STATE OF CONNECTICUT

OFFICE OF THE CHILD ADVOCATE

CHILD FATALITY REPORT:

CHILDREN BIRTH TO THREE (2013)

PREVENTING INFANT—TODDLER DEATHS IN CONNECTICUT

COMPREHENSIVE REVIEW AND ASSESSMENT
INFANT AND TODDLER DEATHS IN 2013
BEST PRACTICE RECOMMENDATIONS

July 31, 2014

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INTRODUCTION

The death of a child is a profound loss to the family and the community that surrounds the child. Even after a close look at "why" a child dies, there may be questions left unanswered. We submit this report with the utmost respect to families who have lost a child. A review of child fatalities is essential for us to understand how better to support children and families and how to prevent tragedies in the future. Infants and toddlers are most at risk for sudden and untimely death and we therefore focus this report on them. They are completely dependent on an adult caretaker and are the most vulnerable and least visible children in our community. Connecticut and national data confirm that the vast majority of maltreatment-related deaths are children birth to three.[1]

It is vital to note that Connecticut has many promising and innovative supports that effectively reduce and prevent harm to children. It will be our collective obligation as stewards for our youngest children to bring our ingenuity to scale and support infant-toddler survival.

The Office of the Child Advocate (OCA) has a unique responsibility, authority, and access to review, investigate, and report regarding the efficacy of child-serving systems and work with stakeholders to develop and implement recommendations for change. By statute OCA is empowered to investigate unexplained and unexpected child fatalities.

The State Child Fatality Review Panel (CFRP), staffed and currently co-chaired by OCA, reviews unexplained or untimely deaths of children for the purpose of facilitating "development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state."[2]

Section I of this report will outline the manner of death for all infants and toddlers that came to the attention of the Office of the Chief Medical Examiner (OCME) during 2013.[3] Manner and cause of death are findings made by the OCME. The manner of death is a general finding regarding the circumstances in which the death happened.[4]Cause of death is a determination of the physiological findings. Classifications for manner of death for the purposes of this report include 1) Natural; 2) Undetermined; 3) Accident; and 4) Homicide.

Section II next looks at the fatalities of infants and toddlers whose families had involvement with the Department of Children and Families (DCF) prior to the child's death, and includes a detailed analysis of documented risk factors in the home. Section II will also include findings from a review of children's pediatric records. Section III concludes this report with detailed recommendations for prevention.

The Office of the Child Advocate would like to acknowledge the following people for their contribution to this report: Joan Kaufman, Ph.D., Karen Snyder, M.A., the Child Fatality Review Panel, Ankeeta Shukla from Yale School of Public Health, and Felicia McGinniss from University of Connecticut School of Law.

[1] Nationally, "four-fifths (82%) of children who died from *maltreatment* [as opposed to accidental or other preventable manners of death] were under the age of 4 years; 42% were younger than 12 months." CHILD WELFARE LEAGUE OF AMERICA, QUALITY IMPROVEMENT REPORT 32 (2014).

[2] CONN. GEN. STAT. § 46a-131 *et seq.* (2012).

[3] Not all deaths of children or adults fall under the jurisdiction of the OCME. Only sudden, unexplained, untimely deaths of children are reported to OCME.

[4] R. HANZLICH ET AL., NATIONAL ASSOCIATION OF MEDICAL EXAMINERS: A GUIDE FOR MANNER OF DEATH CLASSIFICATION 45 (1st ed. 2002).

METHODOLOGY

This report is based on:

- Review of documents from the Office of the Chief Medical Examiner;
- Cross-check of child welfare records for all infant and toddlers whose deaths were reported to OCME and OCA and review of child welfare records (N=24) for all infants and toddlers whose families had DCF involvement at the time of or prior to the child's death;
- DCF records reviewed included all records available in LINK—records related to investigation, ongoing case work activity, supervision, risk assessment, and treatment planning;
- DCF Internal Special Review Fatality Report;
- Review of pediatric health records for children with DCF involvement;
- Multiple interviews with pediatric providers;
- Collaboration with Yale University researcher Joan Kaufman, Ph.D. to analyze data relevant to an understanding of 2013 child fatalities;
- Consultation with treatment providers;
- Literature review on the topics of child fatality review, risk, and safety assessment; pediatric best practices, fatality prevention, Sudden Explained Infant Death, early-childhood homicide, child welfare system quality assurance; and
- Review of child death reports across the country, including a recently published report by Casey Family Programs-Florida in 2013 and a report by the Child Welfare League of America, commissioned by Governor Deval Patrick of Massachusetts in 2014.

OVERVIEW OF INFANT TODDLER CHILD FATALITIES IN CONNECTICUT

In 2013, OCA reviewed 82 fatalities of children age birth to three; 59% of these children were boys and 41% were girls. The manner of death can be broken down as follows:

Overall 2013 Child Fatalities N=82	Child Fatalities with DCF Involvement N=24
Natural=44 (54%)	Natural= 3 (12%)
Accident=12 (15%)	Accident=6 (25%)
Homicide=10 (12%)	Homicide=5 (20%)
Undetermined=16 (19%)	Undetermined=10 (41%)

SECTION I

Overview of Fatalities of Children in Connecticut Birth to Three

NATURAL DEATHS OF CONNECTICUT CHILDREN

AGE BIRTH TO THREE

A child's death may be classified as natural where a child dies from complications due to prematurity, known medical illness or disease, or even when there is a finding of Sudden Infant Death Syndrome (SIDS). There were 44 deaths of children age birth to three in 2013 that were classified by the OCME as Natural. Important prevention findings may arise even from natural deaths. For example, some prematurity-related deaths may implicate quality of prenatal care, presence of prenatal substance abuse, or other mutable health factors. Fourteen of the natural deaths were deemed caused by complications from prematurity.

A child's death may be classified as natural and due to SIDS—a finding historically attributed to a sudden death of a child where there were *no other physiological findings present.* However, data continues to reveal that many children whose deaths are classified as natural/SIDS are often found in unsafe sleep environments. Last year, 7 of the natural deaths were deemed to be caused by SIDS.

Unsafe sleep-related causes of infant death are linked to how or where a baby sleeps. Deaths may be due to blockages of the nose/mouth, entrapment/chest compression (when an infant gets trapped between two objects, such as a mattress and wall, and cannot breathe, or overlying), or suffocation from a low oxygen/high carbon dioxide environment (under a blanket).

Because of a lack of uniformity in classifications, some Connecticut infant fatalities associated with unsafe sleep conditions in 2013 were classified as "Natural" and some were classified as "Undetermined." To calculate how many infants' deaths are associated with unsafe sleep conditions, the numbers of SIDS and Undetermined deaths that revealed unsafe environmental sleep factors must be added together.

