer Product Safety Commission . . . . www.cpsc.gov

Harborview Injury Prevention and Research Center . . . . http://depts.washington.edu/hiprc

Missouri Child Fatality Review Program . . . . .http://dss.missouri.gov/stat/mcfrp.htm

Missouri Child Death Pathologists' Network . . . . http://dss.missouri.gov/stat/cpn/htm

Missouri Children's Trust Fund www.ctf4kids.org
Missouri Prevention. . . . . .www.missouriprevention.org
National Center for Injury Prevention and Control . . . . .www.cdc.gov/ncipc
National Center on Shaken Baby Syndrome . . . . www.dontshake.com
National MCH Center for Child Death Review . . . . www.childdeathreview.org
National Safe Kids Campaign . . . . www.safekids.org

Prevention Findings: The Final Report

"Injury is a problem that can be diminished considerably if adequate attention and support are directed to it. Exciting opportunities to understand and prevent injuries and to reduce their effects are at hand. The alternative is the continued loss of health and life to predictable, preventable and modifiable injuries."
-Dr. William Foege, Former Director of the Centers for Disease Control and Prevention

The difference between a fatal and nonfatal event is often only a few feet, a few inches, or a few seconds. In the past, most people believed that serious and fatal injuries were random or unavoidable events, or simply the result of individual carelessness. Fortunately, the science of injury prevention has moved away for this fatalistic approach to one that focuses on the environment and products used by the public, as well as individual behavior. As a result, unintentional injury-related death rates among children in the United States have declined dramatically over the last two decades. Injuries are now widely recognized as understandable, predictable and preventable.

A *preventable child death* is defined as one in which awareness or education by an individual or the community may have changed the circumstances that lead to the death. Prior to August 2000, CFRP panels were asked to report their conclusions and prevention responses for each death reviewed on the Data Form 2. Legislation passed in 2000, now requires that the panel complete a Final Report, summarizing their findings in terms of circumstances, prevention messages, and community-based prevention initiatives.

The death of a child is a sentinel event that captures the attention of the community, creates a sense of urgency and a window of opportunity to respond to the questions, "What can we do?" County-based prevention activities serve to raise awareness, educate parents and caretakers, influence public policy and involve the community in prevention initiatives that protect and improve the lives of children. In 2005, CFRP panels throughout our state reported their findings and prevention responses utilizing the Final Report. The initiatives highlighted below demonstrate how a few volunteer professionals have been able to measurably reduce or eliminate threats to the lives and well being of countless Missouri children.

Legislation, Law or Ordinance:

An eleven-year-old girl committed suicide by means of a self-inflicted gunshot wound. She had a history of depression and behavior disorders. Her father had attempted to find her mental health placement but, due to budget cuts, there were no beds available in the area. The panel suggested that this case be used to lobby legislature to restore the funding for mental health facilities.

An infant died at the age of seven days, as a result of complications of prematurity and the effects of drug exposure. Both the baby and his mother tested positive for methamphetamine and marijuana. The panel recommended that legislation be enacted that would make it a crime for a mother to knowingly take drugs or other substances that would cause harm to her unborn child.

Community Safe Project:

While riding on an ATV with her sibling, a 17-year-old girl was thrown from the vehicle after losing control. She died after striking her head on a utility pole; she was not wearing a helmet. The panel held a community-wide safety day regarding helmet safety on both ATV's and bicycles.

A sixteen-year-old girl was accidentally shot by a peer, who was experimenting with a loaded gun. The panel suggested that gun safety should be promoted throughout the community. They recommended that the focus be on correct storage of firearms in the home and hunter safety.

Public Forums:

A sixteen-year-old boy drowned while swimming in a lake with his friends. The boys had been swimming outside the posted safety boundaries. The panel worked with the local Health Department and Water Patrol to organize a town meeting regarding water safety.

