SECTION FOUR: Intentional Injury Deaths

Intentional injury includes child deaths designated by death certificate as homicide and suicide, along with other child deaths identified by the Child Fatality Review Program as Fatal Child Abuse and Neglect deaths. In considering Intentional Injury, note that the term "intentional" does not necessarily describe the mindset of the victim or perpetrator, but indicates only that the circumstances involved harmful, volitional acts.

Manner of Death

Homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to kill is a common element, but is not required for classification as homicide. *Suicide* results from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.

Homicides

Homicide was listed as the death certificate manner of death for 45 Missouri children in 2002.

For the purpose of analysis of child deaths and their prevention, homicides are divided into three categories, based on the relationship of the perpetrator to the victim:

(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 2002, **38** Missouri children were victims of Fatal Child Abuse and Neglect; of those, **24** 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 **21** such fatalities among Missouri children in 2002.

(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 most often include motor vehicle-related deaths involving drugs, alcohol and other criminal behavior. In 2002, there were no homicide deaths of this type among Missouri children.

Figure 30. Homicides by Age

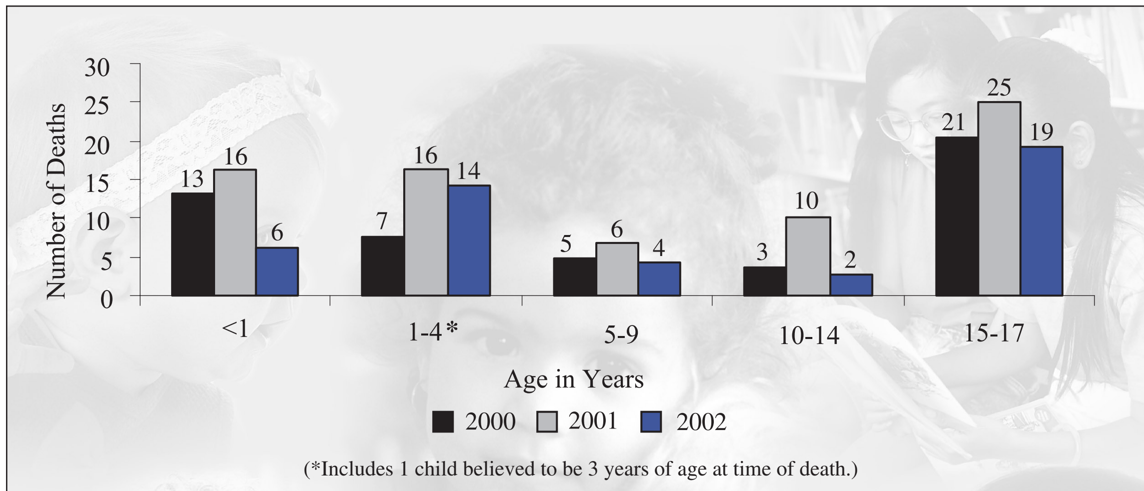
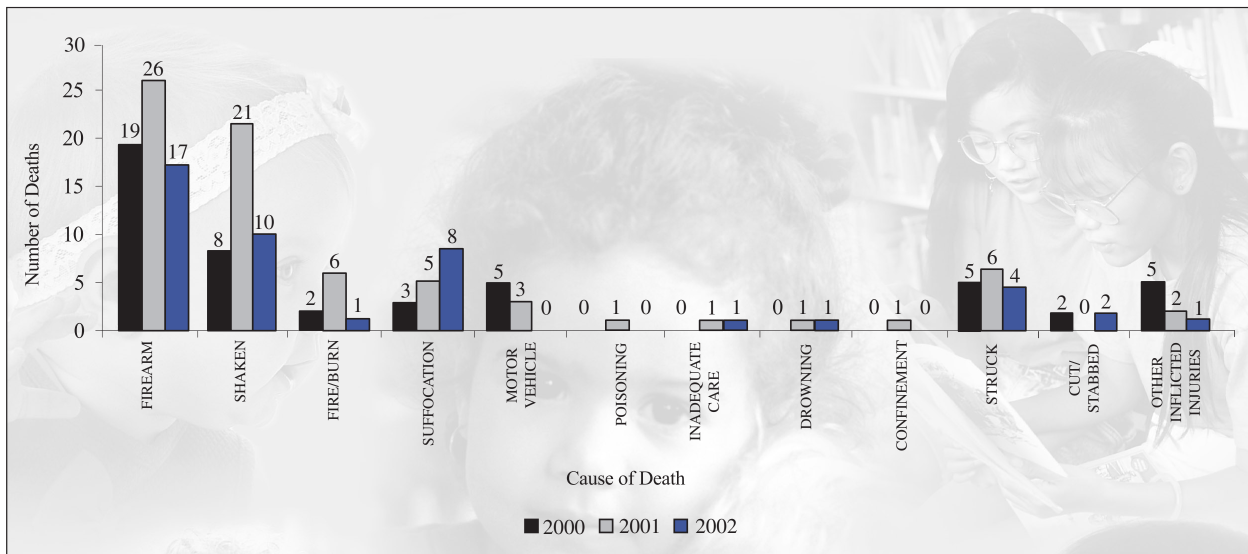


