

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 46 Missouri children in 2003.

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 2003, 44 Missouri children were victims of Fatal Child Abuse and Neglect; of those, 22 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 24 such fatalities among Missouri children in 2003.

(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 2003, there were no homicide deaths of this type among Missouri children.

Figure 30. Homicides by Age

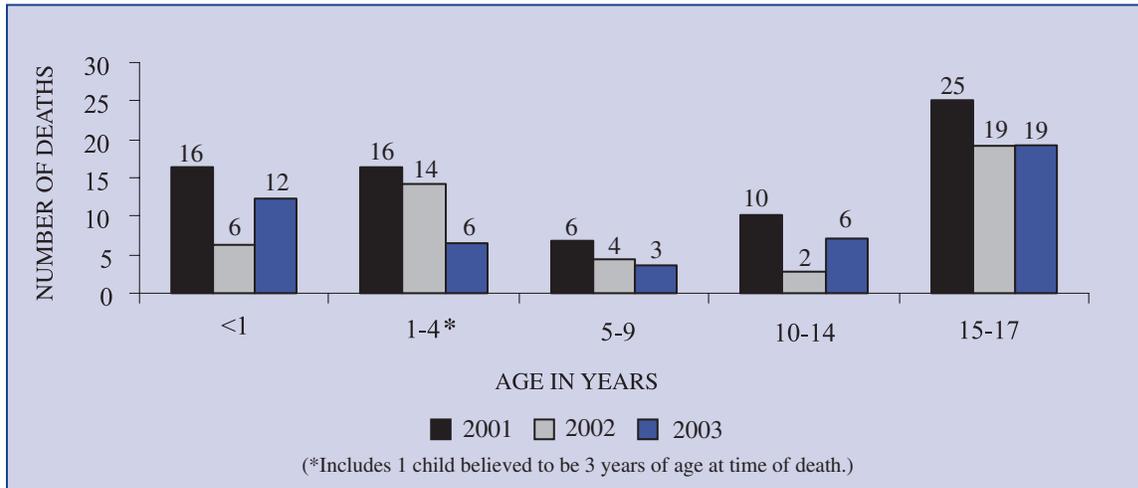
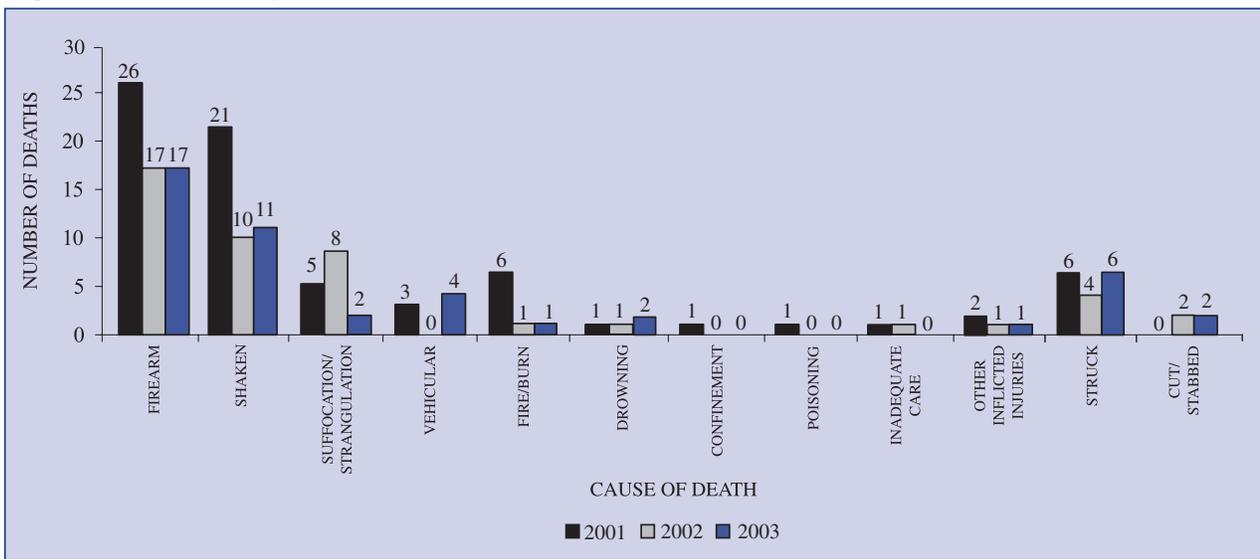


Figure 31. Homicides by Sex and Race

Sex	2001	2002	2003	Race	2001	2002	2003
Female	27	19	13	White	29	24	25
Male	46	26	33	Black	44	20	21
				Other	0	1	0
	73	45	46		73	45	46

Figure 32. Homicides by Cause



Fatal Child Abuse and Neglect

Of the 46 child homicides in Missouri in 2003, 22 (48%) children died of physical abuse injuries at the hands of a parent or caretaker.