The National Association of Medical Examiners recommends that generally SIDS deaths should be classified as "Undetermined" rather than "Natural" because by the nature of the child's death, the definitive cause is not known.[5] This is particularly true when investigation reveals the presence of external sleep factors, such as bed-sharing, which heightens the probability of contributing to the cause of death.[6]

UNDETERMINED DEATHS OF CONNECTICUT CHILDREN

AGE BIRTH TO THREE

A child's death may be classified as Undetermined where no definitive cause is suggested by the physiological findings. Undetermined is often the classification for manner of death where an infant dies suddenly, without identifiable injury or medical cause, and/or where investigation reveals the presence of unsafe sleep factors, such as bed-sharing or sleeping on the stomach. There were 16 children in 2013 whose deaths were classified as undetermined.

[5] *Id.* at 16.
[6] *Id.*

Connecticut Infant Deaths Associated with Unsafe Sleep in 2013

In 2013, there were at least 18 infants whose deaths were classified as Natural (due to SIDS) or Undetermined and where risk factors associated with their sleep environment were present. The majority of these infants were boys and the average age at the time of death was 3 months. These deaths should be considered largely preventable.

Rates of sudden, unexplained infant death have been relatively consistent over the last several years.

OCA-CFRP data shows that infants in Connecticut are more likely to die from unsafe sleeping conditions than from child abuse, car accidents, choking, drowning, falls, or any other source of accidental injury.

Baby G was nearly 6 months old when he died unexpectedly. He was fed at 11pm. Baby G was often put in his swing after he ate. However, his mother fell asleep and when she awoke a few hours later she assumed that that the baby's father had put him in the baby swing. A couple of hours later, the parents discovered the baby face down in their bed. Baby G was swaddled in a manner that made it difficult for him to move. Baby G's death was classified as Undetermined.

Most Common Unsafe Sleep Environments in Connecticut Fatality Cases

- Co-sleeping in an adult bed with parents or siblings
- Sleeping in a car seat overnight, not in the car
- In a crib with blankets, pillows, or placed on their stomachs
- Put to sleep with a bottle in an adult bed

ACCIDENTAL DEATHS OF CONNECTICUT CHILDREN

AGE BIRTH TO THREE

A child's death will be classified as accidental when death results from an unintentional injury. Twelve children ages birth to three died in 2013 from accidental injuries.

Fatality due to unintended injury is one of the leading manners of preventable death, both in Connecticut and across the nation. Across the years, the leading causes of accidental injury were motor vehicle accidents followed by drowning.

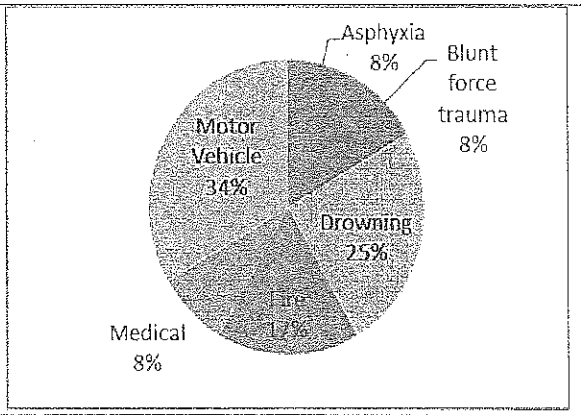
The causes of deaths of young children classified as accidental are delineated below. Children under 3 are at the greatest risk for unintentional injuries resulting in death.

Two-and-a-half year old Baby J's parents took him off life support two days after he was found in a pool. The little boy had been playing with his family and friends when he left the house, unnoticed. The ladder to the pool had been pulled up and there was an alarm on the door leading to the pool. However, the alarm was not activated because the door had not been properly closed. Though many safeguards were in place, they were ineffective at keeping J safe. Baby J's death was ruled an Accident.

Deaths listed here caused by drowning and asphyxia highlight supervision issues above any other prevention activity. At least one of the motor vehicle accidents involved a 2 year old child being run over in his own driveway, implicating the capacity of the driver (who was later deemed under the influence) and parental supervision. Two out of the 3 children who drowned died in family pools. The third child died in a bathtub after the mother fell asleep—investigation later revealing that she was under the influence at the time of the child's death.

Accidental Death (N=12) Broken Down by Cause Among 0-3 year olds in 2013

Cause	Number (%)
Asphyxia	1 (8%)
Blunt force trauma	1 (8%)
Drowning	3 (25%)
Fire	2 (17%)
Medical	1 (8%)
Motor Vehicle	4 (34%)



DEATHS DUE TO HOMICIDE OF CONNECTICUT CHILDREN AGE BIRTH TO THREE

A child's death may be classified as a homicide when a violent death results from another person's reckless, hostile, or illegal acts against another person. In 2013, there were 10 homicides of children age birth to three in Connecticut. This is the highest number of reported homicides of young children in Connecticut since OCA and CFRP began collecting data on child deaths more than 10 years ago. The method of death among these 10 young homicide victims was as follows:

- 7 children died from abusive head trauma or other blunt force traumatic injuries
- 2 children died from gunshot wounds
- 1 child died as a result of homicidal asphyxia

The alleged or convicted perpetrators in these homicides were primarily men; fathers in 4 cases (40%), mother's boyfriend in 3 cases (30%), maternal grandmother in 2 cases (20%)—(1 incident), and unknown in 2 cases (20%).[7]

Since 2001, there have been 61 homicides of children 0-5, of which 58 (95%) were children 3 and under. Averaging across the years, birth to three year olds were approximately 20 times more likely to die of homicide than 4 or 5 year olds. The change in risk of fatality among very young children is enormous, and likely not appreciated enough in calculating safety risk for young children. As noted above, more young children died of Homicide in 2013 than in any of the previous years. It will be important to determine if this was an anomaly or the initiation of a disturbing trend.[8]

[7] Due to the notable number of young child homicides this past year, the Public Health Committee of the General Assembly has commissioned a study of Family Violence to derive recommendations for improving outcomes for vulnerable children and families.

[8] Please see Appendix to this Report, entitled OCA/CFRP Public Health Alert: Infant and Toddler Homicides.

More than 2,000 children die each year from child abuse and neglect in the United States. Most deaths result from fatal head trauma such as when an infant's head is violently shaken, slammed against a surface, struck by a caregiver, or from fatal abdominal injury, when a child's abdomen is struck, and leading to internal bleeding. Connecticut, similar to the rest of the country, sees a higher incidence of child maltreatment fatalities in boys.

Providing information and support to mothers about the strengths and needs of fathers and male partners when it comes to child care is also essential for child maltreatment prevention.

Connecticut and national data confirm that male caregivers are more likely to be the perpetrators of fatal injuries to young children.[9] Some of these male caregivers reported that they fatally injured the infant or child because they lost patience when the child would not stop crying or would not sleep. Male caregivers are less likely to accompany mothers and their children to well-child care appointments and therefore may be missing important information about child development.