Figure 31. Homicides by Sex and Race

Sex	2000	2001	2002
Female	19	27	19
Male	30	46	26
	49	73	45

Race	2000	2001	2002
White	22	29	24
Black	26	44	20
Other	1	0	1
	49	73	45

Figure 32. Homicides by Cause



Fatal Child Abuse and Neglect

Of the 45 child homicides in Missouri in 2002, 24 (53%) children died at the hands of a parent or caretaker. Of those, 23 children died of physical abuse injuries and one child died of neglect.

In 2002, **38** Missouri children were designated as victims of Fatal Child Abuse and Neglect by the Child Fatality Review Program; of those, **24** were reported by death certificate as homicide.

Representative Cases:

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

  The mother of a 9-month-old female left the baby in the care of her boyfriend while she went to work. A short time later, she was rushed to the hospital after allegedly choking on food. She was unconscious on arrival and died a few hours later. Autopsy revealed external bruises and massive internal injuries.

  A 6-month-old female was left in the care of an adult female babysitter while her mother was looking for a job. The babysitter picked up the child and shook her until she stopped crying. The baby became unconscious and was rushed to the hospital, where she died.

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

  A 3-year-old male died as a result of a neck injury and intentional suffocation inflicted by his mother's boyfriend. At autopsy, there was evidence of previous physical and sexual abuse.

  A 2-year-old male with a severe inflicted brain injury was admitted to a hospital from a foster home. He died at the hospital. He had been seen one week prior with a possible seizure and altered level of consciousness, but was released back to the foster home.

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

  A 2-year-old girl was rushed to the hospital in cardiac arrest. The parents gave a history of a fall and injury to the head the previous day. Upon examination, she was found to have multiple bruises, abrasions and other external injuries, as well as retinal hemorrhages and severe brain trauma. She died at the hospital.

  A 2-year-old male died after being shaken and thrown against a door by his father. There was a history of domestic violence and child abuse in the household.

  An 11-month-old female was left in the care of her mother's boyfriend for less than 30 minutes. The mother returned to find the child unconscious. She was rushed to the hospital by EMS, where she died of abusive head injuries. The boyfriend admitted to shaking the child violently just before she became unconscious, because she would not stop crying.

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 (NCANDS). However, it is well documented that child abuse and neglect fatalities are underreported and that, nationally, at least 2000 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 & Senior Services' Bureau of Vital Statistics, Department of Social Services, Children's Division** and the **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 used 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

In Missouri, the Children's Division is the hub of the child protection community. 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, DFS 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 Child Abuse and Neglect