In 2003, **44** Missouri children were designated as victims of Fatal Child Abuse and Neglect by the Child Fatality Review Program; of those, **22** were reported by death certificate as homicide.

Representative Cases:

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

A 6-month-old was brought to the emergency room in full arrest; doctors found bruises on the child's head and buttocks. His parents had shared custody and the baby was in the care of his father at the time of the incident. Autopsy revealed that the infant died of blunt trauma injuries to the abdomen.

A 5-month-old infant was sleeping with his step-father while the mother was at work. The mother arrived home in the morning to find the step-father still sleeping and the infant dead, with a pillow covering his face. The step-father was charged with murder.

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

A 10-month-old was rushed to the hospital with extensive third-degree burns suffered when her father immersed her in scalding water; she died within hours. The family had an extensive history of medical and physical neglect, bruising and sexual assault. The mother's other children had been in foster care prior to this incident.

A 2-year-old was left in the care of his mother's boyfriend, while the mother went out drinking with friends. The next morning, the child was found dead with bruising to the chest and abdomen. The boyfriend had a history of child abuse, but had never been charged. The mother had previously agreed to a safety plan, which stated specifically that the boyfriend would not be allowed around her children.

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

A 3-year-old was in the care of his mother, but was being "disciplined" by the mother's boyfriend when he was shaken, struck and thrown onto furniture. The mother and her boyfriend were charged with murder.

In 1998, a female infant was injured in the seventh week of life by her biological father, who was 15 years old. The infant was shaken and thrown because she would not stop crying. She was left with devastating brain injuries, blindness and seizures. She died in 2003. The father was charged with murder.

A 3-month-old infant was left in the care of an adult babysitter. Late in the morning, the sitter called the mother at work to report that she had not been able to wake the baby from her morning nap. The mother called 911 and the infant was rushed to the hospital, where she died of massive brain injuries of Shaken Baby Syndrome. The babysitter, who had no experience with infants, denied abusing the child.

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, Children's Division would determine that there was *probable cause* to believe that this child was a victim of *neglect*, specifically, lack of supervision.

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

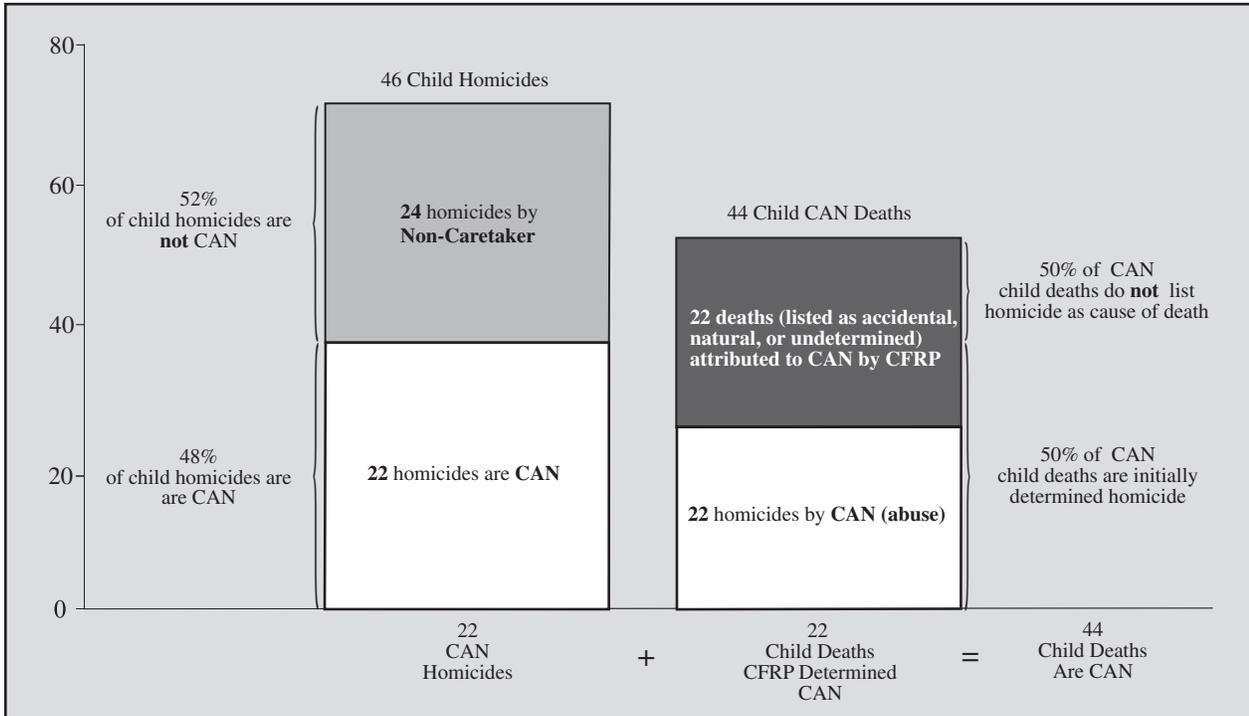
Child fatalities represent the extreme of all issues that have a negative impact on children. Despite an increasing awareness of severe violence against children, very little was known in the past about fatal child abuse and neglect. In the late-1980's, Missouri researchers discovered that many fatal 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 2002 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**