National and state data informs us that children are more at risk for fatal child abuse while in the care of a male partner or father without the presence of the mother.[10] However, research also confirms the positive role that fathers play in children's lives and the decreased likelihood for maltreatment generally in two-parent families.[11] There should be engagement with young and at-risk fathers and male partners by local health care providers, hospitals, pediatrics, Ob-Gyn providers, and home visitors to identify support and other needs as well as strengths of the father/male partners. This work will be essential to increasing parental competencies, reducing frustration, and addressing other identified risks. Service providers must also have strategies to engage male partners and fathers who are not living in the home but who may at times have a caretaking role with children. Educating both male partners and mothers about the dangers of shaking a baby can also be an effective prevention tool.[12]

When Baby M was 13 months, her mother brought her to the emergency department after mother's boyfriend, who had been babysitting M, said the baby had bumped her head while crawling and did not seem like herself. At the hospital the baby was reportedly alert and acting normally. Mom reported she had been dating the boyfriend for about 2 months, but she had known him for many years.

Two days later Baby M was brought back to the emergency department with fatal injuries. The boyfriend reported that Baby M had fallen off the bed and wasn't moving. He put her in the car and drove to the hospital. He did not call 911. Mother's boyfriend gave different explanations to the police for how Baby M could have gotten hurt, including falling off the bed, and her head snapping back and forth when mother's boyfriend tossed her in the air.

The autopsy report indicated that Baby M suffered a subdural hemorrhage of her spinal cord and a retinal hemorrhage. She had abrasions of her mouth, her back, and her left wrist. Baby M had sustained blunt head trauma, and acetaminophen and opiates were present in her system. The Medical Examiner ruled Baby M's death a Homicide. The boyfriend was arrested for Baby M's death.

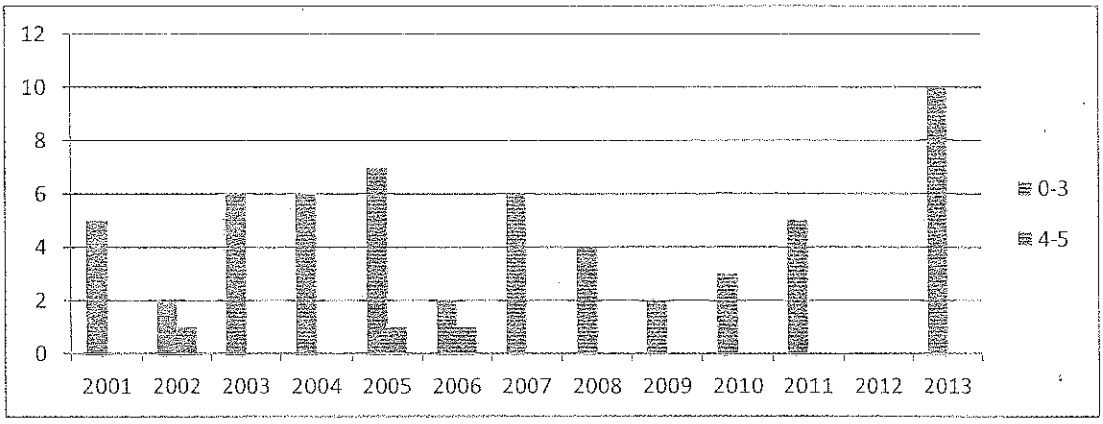
[9] *See generally* DEPT. OF HEALTH AND HUMAN SERVICES, MALE PERPETRATORS OF CHILD MALTREATMENT: FINDINGS FROM NCANDS (2005), *available at* http://aspe.hhs.gov/hsp/05/child-maltreat/report.pdf (report describes findings that males are more likely to be the perpetrator in a child abuse case).

[10] *Id.*

[11] *Id.* at 2 (referencing a 2002 Child Trends Report).

[12] Video: Portrait of a Promise: Preventing Shaken Baby Syndrome 2002 (New York City Administration for Children's Services); E.M. Douglas, *Child Maltreatment Fatalities: What do We Know, What Have We Done and Where Do We Go From Here?, in* CHILD VICTIMIZATION 4.1–4.18 (K. Kendall-Tackett and S. Giacomoni, Eds. 2005).

Connecticut Child Homicide Data 0-5



FINDINGS REGARDING CHILD FATALITY REPORTING

Connecticut, like many states, struggles to collect and report data regarding preventable infant and toddler deaths, particularly those that are associated with concerns of possible abuse or neglect. For example, we are not able to *reliably* report how many "Unexplained," "Sudden Unexplained Infant Deaths," or SIDS deaths are associated both with "unsafe sleep conditions" *and* concerns regarding parental substance abuse. The Office of the Child Advocate was challenged in compiling meaningful trend data for this report to better inform policy makers and the public.

A federal Government Accountability Office (GAO) report in 2011 indicated that many states are challenged in determining and reporting data regarding whether a child's death is caused by abuse or neglect.[13] This means that we do not know the true extent of fatalities caused or contributed to by abuse or neglect. In response to the GAO report, a federal commission has been charged with making recommendations to the President and Congress. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) is a federal advisory committee established by the Protect Our Kids Act of 2012.[14] According to the enabling legislation, the commission's work includes an examination of

> best practices in preventing child and youth fatalities that are intentionally caused or that occur due to negligence, neglect, or a failure to exercise proper care; the effectiveness of Federal, State, and local policies and systems . . . aimed at collecting accurate and uniform data on child fatalities . . . ; the current . . . barriers to preventing fatalities from child abuse and neglect, how to improve child welfare outcomes; trends in demographic and other risk factors that are predictive of or correlated with child maltreatment, such as age of the child, child behavior, family structure, parental stress, and poverty; methods of prioritizing child abuse and neglect . . . ; and methods of improving data collection and utilization, such as increasing interoperability among state and local and other data systems.[15]

[13] U.S. GOV'T ACCOUNTABILITY OFFICE, CHILD MALTREATMENT: STRENGTHENING NATIONAL DATA ON CHILD FATALITIES COULD AID IN PREVENTION 9–16 (2011).
[14] Protect Our Kids Act of 2012, Pub. L. No. 112-275, 126 Stat. 2460 (2013).
[15] Protect Our Kids Act of 2012, Pub. L. No. 112-275, 126 Stat. 2460(g)(a)(2).

SECTION II

Fatalities of young children where caregivers had involvement with the Department of Children and Families (DCF)

Overview

The Office of the Child Advocate has a unique responsibility to review, investigate, and report regarding the efficacy of child-serving systems. The OCA has a responsibly to examine those child deaths that had involvement with our state child welfare safety system. Twenty-four of the infant and toddlers deaths that came to the attention of the Medical Examiner and OCA in 2013 lived in families with DCF involvement prior to or at the time of the child's death.