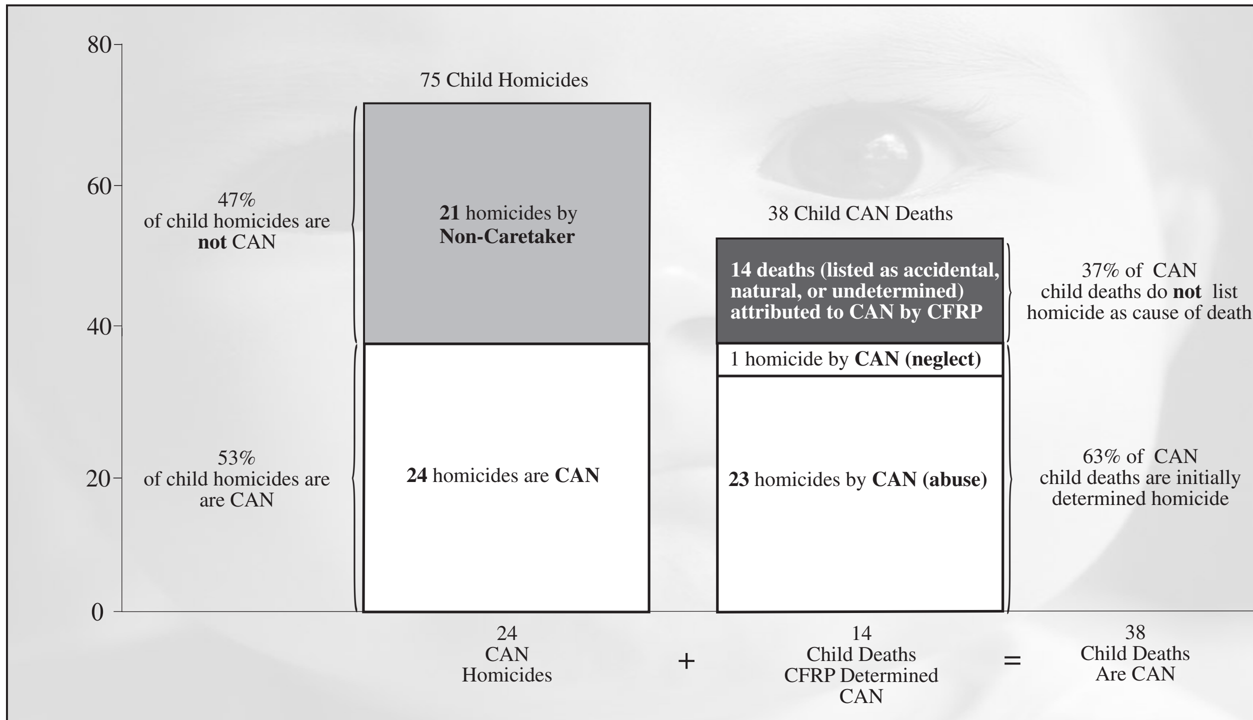
Child fatalities represent the extreme of all issues that have a negative impact on children. Despite an increasing awareness of severe violence against children, very little was known in the past about fatal child abuse and neglect. In the late-1980's, Missouri researchers discovered that many fatal 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.

The Child Fatality Review Program annual reports for 1999 to 2001 refined the reporting and analysis of CFRP data in many ways, including an examination of data concerning "Fatal Child Abuse and Neglect." 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

2002 CFRP Child Abuse/Neglect (CA/N) Fatalities



Fatal Child Abuse and Neglect: Inflicted Injury

In the United States, the majority of fatal inflicted injury deaths among children result from abusive head trauma, commonly known as Shaken Baby Syndrome. In Missouri in 2002, **10** (43%) of the **23** children who died from inflicted injury at the hands of a parent or caretaker were victims of abusive head trauma (SBS).

In the United States, the next most common type of physical abuse deaths involve punching or kicking the abdomen, resulting in massive internal injuries and bleeding. 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. In 2002, **3** Missouri children died of blunt trauma injuries when they were punched, kicked or thrown.

In Missouri in 2002, **7** children died of intentional suffocation. **Two** children died of intentional gunshot wounds inflicted by male family members, one father and one grandfather. The Child Fatality Review Program also received a report of the "late death" of a 14-year-old female who had suffered anoxic brain injury during a sexual assault as a toddler.

Child Abuse and Neglect Fatalities by Age	
<1 year	11
1 - 4 years	21
5 - 9 years	4
10 - 14 years	1
15 - 17 years	1

Child Abuse and Neglect Fatalities by Race and Sex			
Females	16	White	27
Males	22	Black	10
		Other	1

Child Abuse and Neglect Fatalities by Cause			
Suffocation	11	Fire/Burn	2
Shaken Baby	10	Blunt Force Trauma to Abdomen	2
Drowning	5	Beaten and Sexually Assaulted	1
Vehicular	3	Medical Neglect	1
Firearm	2	Malnutrition and Dehydration	1

Shaken Baby Syndrome

The most common mechanism of child abuse fatalities in the United States is abusive head trauma or Shaken Baby Syndrome (SBS), which involves the violent shaking of an infant or young child, usually under the age of 4 years. Babies' heads are large and heavy in proportion to their total body weight and their neck muscles are too weak to support such a disproportionately large head. Because a baby'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. Brain tissue is bruised or destroyed.

Shaken Baby Syndrome involves an *extremely violent* act. Age-appropriate play, gentle shaking to awaken an unconscious child and CPR do not cause the massive destruction seen in Shaken Baby Syndrome. Short falls from sofas, beds and changing tables, and falls associated with the caretaker falling while carrying the child, do not produce the severe brain injuries of Shaken Baby Syndrome.