2003 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 2003, **11** (50%) of the **22** children who died from inflicted injury at the hands of a parent or caretaker were victims of abusive head trauma (SBS). One of those children was injured in 1998 in the seventh week of life by her biological father, who was 15 years old. The child suffered devastating brain damage, blindness and seizures. She died in 2003.

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 2003, **five** Missouri children died of blunt trauma injuries to the abdomen or head when they were struck, punched, kicked or thrown.

In Missouri in 2003, **four** children died of intentional suffocation. **One** infant was drowned by her mother, who then committed suicide. And **one** Missouri infant, a victim of chronic neglect, died after she was placed in scalding water by her father.

Child Abuse and Neglect Fatalities by Age	
< 1 year	19
1 - 4 years	15
5 - 9 years	4
10 - 14 years	5
15 - 17 years	1

Child Abuse and Neglect By Sex	
Females	16
Males	28

Child Abuse and Neglect By Race	
White	32
Black	12

Child Abuse and Neglect Fatalities by Cause			
Drowning	5	Other Cause (Mauled by Dog)	1
Electrocution	1	Other Inflicted Injury	5
Fall	1	Illness/Natural Cause	1
Fire/Burn	2	Suffocation	7
Firearm	3	Undetermined	1
Shaken	11	Vehicular	6

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 **22** Missouri children who died of fatal inflicted injury in 2003, **11** (50%) were victims of Shaken Baby Syndrome.

