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.

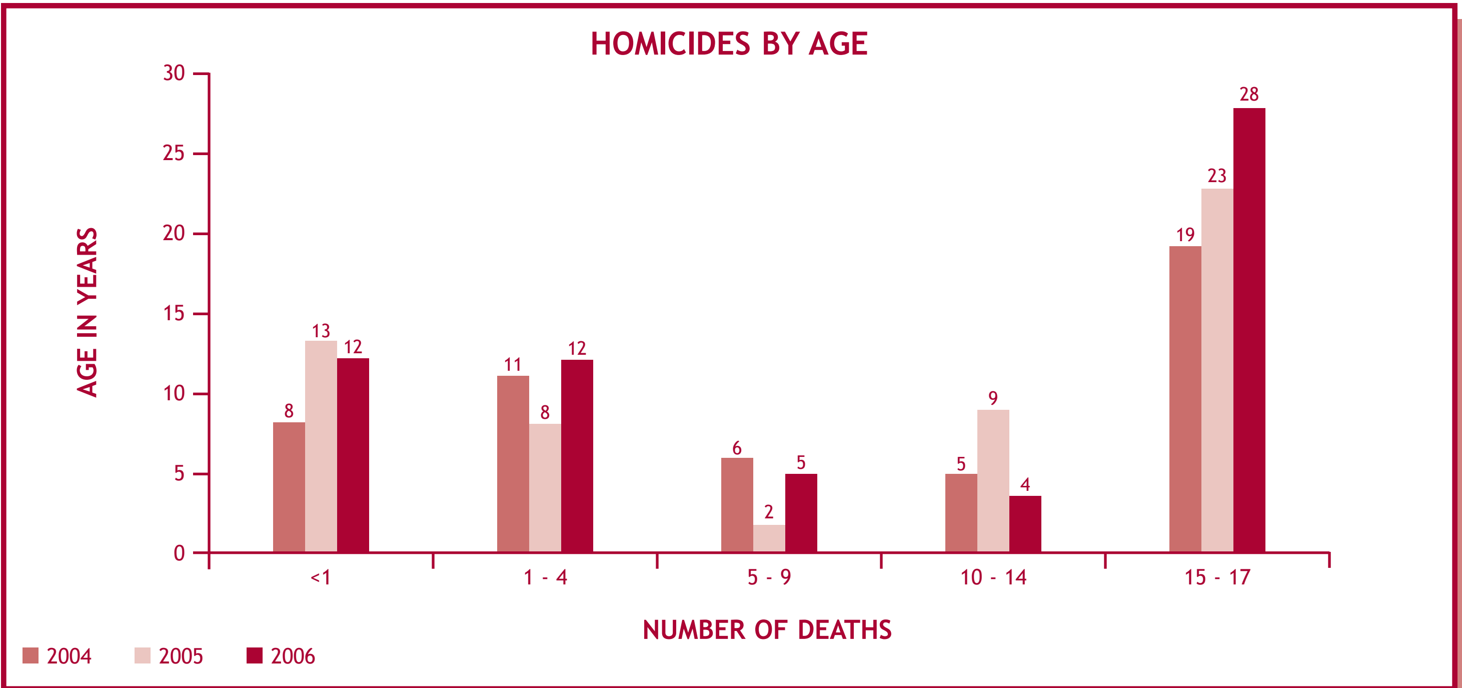
Homicides

In 2006, homicide was listed as the death certificate manner of death for 61 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 2006, a total of **79** Missouri children were identified by CFRP panels, as victims of Fatal Child Abuse and/or Neglect; of those, **27** were reported by death certificate as Homicide.