Immediate consequences include a decreased level of consciousness and seizures; breathing may stop; the heart may stop and the baby may die. Shaken Baby Syndrome is so lethal that 20-25% of SBS victims die of their injuries. Long term consequences for survivors may include physical disabilities, blindness, speech disabilities, seizures, learning disabilities and death. For survivors, research has established that a significant number of SBS cases are unrecognized and underreported.

Of the **23** Missouri children who died of fatal inflicted injury in 2002, **10** (43%) were victims of Shaken Baby Syndrome.

Figure 35. Shaken Baby Syndrome Deaths by Age

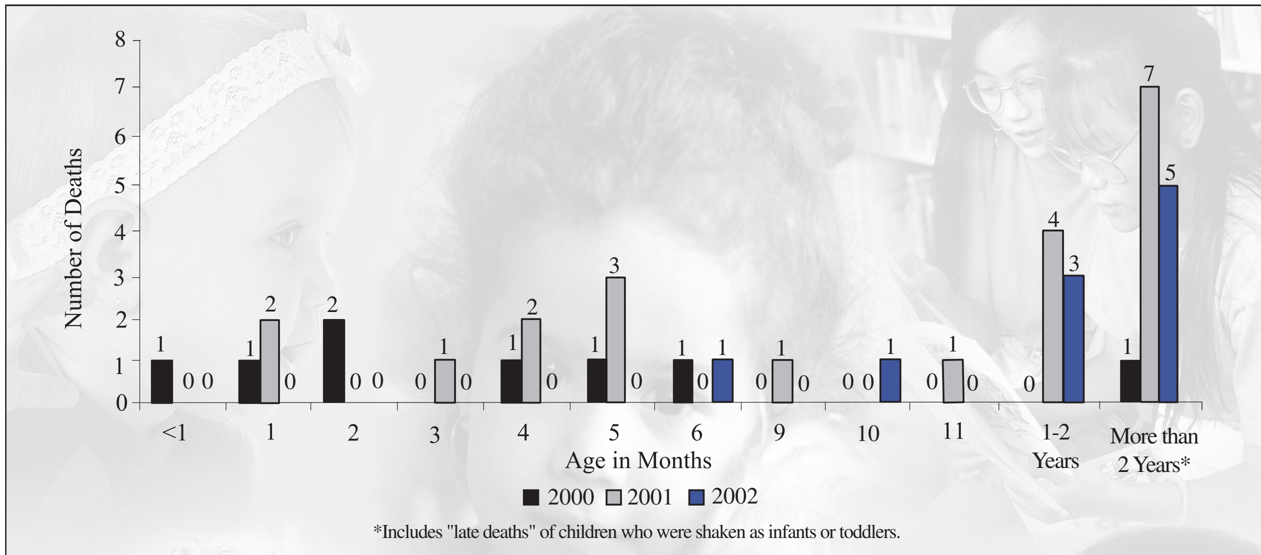


Figure 36. Shaken Baby Syndrome Deaths by Sex and Race

Sex	2000	2001	2002
Female	2	15	7
Male	6	6	3
	8	21	10

Race	2000	2001	2002
White	5	13	7
Black	3	8	3
	8	21	10

Deliberate shaking of an infant or young child is usually the result of frustration or anger. This occurs most often when the baby won't stop crying. Other triggering events include toilet training difficulties and feeding problems.

Figure 37. Shaken Baby Syndrome Deaths by Apparent Triggering Event

Cause	Number of Deaths
Crying	2
Difficulty Feeding	1
Unknown	7
	10

Perpetrators of Shaken Baby Syndrome can be anyone. Most individuals who shake infants do not fall into a specific category, yet research shows that certain characteristics make a person more at risk of being a perpetrator. For example, research has established that fathers and other male caretakers are the most frequent perpetrators of SBS. **Nine** (90%) perpetrators of fatal SBS in 2002 were fathers and other male caretakers.

Figure 38. Perpetrators of Shaken/Impact Syndrome

Perpetrator	Number of Deaths
Stepfather	1
Mother's Paramour	5
Foster Parent	1
Child Care Worker	1
Other Child (a 12 year old boy and a 14 year old boy)	2
	10

Fatal Child Neglect: Grossly Negligent Treatment

Negligent treatment of a child is an act of omission, which is often fatal when due to grossly inadequate physical protection or 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 willfully 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 3-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.