DCF, like many child welfare agencies across the country, is transforming its work with families to keep more children home by strengthening the family unit. Because a child dies in a home with an open DCF case does not mean that keeping families together, as a goal, is ill fated or undesirable. Some of the cases described in this Section raise questions and sometimes significant concerns regarding the efficacy of DCF practice with an individual family or the adequacy of its protocols for ensuring infant safety in high-risk homes. Not all case records, however, reveal an established link between a DCF practice issue and a subsequent child fatality, and DCF involvement (or lack thereof) is not always the pivotal factor in each child fatality.[16] Yet, a review of all cases provides useful information regarding risk factors in families that may contribute to the preventable deaths of children. Some of these deaths are due to maltreatment, some are undetermined, and some are accidental. Understanding these risk factors will have implications for our children's safety net, and not just for DCF.

Manner of death for these 24 children:

10 deaths were classified as "Undetermined"
6 deaths were classified as "Accidental"
5 deaths were classified as "Homicide"
3 deaths were classified as "Natural"

Age of the 24 children who died

0 to 12 months: 15 children
13 to 24 months: 6 children
25 to 36 months: 3 children

As previously mentioned, most states are challenged with defining what it means for a child to have died due to actual or suspected abuse or neglect ("maltreatment deaths"). In Connecticut, it has been reported that a "maltreatment" death is so defined when "at least one allegation of abuse or neglect related to the death has been substantiated [by DCF] against a caregiver."[17] A review of DCF records related to deaths described in this Section reveals that there were 9 children's deaths where an investigation by DCF led to the substantiation of an adult caregiver for abuse or neglect.[18] The substantiated adult in these 9 cases was either the parent or the boyfriend of a caregiver. This does not mean that the caregiver/boyfriend who perpetrated the abuse or neglect was always known to DCF prior to the child's death.[19]

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[16] See infra n.19.

[17] J. Kovner, *With Child Abuse, Neglect Deaths Rising, Early-Detection Doctors Deployed*, June 29, 2014, HARTFORD COURANT, June 29, 2014.

[18] A tenth child's post-death investigation also included a substantiation of neglect, but the DCF records indicate that the substantiation was for exposure to conditions injurious to the children's well-being. DCF records did not draw a clear link between those conditions and the child's death.

[19] DCF reviewed a draft of this report and provided feedback on this data point. DCF stated in a written response that it would not classify these 9 fatalities as "maltreatment" fatalities because they were not all acts committed by the parent. DCF further indicated that "at most, five homicides fit that category but, even of the five, there is a question… because in [two cases] the primary caregiver known to us was not the perpetrator of the act that caused the child's unfortunate fatality. We want to be clear that of the 9 fatalities, all of them are tragic and could have been prevented." Letter from Joette Katz, DCF Commissioner, to Sarah Eagan, OCA (July 18, 2014) (on file with author).

Regardless of whether a preventable death is ultimately classified as due to "maltreatment," it is important to recognize the risk factors that exist prior to a child's death. For example, several of the infants who died while co-sleeping with a caregiver were exposed prenatally to substances and lived in homes with caregivers continuing to struggle with substance abuse. Not all of these caregivers, however, were substantiated by DCF for abuse or neglect related to the child's death.[20]

Section II focuses on all 24 of the children, most of whom died from preventable causes, and examines the risk factors present in the home and the implications for child welfare practice and a multi-agency public health response.

Most of the families who had involvement with DCF were also involved with other providers and systems of support and intervention such as doctors, community providers, the judicial system, and other state agencies. Prevention of maltreatment and child fatalities starts with a public health approach to healthy parent-child relationships, supported and strengthened by holistic pediatric care, a robust early-childhood system of care, and access to intensive, therapeutic parent-child supports.

Recommendations emanating from this focused review fall into 2 categories. The first category is comprised of actions that the child welfare agency can take to specialize its approach to our most at-risk children: infants and toddlers who are suspected victims of abuse or neglect. The second category includes things the community and health care systems can do to improve interventions for parents and children and prevent maltreatment before it occurs.

Concurrently, it is also critical to note that at any given time DCF works with thousands of children age birth to three, many living at home with a caregiver and others in foster care. There are many successes to report and an increasing number of services that support parents and children in the home. DCF is incorporating more evidence-based teaming (a collaborative decision-making model for child welfare-involved families) into its practice and assisting with development and expansion of innovative parent-child treatment services. DCF has also begun to scale up its training for case workers regarding the specialized needs of infants and toddlers and is working to further professionalize its workforce and improve the quality of supervision. These efforts are critically important.

DCF, along with child protection agencies in many states, is moving towards a family preservation model of child welfare practice, one that looks to keep children home whenever possible and reduce reliance on foster care. Given this shift in child welfare practice, it is imperative that we recognize the workforce development implications for the child welfare agency and community providers as well as the critical need for services that will be effective for parents–particularly of infants–who struggle with mental health challenges, substance abuse, or domestic violence. The cases reviewed here show that gaps remain between what we aspire our practice and community services to be and what is actually being provided. These gaps have implications for workforce development, investigations, risk assessment, service development and strategic funding, caseload levels, quality assurance, and strong community partnerships.

[20] For example, in one case a caregiver was substantiated for having the baby in an unsafe sleep environment, but in at least two other cases where a baby was found in the bed and the caregiver admitted drinking alcohol before going to sleep, there were no resulting substantiations.

Statistical Overview

Comparison with Non-DCF Cases. Compared to children without a DCF history, children with a history of DCF involvement were half as likely to die by Natural causes, twice as likely to die by Accident, and more than three times as likely to die by Homicide.

Case Status. Of the 24 cases with a history of DCF involvement prior to the child's death, 10 cases were open at the time of the child's death, 4 cases had closed within 6 months of the child's death, 5 cases had closed within a year of the child's death, 4 cases had closed more than a year before the child's death, and the last case was referred once and tracked for a family assessment review.

Number of Prior Referrals. Families had on average 4 prior referrals to DCF (range: 1-14), and there was no statistical difference in the number of referrals for families of children who died of Accident, Homicide, Natural, or Undetermined causes.

Risk Factors. The majority of the adult caretakers in these children's lives had multiple risk factors– 15 (62.5%) of the mother's had a history of DCF involvement as children; 9 (37.5%) had known criminal histories; 12 (50%) had known substance abuse problems or admitted use near the time of the child's death; 13 (54%) had a history of domestic or family violence; and 15 (62.5%) had known mental health problems. The male partners of these women also had numerous known risk factors: 9 (38%) had a history of DCF involvement as children; 16 (66.7%) had known criminal histories; 12 (50%) had known substance abuse problems or admitted alcohol or drug use at or near time of death; 9 (37.5%) were involved in violent relationships; and 9 (37.5%) had known mental health problems.