Figure 33. Shaken Baby Syndrome Deaths by Age

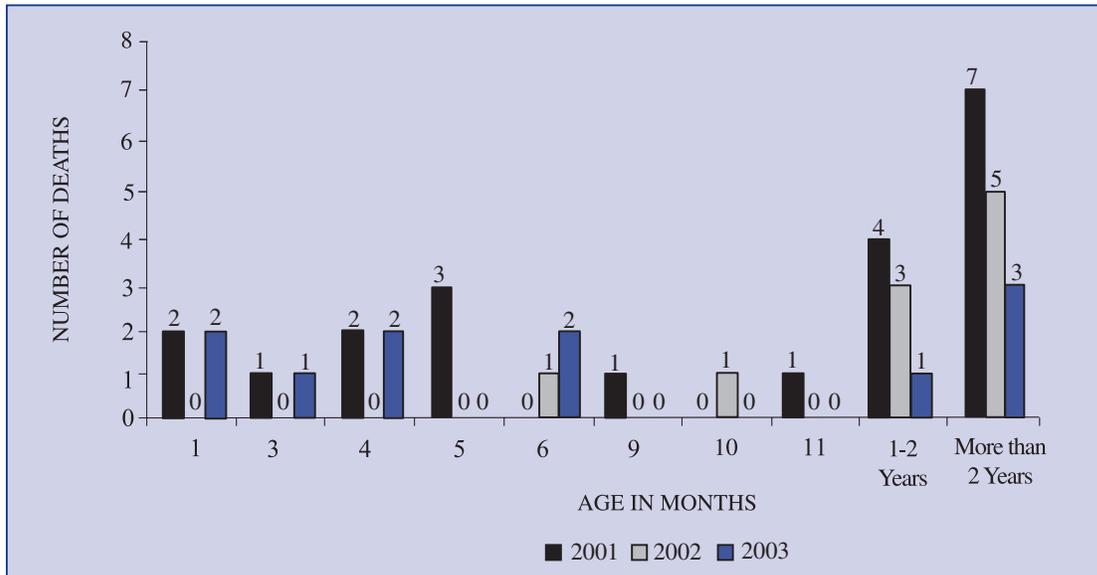


Figure 34. Shaken Baby Syndrome Deaths by Sex and Race

Sex	2001	2002	2003	Race	2001	2002	2003
Female	15	7	1	White	13	7	9
Male	6	3	10	Black	8	3	2
	<u>21</u>	<u>10</u>	<u>11</u>		<u>21</u>	<u>10</u>	<u>11</u>

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 35. Shaken Baby Syndrome Deaths by Apparent Triggering Event

Cause	Number of Deaths
Crying	2
Unknown	9
	<u>11</u>

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** (82%) perpetrators of fatal SBS in 2003 were fathers and other male caretakers.

Figure 36. Perpetrators of Shaken/Impact Syndrome

Perpetrator	Number of Deaths
Father	6
Mother's Paramour	3
Child Care Worker	1
Unknown	1
	11

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 2003, 22 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:

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

Infant, bed-sharing with mother, who was under the influence of alcohol.

Infant found unresponsive in a chair next to mother, who was under the influence of alcohol.

Infant, bed-sharing with both parents, who were under the influence of cocaine.

Infant, left in care of a mentally-challenged teen for several days, found face down in bassinet.

- ***Motor vehicle fatalities:***

Toddler died in a single motor vehicle crash. Vehicle was driven by mother, who was under the influence of marijuana.

In two separate incidents, three-year-olds were left unattended near a roadway or driveway and were struck by a motor vehicle.

A 14-year-old driver died in a single motor vehicle crash. Parent had given him permission to drive alone at night.

Another 14-year-old crashed while driving at a high rate of speed, under the supervision of an older sibling.

A toddler, left unattended, wandered onto train tracks and was struck by a train.

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

A two-year-old died in 2003 of complications of near-drowning that occurred in 2001, when he was left unattended by a teen relative.

An infant drowned in a bathtub after being left unattended with two young siblings.

One toddler drowned in a pool while teen babysitter was distracted.

One young child drowned in a lake, after being left unattended.

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

In three separate incidents, children were shot by other children using weapons left in view and/or not properly stored. In one case, the mother witnessed the shooting.

A toddler was electrocuted by exposed wires in the home.

A toddler fell from a second-story window. His mother, who claimed to be in the room at the time, was under the influence of drugs.

Another toddler, left unattended, was mauled by a dog.

An infant died in a house fire that started in the kitchen. The mother was under the influence of drugs.

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

A teen with an extensive history of medical neglect suffered a fatal asthma attack.

*Note that, for data purposes, these 22 deaths were not designated as homicide by death certificate; they are included in previous data sections 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.



Shaken Baby Syndrome



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 Abusewww.childabuse.org
- American Academy of Pediatricswww.aap.org
- Harborview Injury Prevention and Research Centerhttp://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 Syndromewww.dontshake.com
- U.S. Department of Justice
Office of Juvenile Justice and Delinquency Prevention . . .www.ojjdp.ncjrs.org
- ChildAbuse.comwww.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 46 child homicides in Missouri in 2003, 24 involved perpetrators who were not in charge of the child; of those, 15 (63%) involved firearms.

Representative Cases:

Intentional firearm

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

A 16-year-old male was standing in front of his residence when two males started firing shots at him. Moments later, more shots were fired from a passing vehicle, striking the victim in the head. The victim and assailants were members of rival gangs. All involved, including the victim, were armed with handguns.

A 15-year-old male, with an extensive juvenile record, was fatally shot by other teens in retaliation for a shooting he had committed days earlier. Drugs were found in his system at the time of death.