In 2002, **15** Missouri children were identified by the Child Fatality Review Program as victims of grossly negligent treatment that resulted in death.*

Circumstances of grossly negligent treatment include the following:

- ***Exposure to a hostile environment or a hazardous situation:***

Four-month-old infant, exposed to excessive heat; symptoms of malnutrition and dehydration	1

- ***Unsafe sleep arrangements, accompanied by conditions of neglect or exposure to a hazardous environment***

Infant co-sleeping with mother who was known to be intoxicated	1
Sudden, unexpected and suspicious infant death; co-sleeping with adult on a sofa; conditions of neglect	1

- ***Motor vehicle fatalities:***

Motor vehicle fatalities in which a child age 4 years and under was unrestrained (In one case, adult driver was intoxicated and "playing chicken" with another vehicle.)	2
A 3-year-old child left outside unattended strayed into the street and was struck by a car	1

- ***Lack of supervision of young child, resulting in drowning:***

One-year-old left unattended with bathtub water running until the tub overflowed; the baby drowned	1
Four-year-old child left unsupervised during a party at a hotel pool, drowned	1
Toddler, 23-months-old, was put outside to play alone, drowned in a pond	1
Ten-month-old left unattended, drowned in a toilet	1
Five-year-old left unsupervised, drowned in bathtub in 6-8" of water	1

- ***Lack of supervision of young child, resulting in unintentional strangulation:***

Three-year-old playing outside unsupervised, hung himself on a rope, hanging from a tree	1

- ***Lack of supervision of young child, resulting in fire/burn fatalities:***

One-year-old left alone in the home, died in a house fire	1
Two-month-old baby placed on floor grate above the furnace, died of extensive burns	1

- ***Medical neglect: failure to provide medical care for a known condition with potential for serious or fatal outcome:*** 1

Premature infant born at home, received no medical care	1

*Note that, for data purposes, 14 of the 15 deaths listed were not designated as homicide by death certificate; they are included in the data for the appropriate Illness/Natural Cause or Unintentional Injury category, according to the cause and circumstances. It should also be noted that this group of children was not included in Fatal Child Abuse and Neglect totals in CFRP Annual Reports prior to 2001.

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 parents 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.ctf4kids.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 providers.
- 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 panels 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:

National Committee to Prevent Child Abuse . . . . .www.childabuse.org

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

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

Missouri Children's Trust Fund
(Missouri's Foundation for Child Abuse Prevention) www.ctf4kids.org

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

"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

Other Homicides

Of the 45 child homicides in Missouri in 2002, 21 involved perpetrators who were not in charge of the child; of those, 15 (71%) involved firearms.

Representative Cases:

Intentional firearm

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

  A 15-year-old male was found shot to death in the doorway to his apartment building. He had a long history of gang involvement. Police believe the shooting may have been part of a drug turf war.

  A 14-year-old male was shot in his home after a dispute with another juvenile. The gun used was a pistol, found in a night stand in the victim's parent's bedroom.