UNDETERMINED DEATHS WITH DCF INVOLVEMENT

Undetermined is a manner of death that often is listed for infants when no medical cause of death is found; it is unknown. Like certain "Natural" deaths, Connecticut data confirms that often these infants are found in unsafe sleep environments. There were 16 infant and toddler deaths categorized as Undetermined in 2013, 10 of these children were known to DCF. At least 9 of the children's records documented that they were in an unsafe sleep environment at the time of death. Nine of the children were 6 months old or less and 1 child was 17 months old at the time of death. As previously stated, this section not only seeks to examine DCF practice issues, but also to explore risk factors present at the time of a child's death. The purpose of this discussion is to better understand these families and not to lay liability for each fatality with DCF.

Baby J died when she was 2 months old, apparently found in the family bed on her stomach by her father. The family had a history of 10 prior DCF reports, including a termination of parental rights. Both parents had an extensive history of substance abuse and domestic violence. Baby J was exposed to drugs prenatally and a report had been made to DCF. Given both parents' history of alcohol/drug abuse, DCF requested that they submit to a substance abuse evaluation. Mother agreed, and was referred for out-patient services. Father did not agree. DCF kept the case open for ongoing treatment due to family's significant history and mother's pregnancy—a good practice development. DCF's investigation of the report was well-documented and thorough. A DCF substance abuse specialist consulted on the case and gave advice regarding engagement and treatment planning for mother. After the baby's birth DCF was still not able to engage father with evaluation or services. Father spent a significant amount of time with the children, and father was Baby J's caretaker while mother worked. The baby died in father's care while mother was working. Father admitted to drinking beer before bed, but denied being intoxicated. Father denied using Nyquil that was found next to the bed. It appeared that multiple children were also in the bed at the time of death. Father could not explain why baby J was in the bed and not in the bassinet. DCF referred surviving siblings for trauma-informed supports. This case underscores the importance of understanding strengths and risks of both caregivers and using that information to inform case decisions. Father was not substantiated for neglect associated with the child's death.

Family Risk Factors

Children are at greater risk of sudden infant death in homes where the parent/caregiver smokes, is substance using, or has untreated mental health challenges.[21] In these cases, several of the families struggled with substance abuse and mental health issues. We outline the risk factors here given the notable prominence of substance use/abuse and child welfare history.

Substance Abuse (N=10)

- 7 of the children who died in this category had a caregiver with a documented history of substance use or who admitted using alcohol or substances prior to going to sleep with or near the baby;
- 2 of these caregivers indicated they used alcohol before going to bed;
- 3 of the children lived with a caregiver with a history of methadone use;
- 5 of the children were exposed prenatally to substances; and
- 7 of these children lived in families with open DCF cases at the time of their death.

DCF History (N=10)

- All 10 of the children who died lived in families that had been previously reported to DCF;
- 7 of the children's cases were open with DCF at the time of their death;
- Histories with DCF ranged from 1 previous report to 14 previous reports; and
- 8 of the children's mothers had their own history with DCF as a child.

DCF records did not routinely reflect collaborative case planning between providers, the Department, and the family, nor did records clearly document how parenting capacity and child safety was being determined based on provider feedback.

Baby T died when he was 2 months old, while reportedly sleeping in his car seat. His family had a history of 14 prior DCF reports and juvenile court involvement regarding child neglect. DCF had closed the case only days prior to Baby T's death. The most recent report alleged that a relative found Baby T crying on the floor of his parents' room during the night. Parents denied the allegations and said they put the baby in a crib in another room. Parents admitted to drinking the night before, but both indicated alcohol and drugs were not a risk factor in the home. Father stated that he was involved, through probation, with an outpatient substance abuse treatment provider.

DCF referred both parents for substance abuse evaluation but later noted that both parents were a "no show" for the evaluation. DCF's nurse specialist consulted on the case, but there was no documented involvement of DCF's regional substance abuse or mental health specialists. DCF put a safety agreement in place requiring T's parents to use a crib and to refrain from alcohol or drug use while caring for the child. DCF noted that the parents did not comply with the substance abuse evaluation and family's risk level was assessed to be "moderate" based on family history. DCF closed the case stating that "further DCF intervention is not required as the family is adequately caring for the children."

After Baby T's death only weeks later, DCF obtained information from father's outpatient provider that indicated father was in fact engaged in a weekly group program, but had been continually testing positive for alcohol and/or drugs during the preceding months. This information did not appear to have been obtained by DCF investigations before closing the prior investigation.

DCF did not substantiate neglect against either parent in Baby T's death, but they kept the case open for ongoing treatment. Baby T's case raises concerns about the quality of the investigation preceding his death, the minimization of the family's history with DCF, and the impact of stressors in the home on the baby's safety.

[21] *See* FLORIDA STATE UNIV. CTR. FOR PREVENTION AND EARLY INTERVENTION POLICY, PARTNERS FOR A HEALTHY BABY HOME VISITING CURRICULUM: BABY'S FIRST SIX MONTHS RESEARCH BASIS (2011), *available at* http://www.cpeip.fsu.edu/resourceFiles/resourceFile_131.pdf (describing the effects, including death, on young child whose parents smoke, abuse substances, have experienced trauma, or have mental health challenges).

The majority of the mothers, fathers, or male partners presented with multiple risk factors or stressors, indicating a need to increase parenting capacity, address trauma histories, substance abuse challenges, mental health issues, and relationship choices.[22]

Summary of DCF Assessment, Case Planning/Service Delivery for Undetermined Deaths

All of these families had prior histories with DCF and presented with multiple risk factors. Records varied in how these histories were incorporated into assessment and decision-making. Seven of the 10 children whose deaths were deemed Undetermined lived in families with open DCF cases at the time of their death. At least 4 families were involved with some type of in-home service provider. In-home services included a parent-child program for recent substance abusing caregivers, an intensive family preservation service, and traditional home visiting/parent education. Typically these providers visit the home multiple days per week and work to address the parent's need for intervention and support as well as the child's emotional and developmental needs. The services have different clinical focuses and are not interchangeable.

The majority of families were involved in some out-patient treatment program (substance abuse treatment, mental health treatment, medication management). Out-patient services vary in terms of what's offered, whether services are provided one-on-one and how often parents are expected to participate.

DCF records often reflected information sought and obtained from a provider and included the degree of participation, attendance, and drug testing results. Records did not consistently reflect a distinction between a parent's compliance with services versus parental engagement and benefit from treatment provided.

DCF has a "High Risk Newborn Policy" calling for expedited engagement and heightened visitation for children born with positive drug screens, serious medical problems, or whose mother presents with significant challenges, for at least the first 4 weeks post-discharge from the hospital. A review of the 10 Undetermined child deaths revealed at least 5 children who were prenatally exposed to substances. None of these cases resulted in a substantiation of neglect due to the prenatal drug exposure, though all remained open with DCF for ongoing treatment. None of the case records seem to apply the High Risk Newborn Policy, though at least 2 of the cases reflected heightened visitation during the first several weeks of the case. It is important to develop and implement a heightened practice protocol for at-risk newborns and extend the duration of a newborn policy for at least the first 6 months of life.