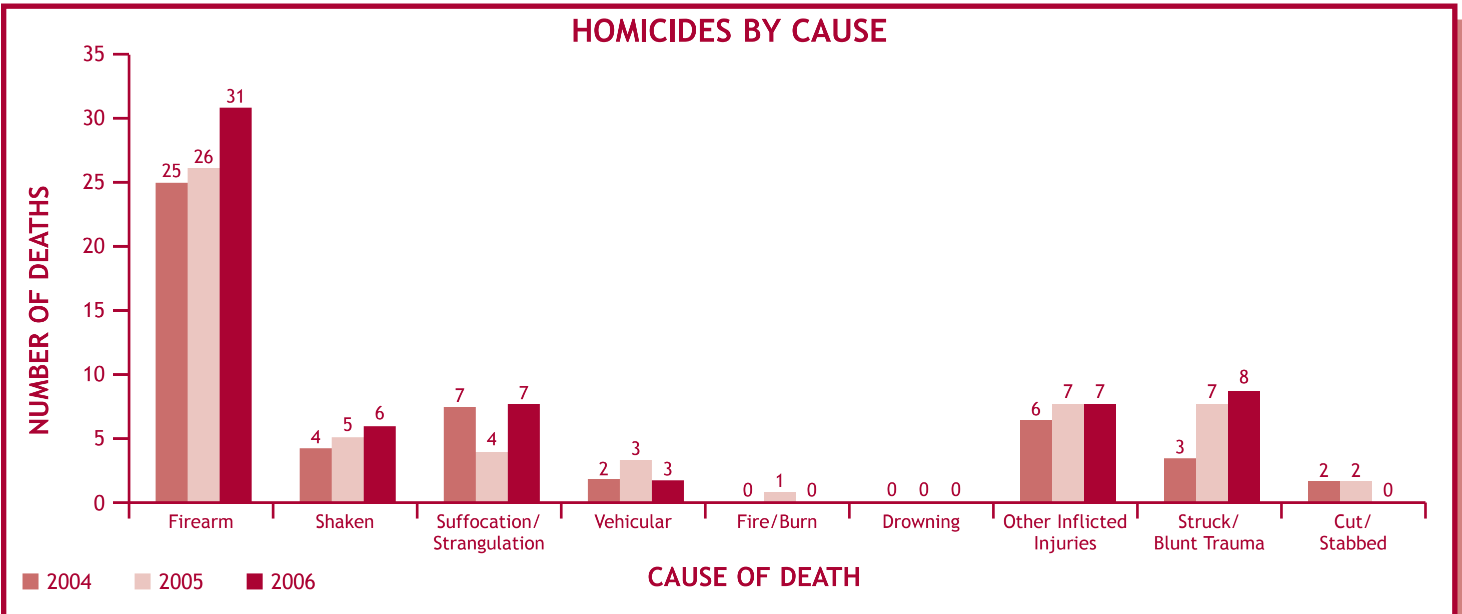
2. **Death of a child in which the perpetrator was not in charge of the child.** This most often includes youth homicides, such as gang-related or drug-related shootings and child abductions that culminate in murder. There were **29** such fatalities among Missouri children in 2006. Of those, CFRP panels identified **five** 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 2006, there was **one** such death of this type among Missouri children.



HOMICIDES BY SEX AND RACE

SEX	2004	2005	2006	RACE	2004	2005	2006
FEMALE	19	17	16	WHITE	20	29	18
MALE	30	38	45	BLACK	29	26	43
	49	55	61		49	55	61



"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 2006, 79 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.**

  The mother of a 10-month-old infant was drinking heavily and smoking marijuana when she became involved in a heated argument with the baby's father. She consumed even more alcohol and took the baby to sleep with her in a full-size bed, along with two other children. The baby was found unresponsive the next morning.

  A seven-month-old was left in the care of his mother's boyfriend, who reported that the infant fell off the bed and stopped breathing. The baby died at the hospital from injuries of Shaken Baby Syndrome. The boyfriend had a history of abuse of other children.

  A woman and her boyfriend brought her unresponsive three-year-old daughter to the hospital emergency room, claiming that she had fallen in the bathtub earlier that evening. The child had numerous bruises all over her body; she died of massive brain injuries.

  A woman was driving while intoxicated with two children in the car. Both children were unrestrained. When she lost control of the vehicle, it overturned several times. The three-year-old child was ejected on to the roadway and died of massive head and chest injuries. The mother had a history of driving while intoxicated.

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

  A one-year-old was left in the care of her mother's boyfriend, while she accompanied a friend to court. When she returned the child was unresponsive. The boyfriend eventually confessed to shaking and hitting the child, because she wouldn't stop crying.

  A two-year-old boy was struck in the head by his mother, until he stopped breathing. Initially, she and the father told police he had fallen down the stairs. The father was arrested for possession of a controlled substance.

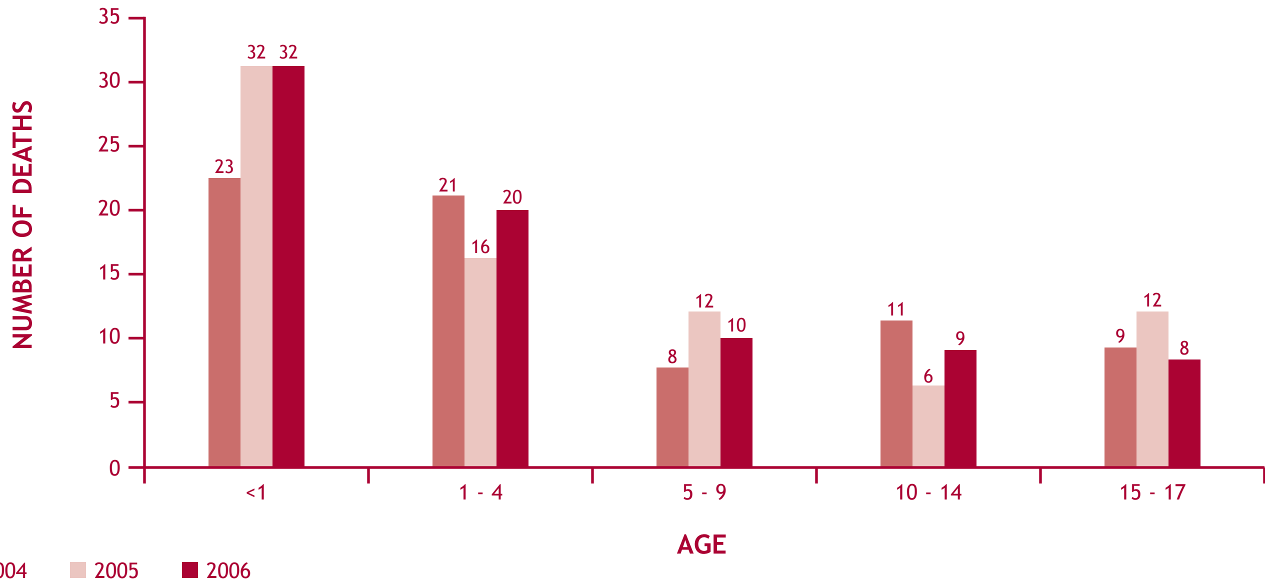
- **Multidisciplinary teams should be developed, supported and trained on the local level to investigate serious offenses against children.**