A six-year-old girl with an extensive medical history died after her bowel became obstructed. She had missed several doctor appointments and was severely malnourished at the time of her death. The child was allegedly home-schooled and not been seen on a regular basis, by anyone other than family. The panel recommended that the parents be held accountable. They also initiated a public meeting to raise awareness of the residents' responsibility to observe neighborhood children and report child abuse and neglect.

Educational Activities in Schools:

A one-month-old boy died after being beaten by his teenage father. He had multiple old and new injuries. The panel thought it would be appropriate to have the school provide life skills and parenting classes to teens who are or are going to be parents. They initiated a child abuse prevention presentation at the local high school, which featured the Shaken Baby Syndrome (SBS) video and educational materials available from the Missouri Children's Trust Fund.

A six-month-old boy was violently shaken by his father and later died of his injuries. The family lived in a Hispanic community and spoke little English. The local CFRP panel discussed ways to reach the growing Hispanic population in the community regarding Shaken Baby Syndrome and the other child abuse issues. The panel is working with Parents as Teachers to encourage them to include child abuse prevention in their curriculum.

Educational Activities in the Media:

A three-year-old boy was left alone to play in his room for over an hour. At some point, he wandered out of his house unobserved and onto a busy highway approximately 800 feet away from his home. He was struck by a car and died of his injuries. Both parents indicated that they were unaware that the child had left his room, each apparently believing the other one was checking on him. The panel drafted a media release to remind parents that small children need constant supervision.

A two-year-old boy wandered away from adults at a family picnic. He was missing for approximately ten minutes, while the family frantically searched the area for him. He was discovered in a pond, where he had drowned. The panel took out a water safety ad in the local paper to remind residents that young children need to be well supervised by a designated adult, especially outdoors near pools, lakes and ponds.

Consumer Product Safety:

A seven-month-old infant was placed in a baby swing for nap. While unattended, the child slid down in the swing and suffocated, when the chest strap became wrapped around her neck. The panel saw this as an opportunity to remind parents never to leave infants unattended and to always make sure that the child is secured in a baby swing or any other device, using straps and other restraints appropriately.

News Services:

A sixteen-year-old male had his driver's license less than six months, when he lost control of his vehicle, while speeding around a sharp corner. He was not wearing a seat belt. He died of multiple head and chest injuries. The local CFRP panel ran several articles in the local paper, stressing the importance of seatbelts. They also worked with the local radio stations to run ads regarding safe driving for teens.

A five-month-old male died as a result of injuries inflicted by his mother's paramour. Upon autopsy, it was revealed that there were many old injuries that had never been diagnosed. During the review of his death, the CFRP panel learned that the infant's mother had been known to leave him in the care of her boyfriend while she worked, despite the fact that he had objected and demonstrated frustration with the baby's crying. The panel released a public service announcement and several newspaper articles focusing on the importance of making appropriate childcare arrangements.

Changes in Agency Practice:

A Missouri teen died from a drug overdose. During the review, the CFRP panel learned that the victim had apparently purchased the prescription medication from a friend, who had stolen it from an elderly relative. The panel discussed this death at length and decided that it

"Alone we can do so little, together we can do so much." -Helen Keller

should be a practice of law enforcement and coroners to confiscate all prescription medication of hospice or elderly patients at the time of their death, so their prescription medication does not end up on the streets.

Other Programs/Activities:

A fourteen-year-old female was hit by a van after running out into oncoming traffic. During the review, the CFRP panel learned that there had been an ongoing problem at the scene of the incident with teens "playing chicken" with oncoming cars at night. The local panel suggested that the Missouri Department of Transportation erect a barrier at this location to restrict pedestrian access to the highway.

A nine-year-old boy was electrocuted while climibing a tree at a friend's house. The CFRP panel contacted the local electric cooperative and made arrangements for educational programs to be presented in the elementary schools regarding electrical safety.

STAT reviews every request for assistance as a training opportunity.

Go to the people
Work with them
Learn from them
Respect them
Start with what they know
Build with what they have

And when the work is done
The task is accomplished
The people will say,
"we have done this ourselves"
-Lao Tsu, China 700 BC