Figure 37. Homicide Firearm Deaths by Age

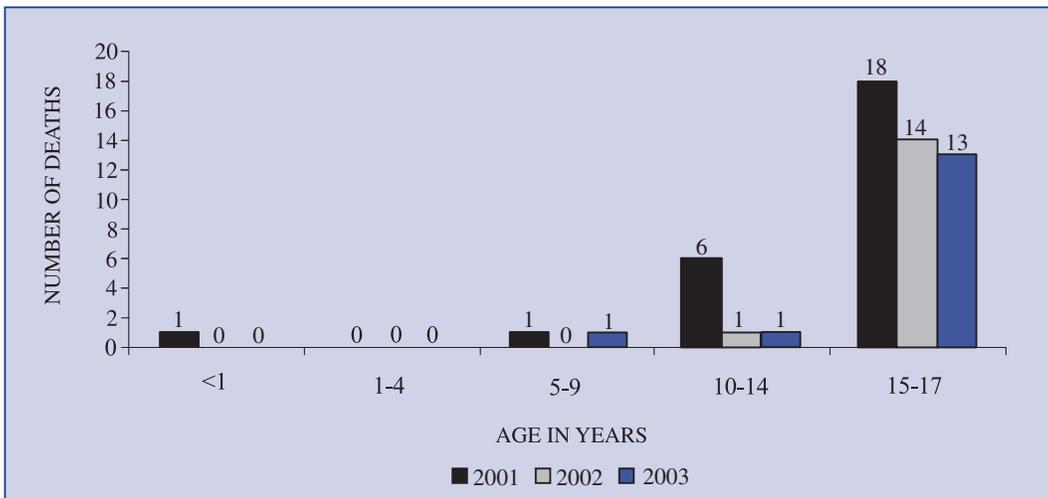


Figure 38. Homicide Firearm Deaths by Sex and Race

Sex	2001	2002	2003	Race	2001	2002	2003
Female	4	2	3	White	5	3	2
Male	22	13	12	Black	21	12	13
	26	15	15		26	15	15

In 2003, **24** 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	6	Firearm	9
Other Inflicted Injury	2	Drowning	1
Vehicular	1	Other Inflicted Injury	2
		Vehicular	3

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 2003.

Representative Cases:

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

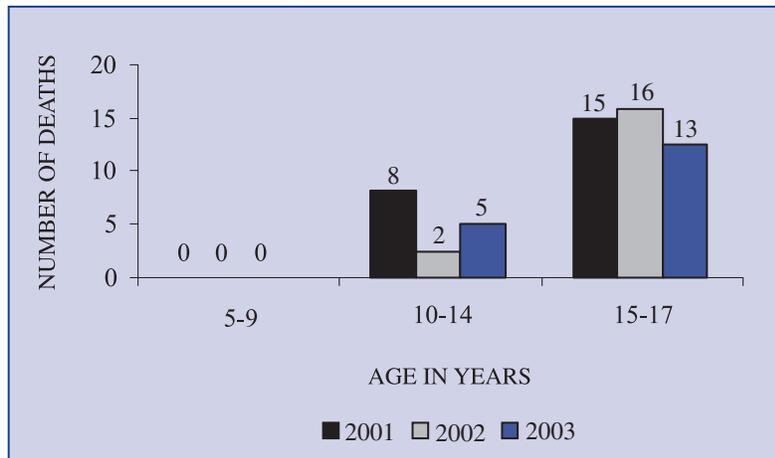
A 17-year-old was found hanging by the neck in a shed. He had become involved in criminal activity and was kicked off the basketball team.

A 16-year-old girl died of an overdose of prescription medication belonging to a family member. She had a history of depression and had been fighting with her mother. There were no prior attempts or talk of suicide.

A 15-year-old was found in the backyard of his home, with severe burns, near a plastic gas can and a lighter. He had been singing a song about suicide in the days that preceded the incident. Police discovered evidence of Internet activity that involved encouragement to commit suicide and suggestions about various methods of suicide.

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 2003, **18** children died of self-inflicted injury; **13** were age 15-17; the remaining **5** were children age 10-14.

Figure 39. Suicides by Age

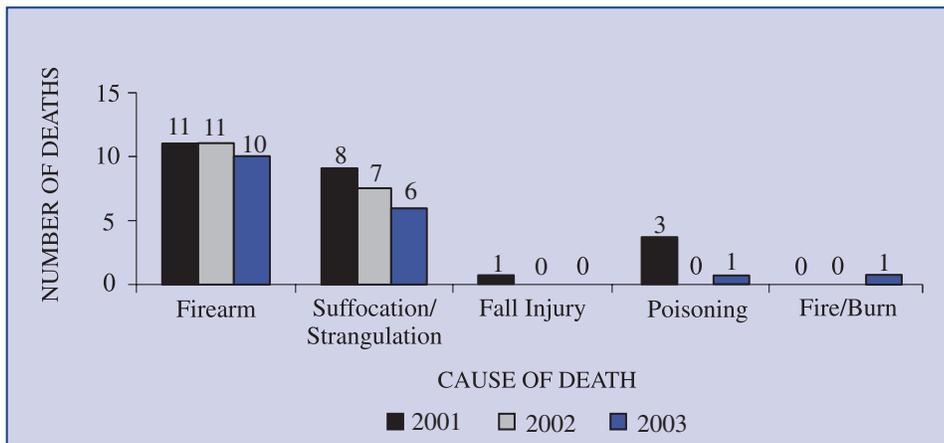


White males comprise the majority of adolescent suicide victims in Missouri. Although more females attempt suicide than males, males are approximately three times more likely to die from suicide.