  The father of an eight-month-old infant allegedly found him in his crib not breathing. The baby was found to have unusual injuries to the head and face. The father later admitted that he had argued with the baby's mother and, after she left, he held the baby's face forcefully against his chest until the baby stopped breathing.

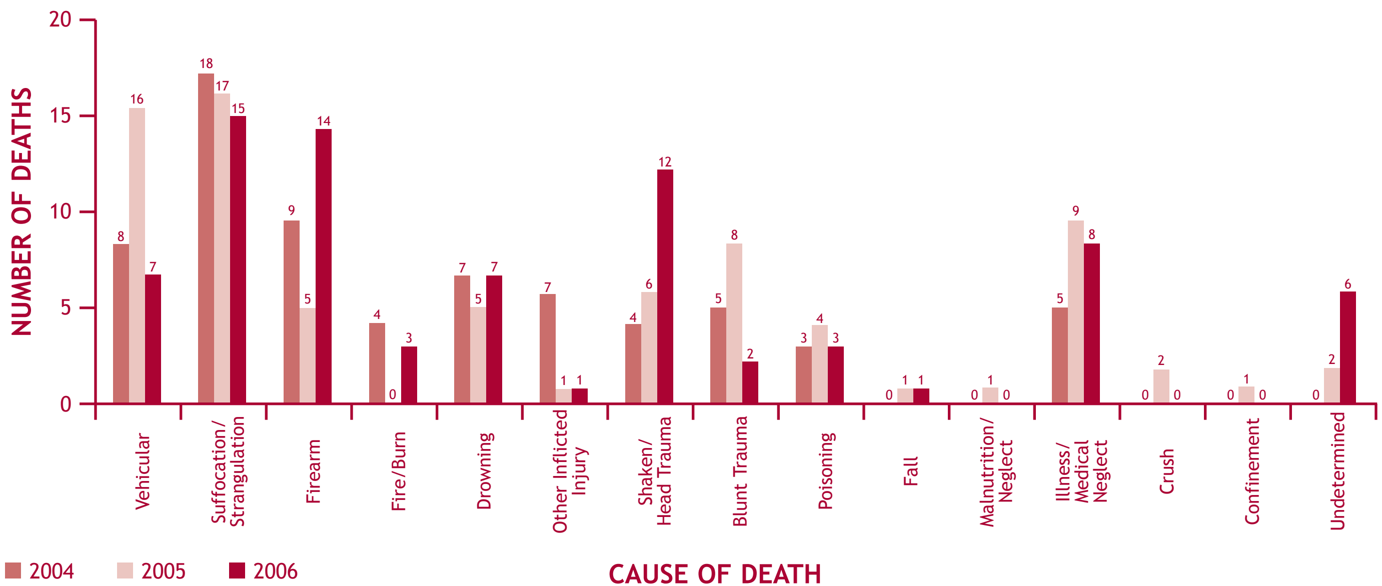
CHILD ABUSE AND NEGLECT FATALITIES BY SEX AND RACE

SEX	2004	2005	2006	RACE	2004	2005	2006
FEMALE	32	35	27	WHITE	48	63	37
MALE	38	43	52	BLACK	22	15	40
UNKNOWN	0	0	0	OTHER	0	0	2
	70	78	79		70	78	79

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 reporting child abuse and neglect fatalities. 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 *preponderance of evidence 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 *preponderance of evidence child abuse and neglect fatality.* Thus, reports classified by the division as *preponderance of evidence 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 *a preponderance of evidence* to believe that this child was a victim of *neglect*, specifically, lack of supervision.

