Child Fatality Review Panel
Meeting Minutes/Held Via Secure Teams
October 22, 2025

Members
Kirsten Bechtel, Co-Chair, Pediatrician, Yale New Haven Hospital
Christina Ghio, Co-Chair, Office of the Child Advocate
Steven Rogers, Injury Prevention, Connecticut Children's Medical Center
Ada Booth, Pediatrician, Connecticut Children's Medical Center
TJ Michalski, Village for Families and Children
Pina Violano, Community Health, Healthcare Consultants, LLC
Liz Corley, Family Strong
Ken, Mysogland, Department of Children and Families
Ivys Arroyo, Sergeant Hartford Police Department
Ted Rosenkrantz, UCONN Health Center
Gregory Vincent, Office of the Chief Medical Examiner
Adelita Orefice, Department of Public Health
Brett Salafia, Assistant States Attorney

Excused
Andrea Barton Reeves, Commissioner of Department of Social Services
Samantha Haynes, Department of Emergency Services & Public Protection
Meghan Scanlon, CT Coalition Against Domestic Violence

Guests
Gary Wallace, CTCADV
Rosemary Wieworka, DCF
Kim Karanda, DMHAS
Shayna LaFlam, DPH
Lisa Backus, Hearst Media
Jaclyn Meserole, OCME
Kate Dormont, OCA Intern
Howard Sovronsky, OBH
Allison Jacobson First Candle
Astread Ferron-Poole, DSS
Thea Montanez, OTG
Melanie Kmetz, DCF
Sierra Yanaway, CTCADV

OCA Staff
Brendan Burke
Lucy Orellano

Minutes
A motion was made to approve September 24, 2025, minutes by Steve Rogers. A second to the motion was made by Pina Violano.

Virtual Packet
Meeting Agenda, Draft Minutes for September 24, 2025.

CFRP Data- Brendan Burke

There were 6 deaths reported to the OCA by the OCME for the month of October, one death was a motor vehicle accident (MVA) and the drivers were the child's parents. The remaining 5 deaths are pending further study (PFS), 2 of those cases involved unsafe sleep practices and one was the child found in the storage bin which made national news. A brief overview of safe sleep deaths that occurred in 2025 was given; in total, there have been 49 non-natural child deaths so far which is trending lower than in previous years.

Presentation (s)

Overview of OCME process in determining manner of death for infants- Dr. Vincent, OCME-

In CT the Office of the Chief Medical Examiner is a state-based system, therefore every non-natural, Suspicious or death that does not occur in a hospital in CT falls under their jurisdiction. Autopsies occur every day of the year and there are exceptions to those who get an autopsy. For the year 2024 there were 25,445 cases called into the OCME, 3,130 of those cases were examined and 2,747 received autopsies. There were 110 pediatric patients (18 yrs and younger), with 32 of those being infants. The differences between Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Death (SUID) and Sudden Unexpected death determinations were explained. SIDS deaths are rare and must meet certain criteria. Most common manner of death for infant's that come to the OCME, is Undetermined. Undetermined is a manner of death that is used when you have two or more equally compelling sets of circumstances to explain how a death occurred. For those aged 1 yr through 18 yrs the most common manner is Accident.

First Candle, Safe Sleep Response Course, Alison Jacobson (HBD)

The Let's Talk program, which is in its third year, has had 364 participants. Program staff engage parents in the community and build relationships with families which results in families who are confident in applying what they have learned. Staff discuss a wide range of topics with parents and provide useful resources. Families are also provided with infant supplies as needed.
First Candle also provides Safe Sleep response training; there are different trainings available depending on the profession of the person responding to the scene or interacting with the family afterwards.
From Trust to Transformation- Frist Candle's Community Bases Safe Sleep Education

Sleeping Safety at Yale New Haven, Kirsten Bechtel MD

The Safe Sleep Quality Improvement Committee at Yale New Haven Hospital (2019) was created to address infant deaths due to unsafe sleep conditions. The multidisciplinary committee consists of various medical staff. The goal of the committee is to review the circumstances surrounding infant deaths and to implement strategies to educate new parents. Strategies include teaching via modeling which occurs when any child under the age of 1 year is admitted to the hospital. There are currently several hospitals participating in the QI process.

Link to Presentation- https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:16625460-5747-4275-b9c2-84da0b39fd35

Related Links

Impact of statewide safe sleep legislation

Executive Session

No Executive Session.

Old business/ Reoccurring items

CFRP co-chairs will work on coming up with a process to add rotating members who have lived expertise/ experience.
Legalization of Marijuana, ingestions, and fatalities.
A possible summit to discuss adolescent deaths may be conducted by the panel at a future date.
Look at the curriculum for CT High School students on safe driving and the GDL program.

Meeting Recording

https://ctvideo.ct.gov/oca/Child_Fatality_Review_Team-20251022_090244-Meeting_Recording.mp4

Motion to Adjourn

Motion to adjourn was made by Pina Violano and Seconded by Brett Salafia.

Next meeting

November 19, 2025