Figure 33. Homicide Firearm Deaths by Age

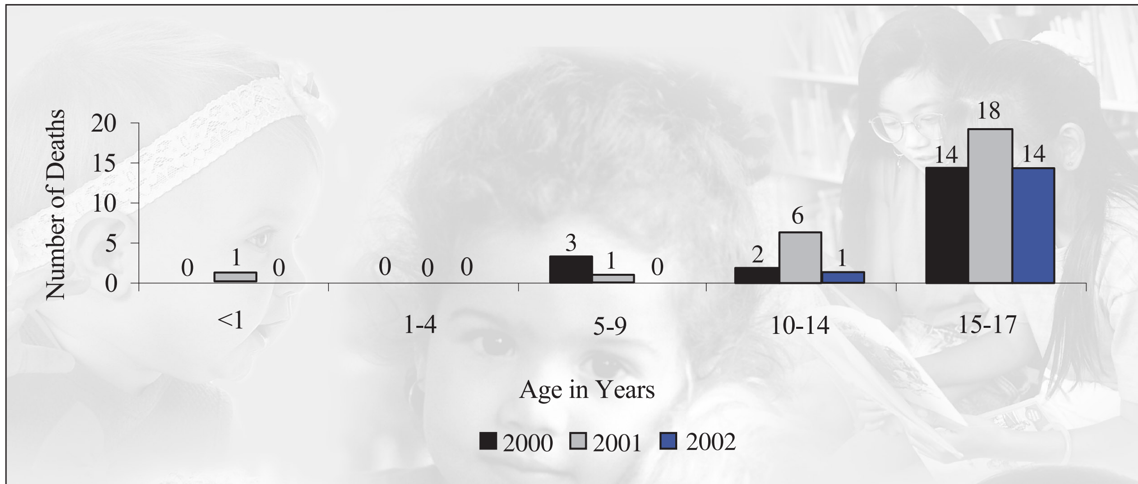


Figure 34. Homicide Firearm Deaths by Sex and Race

Sex	2000	2001	2002
Female	4	4	2
Male	15	22	13
	19	26	15

Race	2000	2001	2002
White	5	5	3
Black	13	21	12
Other	1	0	0
	19	26	15

In 2002, **21** Missouri children were murdered by non-caretakers. The vast majority of victims were adolescents. Most youth homicides involve juvenile crime and violence, or abductions by adults or other adolescents that culminated in murder.

Homicides, Drug or Gang Related		Homicides, Other	
Firearm	12	Firearm	3
Drowning	1	Fire/Burn	1
Victim hid money from a robbery and other members of his gang killed him	1	Disappeared in 1998, but counted in this year's data. Killed by boyfriend during an argument.	1
Stabbed while involved in a large fight.	1	Child abduction by adult perpetrator, culminating in murder	1

Youth homicide:

The most common mechanism of juvenile homicide is firearms, particularly inexpensive, readily available handguns. **Fifteen** Missouri youths died of intentional firearm injuries in 2002. Handguns were used in all fifteen of those murders. Youth homicides are a serious problem in large urban areas, especially among black males. The majority of gun homicides occur in the metropolitan areas of St. Louis and Kansas City. The number of firearm homicides among Missouri adolescents has risen sharply in the last three years, particularly when drug and gang activity is a factor. Other factors known to contribute to youth homicide include poverty, easy access to firearms, family disruption and school failure.

Nationally, the rate of juvenile arrests for violent crime has risen sharply since the mid-1980's. Over the next 10 years (1985-1994), 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.

"It is important to keep the problem of youth violence in perspective...The current portrait of youth presented by the media is not grounded in statistical reality. The vast majority of young people do not carry weapons, do not deal drugs, do not join gangs and do not victimize their friends or neighborhoods...Most young people, like most adults, want nothing more than to lead their lives in peace."

-Harborview Injury Prevention and Research Center

"The causes of violence are many. The multi-faceted nature of violence almost invariably frustrates simplistic approaches to the problem. Youth violence can be prevented, but efforts must start at an early age and be sustained over time. Early childhood experiences, the nature of a child's family, the influence of peers, the neighborhood and society are keys to solving the puzzle." (*Harborview Injury Prevention and Research Center*)

Promising Approaches:

Individuals and organizations working to prevent firearm violence, choose and develop strategies that are specifically appropriate for them to use, depending on what aspect of the problem they would like to address. Interventions can be categorized into three basic types: educational, legal and technological/environmental.

- *Educational programs* are often carried out in the schools, community-based organizations and physicians' offices. They emphasize prevention of weapon misuse, the risks involved with possession of a firearm, and the need for conflict resolution and anger management skills.
- *Legal measures* strive to limit access to firearms-the number and type of people eligible to own or possess firearms, as well as the types of firearms that can be manufactured, owned and carried.
- *Technological/environmental interventions*: Firearm design requirements are both a technological and a legal intervention. Environmental and technological measures are based on the premise that automatic protections are more effective than those requiring specific action by individuals.

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

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

Suicides

Suicide was the manner of death of 18 Missouri children in 2002.

Representative Cases:

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

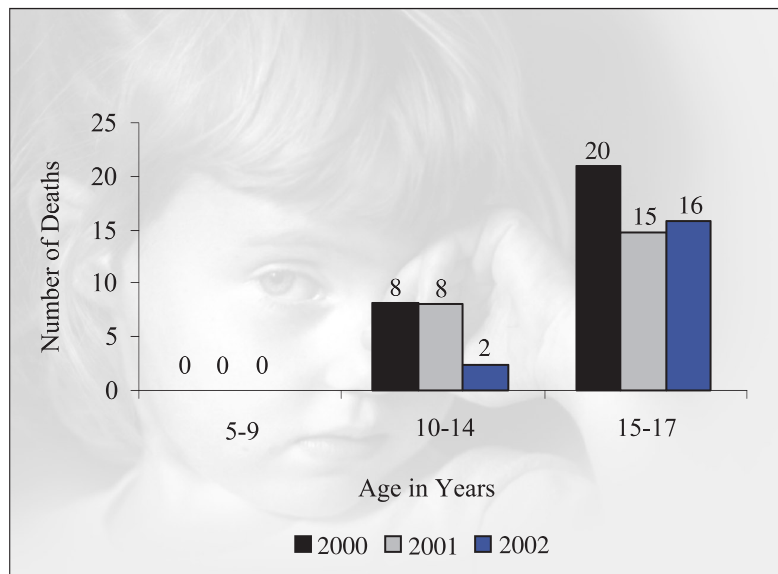
  A 17-year-old female with a past medical history of depression and treatment was found hanging by a swing set in her back yard. She also had a prior suicide attempt.