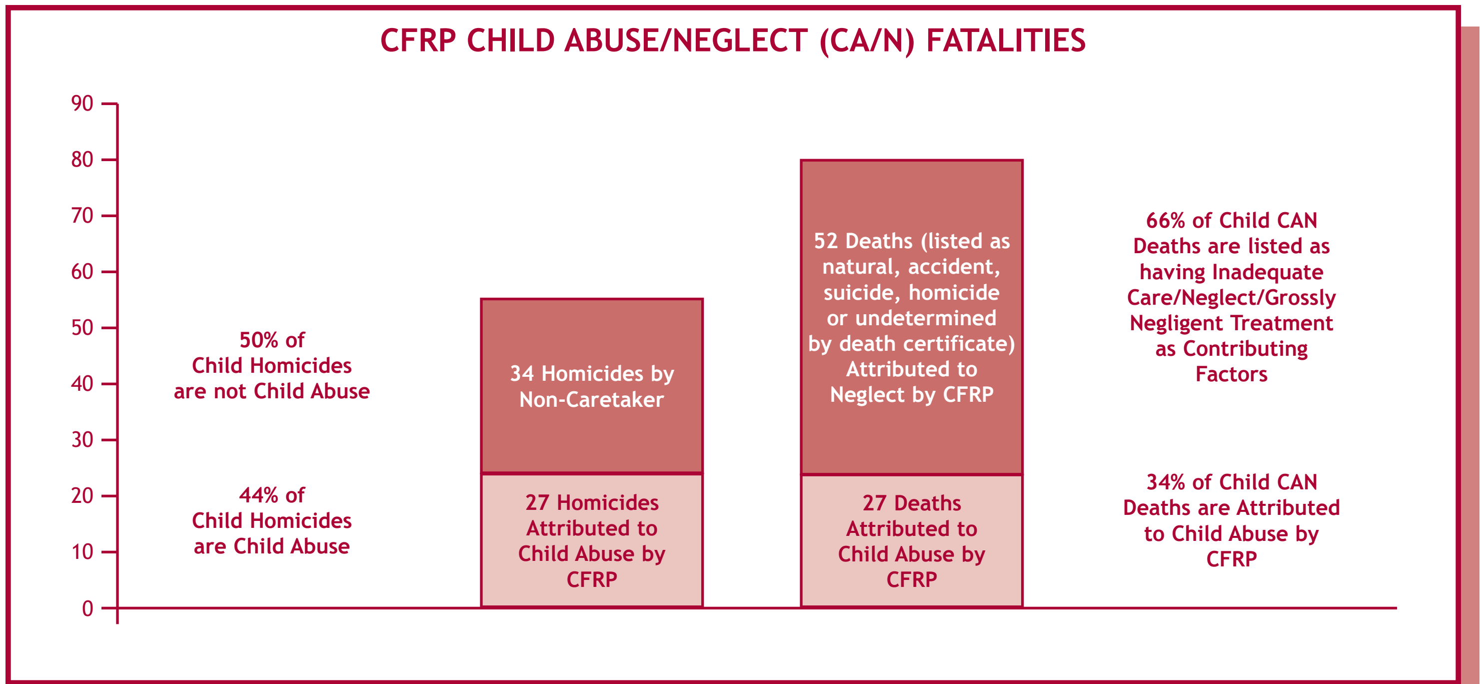
The Missouri Child Fatality Review Program: Fatal Child Abuse and Neglect

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 2006, 27 Missouri children died from inflicted injury at the hands of a parent or caretaker.

Fatal child abuse may involve repeated abuse over a period of time, as in battered child syndrome, or it may involve a single, impulsive incident, such as drowning, suffocation or shaking a baby. Infants and young children under the age of four years are at greatest risk of severe injury and death due to physical abuse. These children are the most vulnerable for many reason, including their dependency, small size and inability to defend themselves. In 2006, **19** of the **27** (70%) Missouri children who died from inflicted injuries at the hands of a parent or caretaker were four years of age or younger. Of those, **nine** (47%), were infants under the age of one year.

In 2006, **two** 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 2006, **12** 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 interfere with breathing. In 2006, **seven** 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	10
1-4 years	11
5-9 years	4
10-14 years	1
15-17 years	1

FATAL ABUSE INFLICTED INJURIES BY SEX	
Females	9
Males	18

FATAL ABUSE INFLICTED INJURIES BY RACE	
White	11
Black	16

FATAL ABUSE INFLICTED INJURIES BY CAUSE			
Shaken Baby Syndrome / Abusive Head Trauma	12	Other - Poisoning	1
Blunt Trauma	2	Firearm	5
Suffocation/Strangulation	7		