Figure 40. Suicides by Sex and Race

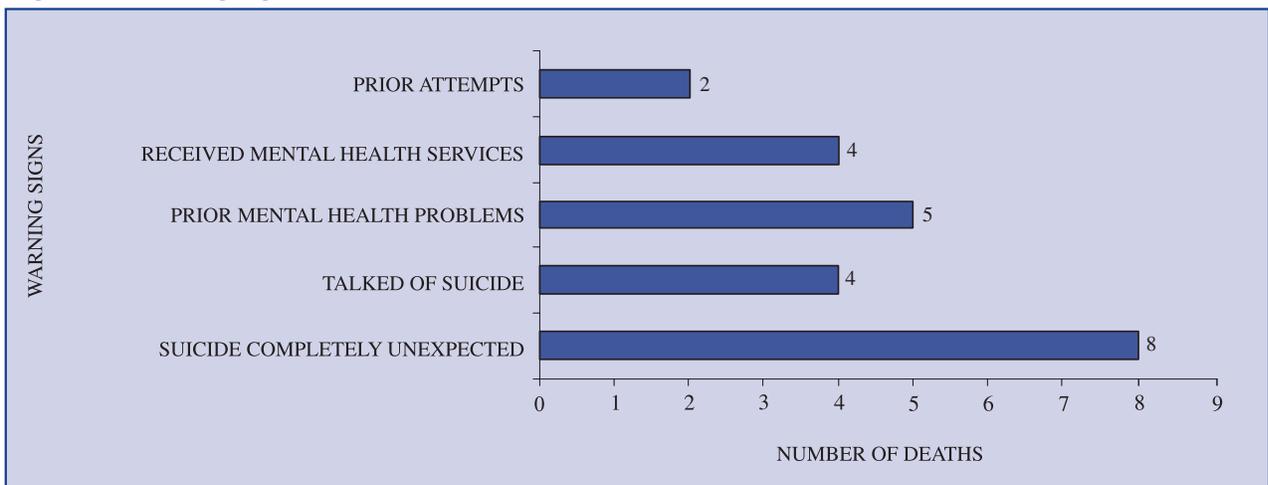
Sex	2001	2002	2003	Race	2001	2002	2003
Female	3	1	4	White	18	17	15
Male	20	17	14	Black	5	1	3
	23	18	18		23	18	18

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 2003, 8 (44%) 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.

Missouri’s Response:

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, a conference was convened that same year in Kansas City titled: “Creating Community Action for Suicide Prevention: Bringing a National Dialogue to the Community.” Missouri delegates met and began to outline strategies to address suicide prevention in our state. Subsequently a small writing group convened to develop a draft of Missouri’s State Plan for Suicide Prevention, which includes specific Missouri statistics, prevention resources within state government, risk/protective factors applicable to Missouri, and specific strategies based on the AIM blueprint.

Prevention resources in Missouri government include the Department of Health and Senior Services, the Department of Mental Health, Department of Elementary and Secondary Education, Department of Social Services, Department of Corrections and Caring Communities. The Department of Elementary and Secondary Education was mandated to develop a suicide prevention plan for schools by SB 994, which was passed in 2000.

Within the Department of Social Services, the child abuse and neglect hotline is a source available to address suicide prevention intervention for the Children’s Division. Foster parents are trained to identify and respond to suicidal behaviors. Each time a child is placed in a new foster home, the suicide risk is addressed. In-home Intervention Service workers attend annual training on suicide prevention and intervention.

The draft of the Missouri Suicide Prevention Plan is available online at Missouri Department of Mental Health website, www.dmh.missouri.gov/cps/suicide/sp1.htm.

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:

Missouri Department of Mental Health www.dmh.missouri.gov/cps/suicide/resources.htm
 National Strategy for Suicide Prevention www.mentalhealth.org/suicideprevention
 American Association of Suicidology www.suicidology.org
 Kids Under Twenty-One (KUTO) www.kuto.org