  A 16-year-old male was found with a self-inflicted gunshot wound to the head. He had a history of drug use and problems with law enforcement. There had been threats of suicide in the past.

  A 15-year-old male was found in his parent's bedroom with a gunshot wound to the head. He had prior attempts of suicide and a history of behavior problems at school.

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 2002, **18** children died of self-inflicted injury; **16** were age 15-17; the remaining **2** were children age 10-14.

Figure 39. Suicides by Age



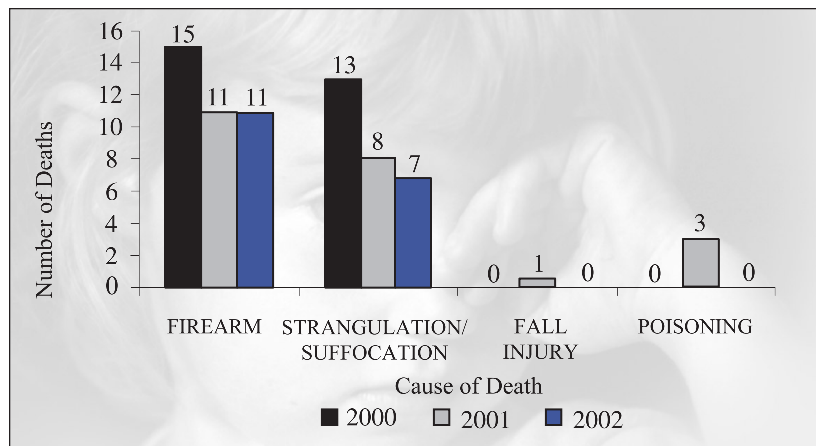
White males comprise the majority of adolescent suicide victims in Missouri. Although more females attempt suicide than males, males are approximately three times more likely to die from suicide.

Figure 40. Suicides by Sex and Race

Sex	2000	2001	2002
Female	4	3	1
Male	24	20	17
	28	23	18

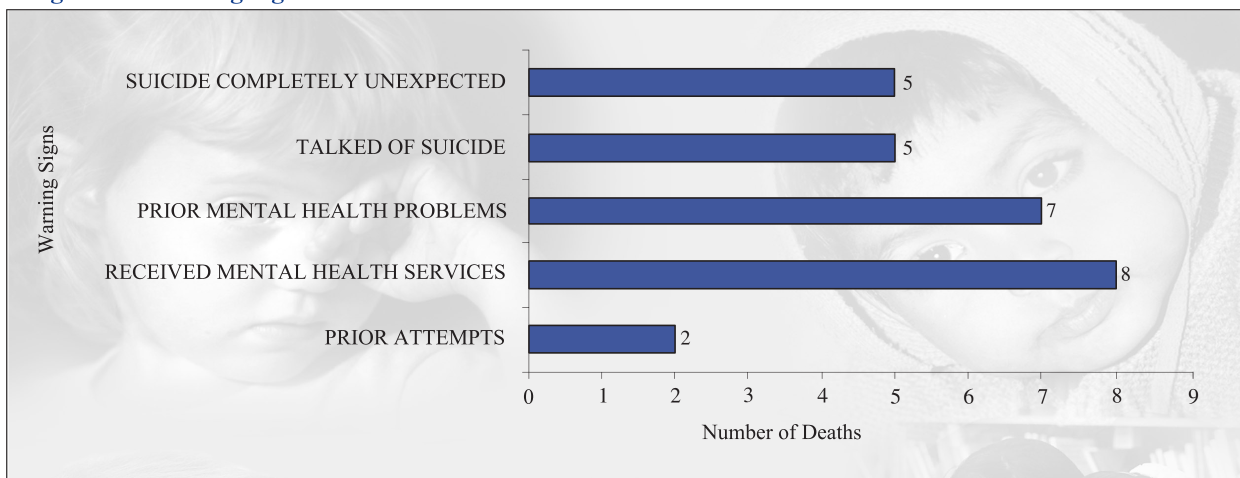
Race	2000	2001	2002
White	24	18	17
Black	4	5	1
	28	23	18

Figure 41. Suicides by Mechanism



Firearms and suffocation/strangulation are the most common mechanisms of suicide among Missouri children.