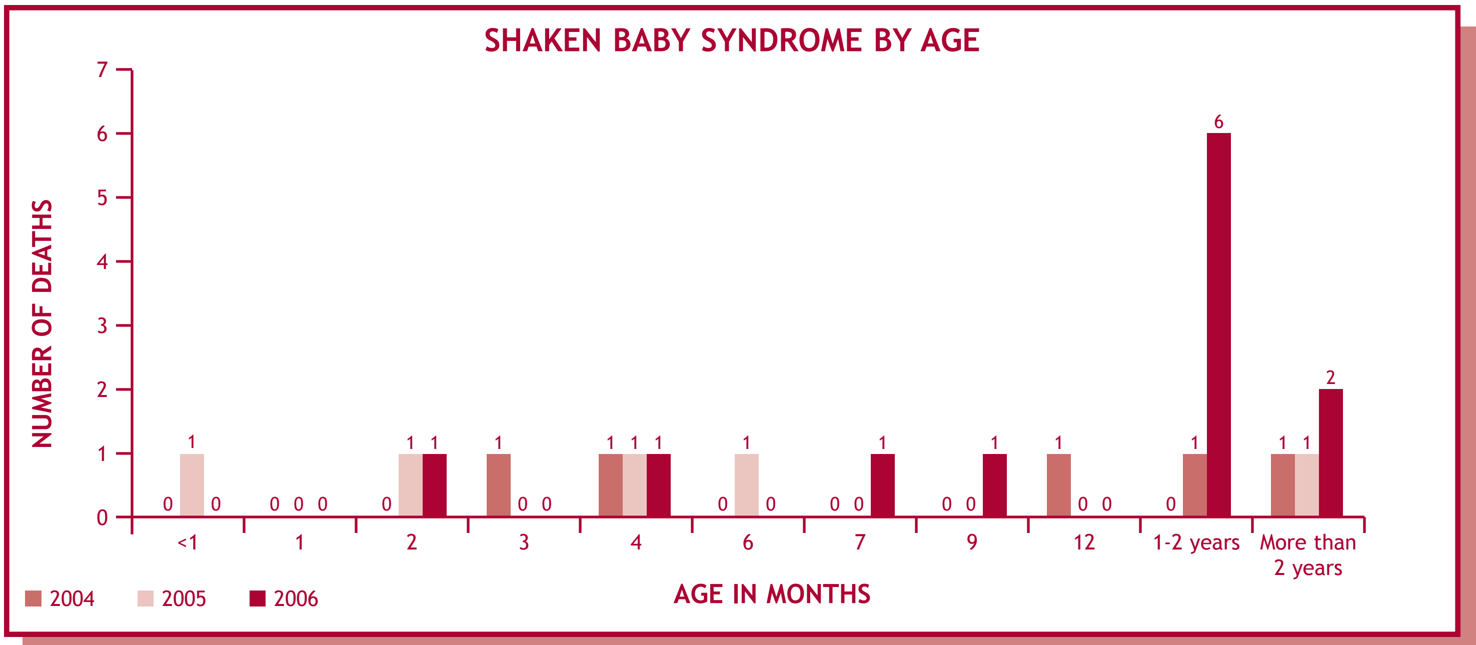
Shaken Baby Syndrome

Of the **27** Missouri children who died from inflicted injury at the hands of a parent or caretaker in 2006, **12** (44%) 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 secondary to trauma, lack of oxygen to the 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 four to six 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 FATALITIES BY SEX AND RACE

SEX	2004	2005	2006	RACE	2004	2005	2006
FEMALE	3	1	4	WHITE	2	5	6
MALE	1	5	8	BLACK	2	1	6
	4	6	12		4	6	12

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 **five** of the twelve SBS abuse fatalities among Missouri children in 2006; other triggering events included toilet training.

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 2006, perpetrators of SBS abuse fatalities in Missouri included **four** mother's boyfriends, **two** birth fathers, **two** birth mothers, **two** stepfathers, **one** stepmother and, in **one** case, both the birth mother and her boyfriend abused the infant.

"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 2006, CFRP panels found Grossly Negligent Treatment had contributed to the deaths of **52** Missouri children; of those **six** 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	
7	Illness/ Natural Cause	0	1	2	5	0	2	Four infants were born preterm and died as a result of drug use by their mothers. One child, diagnosed with leukemia, suffered from medical neglect and unsanitary living conditions.
7	Vehicular	1	0	0	2	6	4	Five young children died in separate crashes, because a parent was driving under the influence of drugs or alcohol. Two other young children were unrestrained, when the vehicle in which they were riding crashed.
14	Sudden, unexpected infant deaths: Suffocation/ Undetermined	2	1	0	1	0	11	Six infants died while bedsharing with adults, exposing them to soft bedding and the possibility of overlay by others in the bed. Eight other infants who died suddenly and unexpectedly were exposed to soft bedding and other unsafe sleep environments that were clearly hazardous; three of those were placed face down onto pillows and other soft bedding that caused them to suffocate.
2	Poisoning	0	0	0	1	0	2	A toddler died, when someone put a narcotic pain-killer in a bottled labeled for the child's prescription antihistamine.
9	Firearm	1	0	0	2	0	9	Two of the children who committed suicide were known to be suicidal; they each shot themselves with guns that were readily accessible in their homes. Another child was shot, when his father got into a heated argument with another man, who began firing into the car. Three children were shot by other children in the home, who were playing with guns left unsecured in the home.
7	Drowning	7	0	0	0	0	1	Seven of the 13 drownings were found to involve grossly negligent maltreatment. One child, who was left in the care of an adult with limited mental capacity, along with nine other children, drowned in a pond. Another toddler was locked in the bathroom by his father and drowned in the toilet.
3	Fire/Burn	1	0	0	1	0	1	One child died in a house fire that started when his father, who was intoxicated, dropped a cigarette onto a sofa. The child was trapped on the second floor.
3	Other	3	1	0	1	0	5	One child fell from a third-story window that was obviously in need of repair. Another toddler was mauled by a dog while his parents were napping.
Total = 52		15	3	2	13	6	35	

*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."
- Herbert Ward

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 Parental Stress 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

Centers for Disease Control and Prevention . . . . www.cdc.gov

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

The National Council of Juvenile & Family Court Judges . . . . www.ncjfcj.org
Publication: *Resource Guidelines: Improving Court Practice in Child Abuse & Neglect Cases*

Child Welfare Information Gateway . . . . www.childwelfare.gov
(Formerly the National Clearinghouse on Child Abuse and Neglect Information)

OTHER HOMICIDES

Of the 61 child homicides in Missouri in 2006, 34 involved perpetrators who were not in charge of the child; of those, 26 (77%) involved firearms.