Baby CS died at 2 months of age while co-sleeping with his mother. Case records indicate that both a visiting nurse and the DCF investigations worker had previously counseled the mother regarding safe infant sleep practices. Mother indicated she had prescriptions for psychotropic drugs and narcotic pain medication.

Mother had a history of substance abuse, and had a positive screen for marijuana a month before Baby CS' death. DCF had investigated prior reports on Baby CS' mother and parents were referred for out-patient substance evaluation and treatment. Mother was also involved with outpatient mental health provider for medication management.

DCF determined the family made progress toward their treatment goals during the course of the open case. The DCF Regional Nurse Specialist consulted on the case, but no documentation indicated that the regional mental health specialist was consulted. The family's case was slated for closure at the time of the child's death.

When Baby CS died, police visiting the scene called in a report to DCF alleging that the baby's home conditions were deplorable. DCF investigated anew, and ultimately substantiated the caregivers for physical neglect. The case raises concerns about the appropriateness of therapeutic interventions, evaluation of progress in treatment, and discrepancy between observations of police and child welfare professionals.

[22] Please note that for both mothers and male partners, some case records do not document a mental health diagnosis though the parent presents or has a history of multiple challenges or stressors such as a criminal history, substance abuse, and domestic violence history. Additionally, some of the information is self-reported and therefore not 100% reliable.

Safe Sleep Counseling

Some of the case records documented counseling regarding "safe sleep" issues for caregivers and babies. Not all records clearly documented this guidance. None of the records reviewed documented a *sustained* counseling effort by DCF or treatment providers to address safe sleeping issues in the home or risk factors in the home that result in children's heightened vulnerability to sudden infant death such as alcohol, substance use, smoking, medication, or untreated mental health issues. None of the case records documented/noted the heightened risk of infant death due to the presence of these factors. Again, this does not mean that these risks are not appreciated by providers, case workers, or supervisors, or that conversations did not take place. Authors refer to a succinct statement from a recent systemic child death review completed in Florida by Casey Family Programs,

> ***Giving information regarding co-sleeping once to drug addicted parents, or to substances abusing parents not established in a recovery process, and having these parents sign agreement to refrain from co-sleeping with infants, is a highly risky and questionable basis for safety planning.*** [23]

Accordingly, frequent reinforcement of the risks of sudden infant death in homes experiencing multiple risk factors or stressors, as well as incorporation of safe sleep practices into a family's case plan, are important steps in preventing these tragedies. As of 2014, DCF has a new policy regarding safe sleep counsel and treatment planning to address the prevalence of this risk for DCF involved families. Ideally, records will reflect how safe sleep issues are being worked on by DCF and community providers, and with what frequency; including whether there are face-to-face meetings to discuss risks, goals, expectations, and progress. Case planning should include discussion and strategies regarding the common issues that may lead to co-sleeping such as concern regarding baby's sleep, parent's lack of sleep and exhaustion, infant fussiness, etc.

The stories included paint a picture of the risk these children lived with: open child welfare cases, substance use, and prior child welfare referrals. Given the number of children and families that DCF and the provider community engage with at any given time, there are

Baby C was almost 4 months old when she was found unresponsive in her crib, placed on her stomach with lots of blankets and an adult size pillow. Her family's case was open with DCF at the time of her death, with a history of 5 investigated reports. A juvenile court judge terminated mother's parental rights to Baby C's siblings 8 days prior to Baby C's death. Baby C's mother used drugs while pregnant. DCF held a considered removal team meeting with the family shortly after the baby's birth to determine whether C needed to be removed due to mother's substance abuse. Considered removal is an evidence-based collaborative case planning model. Parents agreed to cooperate with DCF and community services, and Baby C went home with them. The mother was determined to be not eligible for the in-home program for recently substance abusing mothers because her use was not recent enough.

DCF referred C's parents for parenting education, Intensive Family Preservation (an in-home service), and outpatient substance abuse/methadone maintenance services. Mixed reports from providers were documented in the child welfare records. Social workers received multiple reports that mother did not participate in appointments or that she continued to test positive for drugs. The in-home provider reported some fair to positive feedback, noting that the parents seemed to enjoy discussions about child development. Later, this provider noted missed appointments and an inability to engage father due to his work schedule.

The in-home provider also expressed some concern to DCF that the parents would allow the baby to cry for long periods of time. DCF ultimately filed a legal petition alleging that Baby C was neglected in the care of her parents. The court matter was pending at the time of her death. After Baby C died, the child welfare record documented that the in-home service provider had never seen the child's crib. DCF ultimately substantiated the caregiver/s for neglect. Like other cases referenced, Baby C's case raises concerns regarding the efficacy of interventions and the urgency or appropriateness of child welfare response to an infant residing with actively substance-using parent.

[23] CASEY FAMILY PROGRAMS, REVIEW OF CHILD FATALITIES REPORTED TO THE FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES 3 (2013).

likely many families with similar profiles where no child death occurs. Yet, these stories raise important questions regarding the frequency and effectiveness of therapeutic interventions and supervision, well as the level of communication between DCF, the providers, and the family.

ACCIDENTAL DEATHS WITH DCF INVOLVEMENT

There were 12 accidental deaths in 2013—6 were known to DCF. These child deaths were attributed to accidental causes, including 2 drowning, 2 car accidents, 1 death in fire, and 1 asphyxiation due to compression behind a piece of furniture. None of these families' cases were open at the time of the fatality. And not all child deaths are linked to maltreatment. Two of the deaths resulted in a new DCF investigation and ultimately a substantiation from DCF for abuse or neglect—both fatal incidents deemed related to alcohol or drugs.

> KJ was 2 years old when he was run over in the family driveway. This child's family had extensive involvement with DCF, including 11 prior reports. Many services were involved with the family over an 8 year period. The most recent DCF case closed 3 weeks prior to KJ's accidental death. The driver was later determined to be under the influence of alcohol and drugs, and substantiated by DCF as a perpetrator of neglect in the matter of KJ's death. This is an example of an accidental death related directly to abuse or neglect.

Families' Prior History with DCF

Two families had 1 prior report; 2 families had 2 prior reports; 1 family had 11 prior reports, including involvement that ended weeks before the child's death; and 1 family had 8 prior reports.

Accidents and Substance Abuse

Both of the maltreatment related accidental deaths involved caregivers who were impaired by alcohol or drugs, had a documented history of substance abuse, and had lengthy histories with DCF.

Summary of DCF Assessment, Case Planning/Service Delivery Regarding Accidental Deaths

Records as to all 6 children show a variety of referrals made by DCF and different levels of engagement by community providers (*primarily out-patient*). Both of the substance abuse/accident stories above revealed lengthy DCF histories and a record of numerous out-patient referrals for the families. Questions include the efficacy of the services, the match between the needs/strengths of the family, and the intensity, frequency, and duration of services provided. It is imperative that we measure the impact of such services for improved parental capacity, judgment, and protection of children's safety.