Figure 42. Warning Signs of Suicide



Of the **18** suicide victims age 17 and under in 2002, **10** (56%) had displayed one or more warning signs.

"Suicide is not about death. Young people who give serious consideration to suicide don't want to die; they want an end to the incredible emotional pain they feel...Young people don't recognize that suicide is a permanent solution to a temporary problem."

-from *Kids Under Twenty-One (KUTO)*

Preventing Youth Suicide:

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. Identified risk factors for suicide and attempted suicide for young people include: mood disorders, substance abuse, certain personality disorders, low socioeconomic status, childhood maltreatment, parental separation or divorce, inappropriate access to firearms and interpersonal conflicts or losses. Only a few studies have examined protective factors among youth for suicidal behavior. Both parent-family connectedness and perceived school connectedness have been shown to be protective against suicidal behavior.

A Summary of Suicide Risk and Protective Factors (Youth and Young Adults)

Suicidal behavior emerges out of a complex and dynamic interplay between an array of individual, social and environmental risk and protective factors. While we know that those at greatest risk are single, young (15-24), Caucasian and aboriginal males, suffering from major depression and substance abuse with easy access of firearms, the reality is that many young people who kill themselves do not fit this statistically determined profile. The chart on the next page summarizes some of the most well known risk/protective factors. Note that it is not an exhaustive list.

The chart is from "Best Practices in Youth Suicide Prevention", developed by the Suicide Prevention Information and Resource Centre (SPIRC) of British Columbia Faculty of Medicine, UBC; 2250 Westbrook Mall, Vancouver, BC, Canada V6T 1W6; email: spirc@interchange.ubc.ca; a more complete discussion can be found in a subsequent document developed by SPIRC: "Practice Principles: A Guide for Mental Health Clinicians Working With Suicidal Children and Youth" www.mcf.gov.bc.ca/youth/suicid_%20prev_manual.pdf

Key Context	Predisposing Factors	Contributing Factors	Precipitating Factors	Protective Factors
Individual	• Previous attempt • Depression/Psychiatric disorder • Prolonged or unresolved grief	• Rigid cognitive skills • Poor coping skills • Substance abuse • Sexual orientation issues • Impulsivity • Hypersensitivity	• Personal failure • Humiliation • Individual trauma • Developmental crisis	• Easy temperament • Creative problem-solving • Personal autonomy • Previous experience with self-mastery • Optimistic outlook • Sense of humor
Family	• Family history of suicidal behavior/ completed suicide • Family violence/abuse • Family history of psychiatric disorder • Early childhood loss/ separation • Social isolation & alienation	• Substance abuse within family • Family instability • Ongoing conflict	• Loss of significant family member • Death, especially by suicide	• Family relationships characterized by warmth & belonging • Adults modeling healthy adjustment • High & realistic expectations
Peers	• Social isolation & alienation	• Negative youth attitudes toward adult assistance	• Teasing/cruelty • Interpersonal loss • Rejection • Death, especially by suicide	• Social competence • Healthy peer modeling • Acceptance & support
School	• Long-standing history of negative school experience • Lack of meaningful connection to school	• Disruption during key transitional periods at school • Reluctance/uncertainty about how to help among school staff	• Failure • Expulsion • Disciplinary crisis	• Presence of adults who believe in them • Parent involvement • Encouragement of participation
Community	• Community "legacy" of suicide • Community marginalization • Political disempowerment	• Sensational media portrayal of suicide • Access to firearms or other lethal methods • Reluctance/uncertainty about how to help among key gatekeepers • Inaccessible community resources • Economic deprivation	• High profile/celebrity death, especially by suicide • Conflict with the law/ incarceration	• Opportunities for participation • Evidence of hope for the future • Community self determination & solidarity • Availability of resources

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 firearms 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:

National Strategy for Suicide Prevention . . . . .www.mentalhealth.org/suicideprevention

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

National Center for Suicide Prevention Training . . . . .www.ncspr.org

Kids Under Twenty-One (KUTO) . . . . .www.kuto.org