Representative Cases:

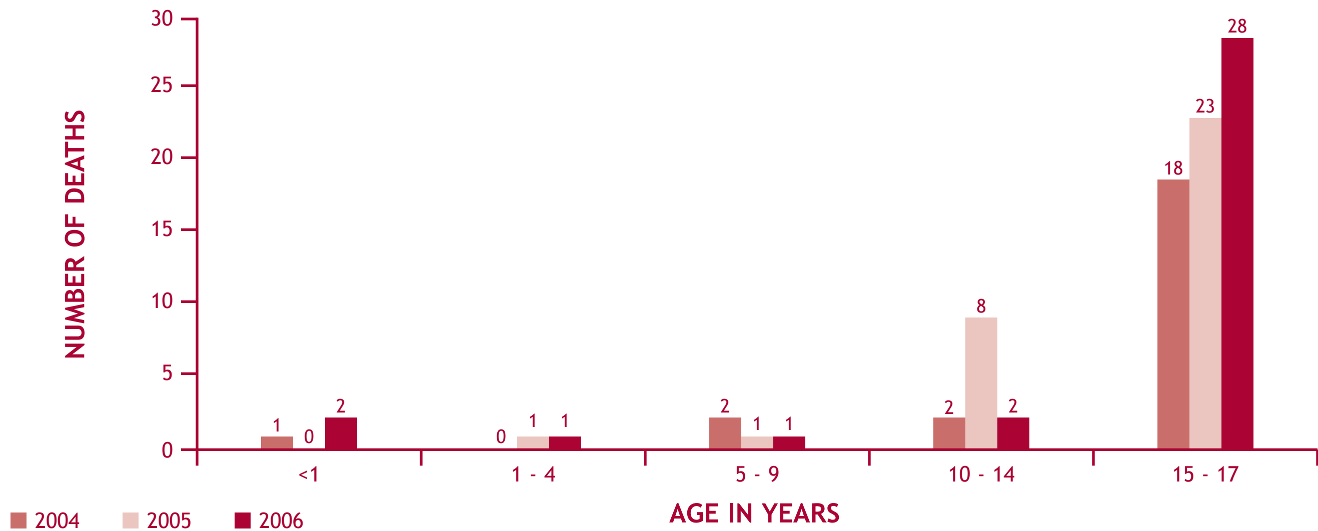
- **The increased availability of guns and drugs contributes to violence.**

  A 17-year-old male was stabbed by his younger brother during a fight in their home.

  A 17-year-old girl was stabbed by her boyfriend during an argument. Both tested positive for drugs.

  A 16-year-old was shot by a member of a rival gang, apparently in retaliation for a fight earlier in the day. The victim was positive for THC.

  A 17-year-old was walking down the street when a male exited a nearby vehicle, struck him in the head with a gun and shot him over an earlier dispute. The victim tested positive for THC.



OTHER HOMICIDE DEATHS BY SEX AND RACE

SEX	2004	2005	2006	RACE	2004	2005	2006
FEMALE	6	10	7	WHITE	7	12	7
MALE	17	23	27	BLACK	16	21	27
	23	33	34		23	33	34

In 2006, **34** Missouri children were murdered by non-caretakers. Of those, **14** 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 **34** Missouri children murdered by non-caretakers, **five** 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. This group of children includes a 17-year-old who was shot when he was caught in the crossfire between two rival gangs and a two-year-old was shot when the driver of a vehicle in which she was riding got into a fight with another adult, who started shooting into the vehicle.

Youth homicide:

The most common mechanism of juvenile homicide is firearms. **Twenty-six** Missouri children died of intentional firearm injuries in 2006. 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.

YOUTH HOMICIDES BY MECHANISM	
Firearm	12
Stabbing	2
OTHER HOMICIDES BY MECHANISM	
Firearm	14
Other Inflicted Injury (Stabbing)	3
Suffocation	1
Vehicular	2

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

SUICIDE

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

In 2006, 21 Missouri children committed suicide.

Representative Cases:

