



OLR BACKGROUNDER: ROLE OF THE CHILD FATALITY REVIEW PANEL AND CHILD ADVOCATE IN INVESTIGATING UNEXPECTED AND UNEXPLAINED CHILD DEATHS

By: Paul Frisman, Principal Analyst

SUMMARY

State law requires the Child Fatality Review Panel (CFRP) to review the circumstances of the death of any child under age 18 (1) placed in out-of-home care or (2) whose death was due to unexpected or unexplained causes. It directs the child advocate (one of CFRP's 13 permanent members) to investigate these deaths. The child advocate also may investigate children's deaths on her own initiative.

CHILD FATALITY REVIEW PANEL (CFRP)

Creation and Responsibilities

The legislature created both the CFRP and the child advocate's office in 1995, in the wake of the brutal death in March of that year of nine-month-old "Baby Emily." An independent panel, formed by Governor Rowland immediately after the infant's death, found numerous instances where Department of Children and Families workers and others had failed to recognize a pattern of abuse in the infant's family.

The independent panel recommended, among other things, that the legislature create a "fully staffed State Child Fatality Review Team" to "coordinate the interdisciplinary investigation of childhood deaths" and "participate in the development and implementation of policies to prevent unnecessary childhood deaths."

The legislature established both the child advocate's office and CFRP by enacting [PA 95-242](#), codified in part as [CGS §§ 46a-13k and 13l](#). The governor appoints the child advocate; the governor and six legislative leaders appoint seven of the 13 CFRP members. The remaining six are state officials or their designees.

The law initially charged the CFRP with reviewing the circumstances of the death of a child “who has received services from a state department or agency addressing child welfare, social or human services, or juvenile justice” ([CGS § 46a-13f](#)).

The panel initially had seven permanent members. These were a

1. pediatrician,
2. law enforcement representative,
3. public child welfare practitioner,
4. community service group representative,
5. medical examiner,
6. the child advocate, and
7. the chief state’s attorney.

EXPANDED RESPONSIBILITIES

In 1999 the legislature expanded the CFRP’s charge to include reviewing the death of any child (1) placed in out-of-home care (including children placed by state agencies and local education agencies in the case of children requiring special education) or (2) whose death is due to unexpected or unexplained causes. At the same time, it allowed the panel to select two experts or interested parties as additional or temporary panel members to help review a specific fatality ([PA 99-2](#), § 8, June Special Session).

One year later the legislature required the state’s chief medical examiner to notify CFRP and the child advocate of the death of any child whose death the medical examiner must investigate ([PA 00-49](#)). ([CGS § 19a-406](#) requires that all sudden, unexpected deaths and deaths occurring in suspicious circumstances be reported to the chief medical examiner.) [PA 00-49](#) also required any agency responsible for the custody or care of children to notify the CFRP and the child advocate of (1) a child’s death and (2) a critical incident involving a child in its custody or care.

In 2005 the legislature increased the CFRP’s permanent membership from seven to 13, adding (1) the chief medical examiner, (2) an attorney, (3) a psychologist, and (4) the commissioners of the departments of Children and Families, Public Health, and Emergency Services and Public Protection ([PA 05-157](#)). The same public act also substituted a social work professional and an injury prevention representative for the former public child welfare practitioner and medical examiner slots, respectively.

Finally, [PA 05-157](#) increased, from two to three, the number of experts or interested parties the panel may select as additional temporary members, and eliminated the requirement limiting these temporary appointees to reviewing a specific death. As before, panel members were to be selected to reflect the state's ethnic, cultural, and geographic diversity to the greatest extent possible.

Investigations

In practice, the chief medical examiner notifies the child advocate of all unexplained or unexpected deaths of children under 18. The child advocate and chief medical examiner meet monthly with CFRP to discuss the cases from the previous month, and the panel determines which cases the child advocate should investigate. However, because of the large number of such cases, CFRP does not direct the child advocate to investigate all cases the chief medical examiner refers to her. For example, she does not investigate the deaths of infants who die in hospitals of natural causes within 24 hours of their birth.

The child advocate primarily investigates homicides, suicides, accidents, and those deaths which the medical examiner rules as undetermined because it cannot precisely determine the cause of death. Such undetermined deaths may include infants who die suddenly and unexpectedly while sleeping, but where there is no identifiable injury or medical cause.

In investigating a child's death, the child advocate contacts state or local agencies that may have had some contact with the child and his or her family, such as school systems, child welfare agencies, and hospitals. She may speak with pediatricians, police, and others. She has subpoena power ([CGS § 46a-13m](#)).

The law requires CFRP to develop prevention strategies to address identified trends and risk patterns, and improve coordination of services for children and families. To that end, the child advocate might identify gaps in services provided to a child or the child's family.

According to the child advocate's office, there is no set protocol that investigations must follow. For example, the child advocate may investigate two unrelated cases in which children accidentally drown. The parents of one of the children may have a history of domestic violence, while the parents of the second child do not. According to the child advocate, she would be likely to spend more time and resources investigating the former than the latter.

The child advocate may investigate not only individual deaths, but a group of unconnected, but similar deaths that occur in a short amount of time, such as an unusual number of suicides among children of similar ages. In such a case, the child advocate would examine risk factors common to those children.

CFRP reports annually to the governor and legislature on its review of child fatalities from the previous year ([CGS 46a-13f](#)).

For the calendar years 2011, 2012, and 2013, CFRP reported 80, 89, and 81 untimely child deaths, respectively. The deaths are broken down into the following categories: homicides; suicides; accidental deaths; undetermined/sudden unexplained infant deaths; and Sudden Infant Death Syndrome (SIDS), as shown in Table 1.

Undetermined/sudden unexplained infant deaths are those in which a precise cause of death has not been determined; SIDS cases are those in which a determination has been made. Accidents include motor vehicle crashes, drowning, fires, and other accidental deaths.

Table 1: Unexpected Child Deaths in Connecticut, 2011-2013

Year	Homicide	Suicide	Accident	Undetermined/Sudden Unexplained Infant Death	Sudden Infant Death Syndrome (SIDS)	Total
2011	13	9	34	16	8	80
2012	27 (20 of these occurred in the Sandy Hook shootings)	12	33	15	2	89
2013	12	10	35	17	7	81

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