> Baby O died when she was 5 months old after her mom fell asleep in the bath tub while holding her. O's mother struggled with substance abuse and records show she was under the influence at the time O drowned. Mother was discharged the previous day from a detox program. There was no DCF involvement at the time of O's death. There were 4 other children in the home at the time of O's death. DCF investigated 8 prior reports on O's family over a period of 6 years. Allegations included domestic violence, parental mental health challenges, and substance abuse. Previous service referrals included domestic violence services, Intensive Family Preservation, and outpatient therapeutic supports. Law enforcement records indicate that at least 6 calls to police were made by the family regarding domestic issues or disputes of varying severity. On two occasions there is a record of a police call to the DCF Careline. One call to police alleged that the father was under the influence, verbally abusing mother, and calling children racially derogative names. OCA's review of Baby O's pediatric records does not reflect awareness of multiple problems or stressors within the family. DCF substantiated the caregiver for neglect after the child's death.

As previously stated, 2013 was an unprecedented year for infant and toddler Homicide. Five of the 10 who died by homicide were known to DCF. All were caused by fatal child abuse: either blunt force trauma or abusive head trauma. Three victims were girls and 2 were boys. All 5 were allegedly killed by male caregivers—all have been arrested. All five alleged perpetrators were substantiated for abuse/neglect by DCF after the children's deaths.

Family Risk Factors

Mothers and male partners presented with risk factors in the areas of substance abuse and mental health challenges. Notably, 4 out of the 5 mothers had a history with DCF as a child, and 4 of the mothers were teenagers when they had their first child. Three out of the 5 male partners had criminal histories and 3 out of the 5 had their own history with DCF as a child. These profiles raise questions as to the history and impact of trauma, abuse, or neglect in the lives of these parents, their own capacity for quality decision-making, and knowledge of appropriate child development and care.

Two Children had Open DCF Cases at the Time of Death

Review of child welfare records indicate that 2 out of the 5 children's cases were open at the time of death, both at the beginning stages of the case (Baby A and Baby N).

Baby A's teenage mother moved to Connecticut from New York State while pregnant. The other state's child welfare agency called Connecticut DCF, requesting the agency follow up with the teenager. CT DCF met with the mother and her boyfriend and discussed referrals for parenting supports and community health resources. Both the mother and the baby's father indicated they were open to supports.

The baby died while in the care of his teenage father approximately 6 weeks after DCF opened its case. Services referred by DCF were not yet in place. Records do not reflect whether other community health providers made recommendations or referrals for home visiting or fatherhood engagement programs for this young couple.

Summary of DCF Assessment, Case Planning/Service Delivery for Homicide Deaths

Three out of the 5 children's cases were closed at the time of the child's death. Two were closed following an investigation and were not kept open for ongoing treatment. One was closed after extensive DCF involvement and a period of protective supervision.

Regarding the 2 case closures at the investigations phase, the first involved a mother that was reported to be possibly substance abusing at or near the time of the baby's birth. This charge was not substantiated after investigation, and after reviewing conditions of the mother's home and personal circumstances, DCF closed the case. The record does not reflect how or if the following factors were considered: the mother's young age, first-time parent status, trauma history, or involvement with DCF as a child. The record does not indicate that any referrals for home visiting or other parenting supports were discussed or made at the time of case closure.

Baby N was referred to DCF due to concerns raised by the 3-year-old's pediatrician regarding her out-of-control behavior and suspicious bruising on her buttocks. DCF accepted the report for Family Assessment Response. During the assessment period, the child's mother was not forthcoming about risk factors in the home or the presence of a boyfriend. Less than 3 weeks later, Baby N died from severe beating, allegedly at the hands of mother's boyfriend.

DCF's investigation after the child's death revealed numerous risk factors, including domestic violence between Baby N's mother and her boyfriend that had led to his prior arrest and incarceration. Other risk factors included mother's involvement with DCF as a child and her boyfriend's history of substance abuse.

The second case also closed at investigations after a finding that the baby had been abused, but where no clear perpetrator was identified, a clear and concerning departure from best practice. At the time of the incident, it was DCF's position that the agency could not substantiate abuse without identifying a perpetrator. Neither of the children's records reflected case planning or consultation with a DCF ARG specialist prior to case closure.

The last case was that of Baby J. His family's story reveals important and challenging themes regarding child maltreatment prevention.

Baby J died while in the care of his father. His family was known to DCF before Baby J's birth. His mother had her first child when she was a teenager and struggled with numerous stressors over time, including substance abuse, domestic violence, mental health issues, and her own DCF history as a child. DCF records indicate that numerous services were provided to the mother over the course of her DCF involvement, including parent-child psychotherapy and individual therapy. Her participation in these services was overseen by DCF and the juvenile court. Mother was noted to make progress toward her goals as set forth by the court. Judicially ordered protective supervision of mother's older children expired while mother was newly pregnant with Baby J, and DCF closed their case after assessing the risk level in the home as moderate.

At the time of case closure, DCF expressed some concern about mother's new pregnancy, new partner relationship, and indicated a need for mother to maintain individual therapy in the community. Child welfare records after Baby J's death indicate that the baby's father had his own challenges, including DCF history as a child, mental health history, and substance abuse history.

Baby J's case highlights difficult aspects of child protection work in several ways. First, DCF cannot mandate its own intervention or supervision of a family beyond that which is permitted by law or ordered by a court. Here, the parent still demonstrated risk factors that were documented by DCF at the time of closure, but the parent also demonstrated progress with services and compliance with case expectations and orders of the court. The fact that risk may remain does not necessarily provide DCF with statutory authority to maintain supervision of a family. It is unclear what role community providers continued to play for mother, what counsel she received from local health care providers, and what level of engagement the father had with providers following the birth of the baby.

Secondly, this case highlights the degree of entrenched challenges that some caregivers struggle with. Here, the mother presented with many risk factors: her young age when she had her first child, her own history with DCF when she was a child, a history of substance abuse, mental health challenges, and intimate relationships fraught with domestic violence. She participated in services offered by DCF after her older children were removed by order of the court. She participated in individual counseling and an evidence-based clinical home visiting program. She was candid with DCF towards the end of her case about her anxiety and desire to be living her life in a healthy way. DCF encouraged her at the time of case closure to continue with individual therapy. Mother moved on with her life, pregnant with a new child and beginning a new relationship. At the time of her baby's death, she was reportedly working 60 hours a week at multiple jobs while the baby's father was home caring for all 3 children, 2 of whom were not his biological children.

This family's story outlines the formidable work of family preservation, child protection, and the challenges and responsibilities that we must address to support caregivers and protect children. These cases collectively underscore the importance of accessible high quality child care.