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

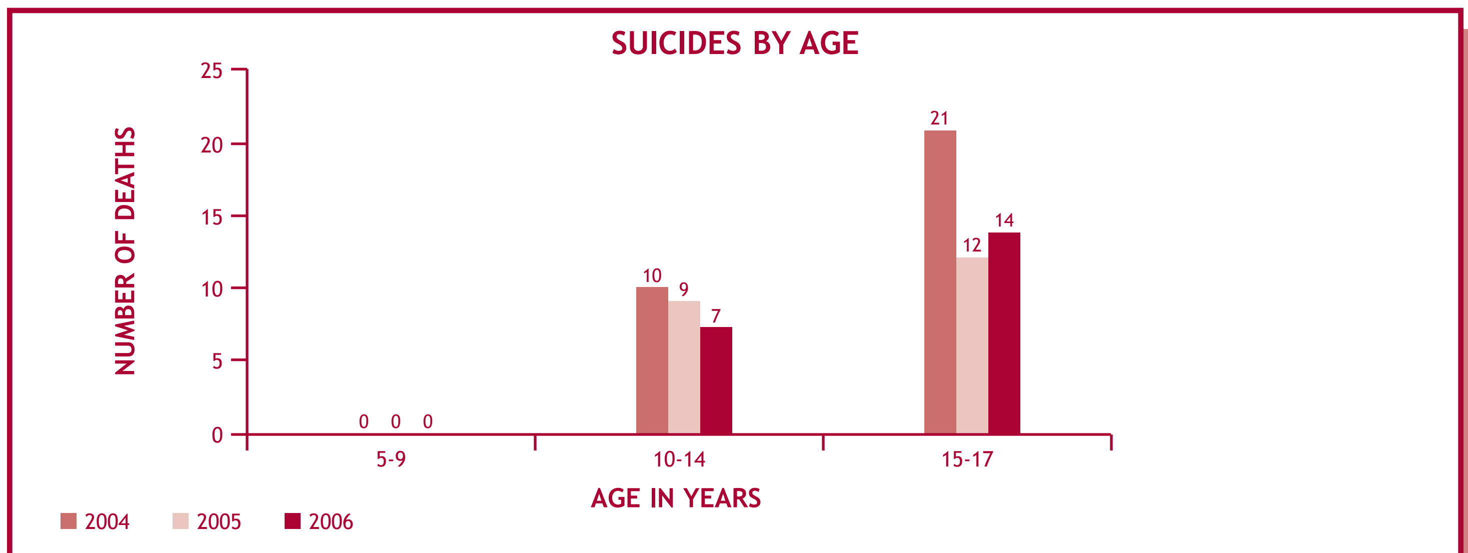
  A 15-year-old shot himself with a gun belonging to his father. The gun was kept in a lock box, but the teen found the key. Friends were aware that he had threatened suicide in the past, but the parents denied any knowledge that their son was having suicidal ideations.

  A 16-year-old had been kicked out of her mother's home, because of drug abuse and behavior problems. She was staying in the attic of a relative, where she was found dead from an apparently deliberate overdose.

  A 15-year-old hung himself in his closet. He had a history of drug abuse, including drug overdose, and depression.

  A 13-year-old hung himself in the basement of his home. He was depressed over poor grades and had been told he would have to repeat the seventh grade.

In Missouri and the United States, suicide is the third leading cause of injury-related deaths for young people following unintentional injuries and homicide. 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 2006, **21** children died of self-inflicted injury; **14** were age 15-17; the remaining **seven** were children ages 10-14.

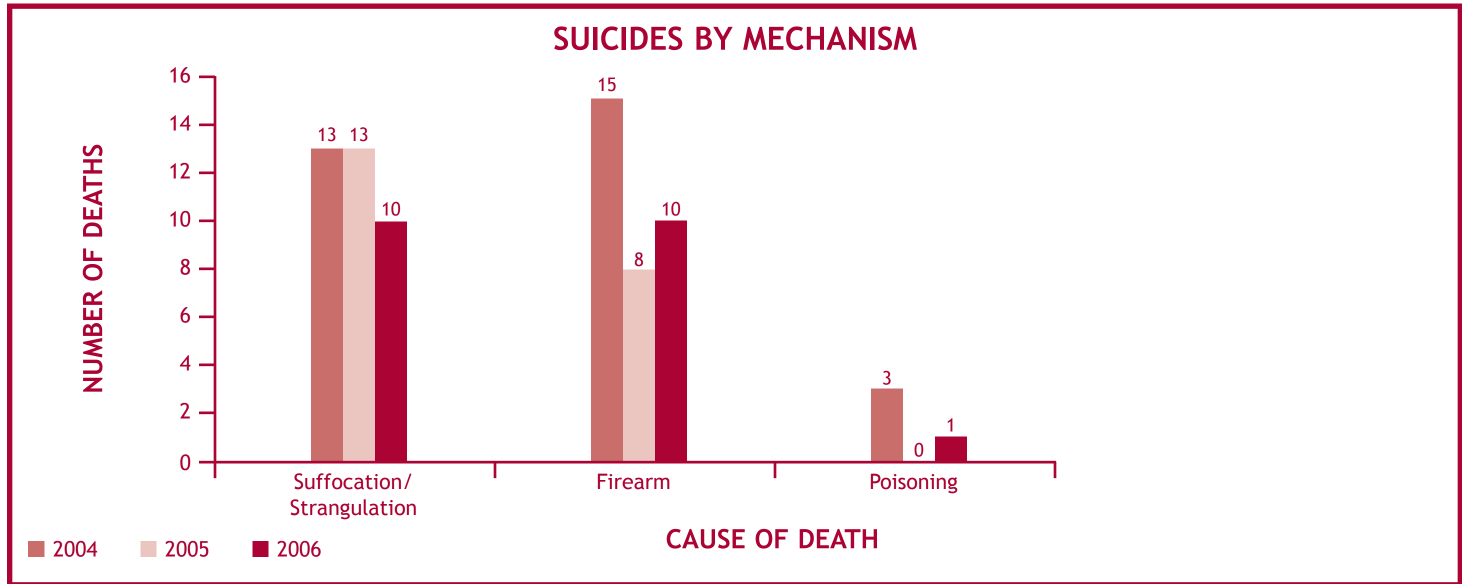


White males comprise the majority of adolescent suicide victims in Missouri. Although more females attempt suicide than males, males are approximately three times more likely to die from suicide.

SUICIDES BY SEX AND RACE

SEX	2004	2005	2006	RACE	2004	2005	2006
FEMALE	9	6	8	WHITE	28	13	19
MALE	22	15	13	BLACK	1	7	2
OTHER	0	0	0	OTHER	2	1	0
	31	21	21		31	21	21

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



Suicide is rarely a spontaneous decision and most people give warning signs that they are contemplating taking their own lives. Of the **21** Missouri children who committed suicide in 2006, **seven** (33%) 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://www.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.spanusa.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 . . . . www.childrenssafetynetwork.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 2006, 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:

A two-year-old child was left in the care of an individual providing daycare in her home. On the third day, the mother arrived to pick up the child and found her unconscious. The childcare provider claimed that she had fallen from a chair shortly before the mother had arrived. The child died at the hospital. The childcare provider later confessed to shaking the child and throwing her to the floor, because she wouldn't stop crying. The panel recommended that all childcare providers should

be required to attend training on prevention of Shaken Baby Syndrome and ways to cope with crying infants and toddlers.

A 12-year-old child was an unrestrained passenger in a vehicle being operated by an older sibling. As the vehicle crossed through an intersection, another vehicle ran the stop sign and struck the victim's vehicle. The 12-year-old was ejected and suffered massive head injuries. The panel recommended that children ages four through 15 should be included in the child restraint law, making restraint use in that age group subject to primary enforcement. They also recommended that the stop sign be replaced with a stoplight at this busy intersection.

Community Safe Project:

A private group took a large group of children and teens to a park near a river. After lunch, the older children went wading in the river, which was running deep with a very swift current. One of the children became caught in the undertow and slipped under the water. Four older children saw what was happening and jumped in to try to save him. All five children drowned. The panel recommended that the Water Patrol post signs along the river warning against swimming. They also met with local community leaders to discuss ways to educate groups about the importance of personal flotation devices whenever activities involve open water.

A 13-year-old was riding a skateboard along a busy road when he was struck by a car, knocking him off the road and into a ditch. He died of a massive head injury. He was not wearing a helmet or any other safety equipment. The panel worked with the local middle school to distribute safety information concerning skateboards and to hold a safety event to provide helmets and education. The panel also recommended that the parks department consider adding a skateboard facility so teens would have a safe place to ride.

Public Forums:

A 15-year-old died in a motor vehicle crash on a stretch of highway in a rural area known for its dangerous curves. This was the fourth death on that highway in three years. The panel initiated a public meeting to discuss the problem and made recommendations that the speed limit be reduced and that the highway department redesign that highway to make it safer.

Educational Activities in Schools:

A 16-year-old was killed when the car in which he was riding slid off the roadway and struck a boulder. The damage to the passenger compartment of the vehicle was minimal; however, the teen was ejected because he was not wearing a seatbelt. He was pronounced dead at the scene. The panel worked with the local high school to design posters reminding everyone to wear seatbelts.

A 15-year-old died after ingesting multiple prescription pain medications at a party. He had a history of selling prescription drugs to other teens. The panel worked with a group of teens from the local high school to develop an educational campaign about the dangers of "pharming." The parents spoke at an assembly about the impact of their son's death, warning other teens that even prescriptions can be deadly, if they're not yours.

Educational Activities in the Media:

A eight-week-old infant was found unresponsive in his parents' bed. He had been placed face up, but a pillow had slipped over his nose and mouth, and he suffocated. The panel discussed what is known

about safe sleep for infants and the fact that bedsharing is very hazardous. They contacted local television and radio stations, and provided information and interviews for public education on safe sleep for infants and the dangers of bedsharing.

A 13-year-old and his friend were home alone, playing with a loaded rifle and a loaded shotgun. The shotgun went off and struck the victim in the head. He was pronounced at the scene. The panel issued a press release that focused on the importance of storing firearms unloaded and locked up, with ammunition locked in a separate location, and to use gun locks, load indicators and other safety devices on all firearms. They also recommended that the school implement a gun safety program.

Consumer Product Safety:

A 10-year-old was riding an ATV as a passenger driven by an adult. As the driver attempted to negotiate a turn on a gravel road, he lost control and struck a tree. Both the driver and passenger suffered massive head injuries; neither was wearing a helmet. The panel launched a campaign to remind everyone that children younger than 16 should never ride ATV's and that riders should always wear a helmet.

News Services:

A four-year-old died in a fire in a mobile home. The parents and another child were able to escape. There were no working smoke detectors in the home and the window in the child's room would not open. The panel worked with the local newspaper to place public service ads about the importance of smoke detectors in every home, along with information about how to obtain a smoke detector or batteries free of charge. They ran follow-up stories and ads about practicing family fire drills.

Changes in Agency Practice:

A mother and her three children were staying at a women's shelter. The two older children shared a bed and the mother chose to sleep with the baby in her bed, despite the fact that a crib was available. The mother awoke to find the baby unresponsive. The baby had slipped down between the mother's arm and her side, where he suffocated. Following the panel recommendations, the women's shelter requested training for their staff on safe sleep for infants, so they would be able to provide a safe environment and teach parents about safe sleep.

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