Summary of Findings of All 24 Children

The majority of families presented with substantial risk factors including histories of substance abuse, family violence, mental health challenges, and repeat exposure to the child welfare system. Families' prior histories with DCF included a range of significant and more minor child abuse or neglect concerns. Many of the families' prior cases were closed after the investigations phase and were not opened for ongoing treatment.

History

Many of the families whose records were reviewed had multiple contacts with DCF. Records revealed inconsistent consideration and integration of this information into the risk assessment, decision-making, and case planning process. Histories ranged from 1 prior report to 14. The relevance of history was at times minimized in the risk assessment and case planning process.

Pregnancy

Review of family records reveal at least 6 instances during a family's history with DCF where cases were closed while a parent was pregnant.[24] It is important to examine DCF practice and protocols when concerns are raised about a pregnant parent's capacity, judgment, mental health, or substance abuse, including *when there are no other children in the home*. Currently there are legal complexities to the issue of substantiating neglect of an unborn child and DCF may not even accept a hotline report on a pregnant parent when there are no other children in the home. However, we must also review other engagement opportunities to connect families with community-supports and family strengthening services.

Baby AB died at 20 months of age from fatal child abuse, allegedly inflicted by his father. AB's family was previously known to DCF from a 2012 incident in which he was treated at the hospital for serious injuries. AB's pediatric records indicated that though his pediatrician suspected abuse and referred the child to a hospital, the pediatrician did not make a DCF Careline report. The hospital reported AB's injuries to the Careline. At that time DCF opened an investigation regarding AB's child abuse injuries, which were confirmed by a pediatric child abuse expert to be inflicted rather than accidental.

DCF closed the case one month later despite the severity of Baby AB's injuries and remaining questions about the circumstances surrounding the abuse. Police and DCF were not able to conclude who perpetrated the abuse, though records indicate that DCF suspected the father as a possible perpetrator. Due to not identifying a perpetrator, no adult was substantiated for the abuse. No court petition was filed in this case. DCF provided AB's mother with some financial support to offset day care expenses, and asked mother to sign a safety agreement stipulating that only the mother and maternal grandmother would be allowed to watch Baby AB unsupervised.

DCF did not keep the case open for ongoing treatment or additional referrals. The only interventions were the daycare subsidy and the safety agreement. After Baby AB later died from blunt force trauma while under the care of his father, Baby AB's mother indicated that this was the first time she had left the baby with the father since the time of the DCF investigation.

Baby V baby was born to a mother who used drugs throughout her pregnancy. Mother had 7 prior reports to DCF. At the time of the most recent report—due to Mother's overdose on cocaine—mother was 7 months pregnant with Baby V. At the time, DCF reached a voluntary agreement with the family to have the mother's two other children live with their biological father. No neglect petition was filed.

DCF offered the mother numerous services, she declined, and DCF closed the case. At the time, mother was 34 weeks pregnant. One month later, mother delivered Baby V, who died hours later. The Medical Examiner determined the baby died from natural causes.

[24] This does not mean that this unborn child is the child who later died.

Assessment Tools

The child welfare agency uses a number of standardized tools and instruments to assess a family's needs, and identify risk and safety issues in the home. The use of such validated, research-based tools can assist with quality assessment and decision-making in child welfare cases. The literature also reminds that while the tools are useful, they must be used with rigorous fidelity to the established protocols and must also be combined with highly skilled social work, critical thinking, and quality supervision.[25]

Case Planning/Decision-Making

Many of the families' records indicated that a DCF area specialist (ARG) consulted at some point in the investigation or case planning process. ARG specialists exist in several disciplines at DCF: substance abuse, mental health, nursing, education, and domestic violence. A case worker may approach a substance-abuse ARG specialist to answer a specific question: e.g., "this mother used marijuana during pregnancy, is she now eligible for Family Based Recovery program?" An ARG nurse is often used where an infant is born and records indicate the infant was drug-exposed during pregnancy.

The key issue in some of these cases is that the intensity of the interventions, focused on treatment and safety, are not always consistent with the degree of risk in the home. It is unclear how the quality of improvements in parental capacity, judgment, and decision-making are assessed.

ARGs may possess a level of subject-matter expertise beyond or distinct from that of the social worker or even supervisor. Records reflected great variability regarding when and what type of consultation was sought by the social work team. Though many of the families were assessed to have mental health, substance abuse, or family violence issues in the home, records do not reflect systematic use of related ARG specialists. Only 1 of the 5 homicide case records documented use of an ARG specialist during the duration of the case. This issue of expertise is crucially important as not all front line staff have social work degrees. Child welfare decision–making requires a high level of knowledge regarding assessment, engagement, and case planning—a level of expertise not currently possessed by all front line workers. DCF has indicated that it is currently working to ensure more front line staff and new hires are appropriately credentialed.

The importance of a highly skilled workforce for preventing maltreatment fatalities cannot be overstated.

Service Delivery

In home services were not consistently recommended or provided. In the cases outlined above, approximately 1/3 of families' records use of an in-home provider. Two additional case records documented pending or considered referrals for an in-home service. In home services ranged from Family Based Recovery,[26] Nurturing Families,[27] Intensive Family Preservation,[28] Triple P,[29] and in

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[25] NATIONAL ASSN. OF SOCIAL WORKERS & ASSN. OF SOCIAL WORK BOARDS, BEST PRACTICES IN STANDARDS OF SOCIAL WORK SUPERVISION: TASK FORCE ON SUPERVISION STANDARDS 6, ¶¶ 9-19 (2012), *available at* http://www.socialworkers.org/practice/naswstandards/socialworksupervision/SUPERVISION%20STANDARDS2%20Public%20Comment%20Draft%20August%2016.pdf; *see generally* Pamela Trevithick, *Social Work Skills: A Practice Handbook* (2000); *available at* http://www.mcgraw-hill.co.uk/openup/chapters/0335206999.pdf (discussing the multitude of skills, such as communication, listening, assessment, and critical thinking that social workers must have and perfect).

[26] A parent-child intervention program for a caregiver who is a recent substance abuser.

[27] Parents as Teachers Model works with parents to improve knowledge, judgment, decision-making, child's developmental trajectory, and reduce the incidence of abuse or neglect.

[28] Intensive Family Preservation Services are family-focused, community-based crisis intervention services designed to maintain children safely in their homes and prevent the unnecessary separation of families. Typically caseloads are small and work is shorter term and intensive.

one case, Child First.[30] DCF, along with DSS, DPH and the Office of Early Childhood, has played an important role in supporting development and access to new home-visiting programs for families. Next steps will be to expand access to home-visiting with intensive therapeutic components for parents with mental health challenges and/or substance abuse issues.

Records reveal that home visiting supports were not routinely offered for young or teenage parents. The most common referrals for parents were generated as a result of substance abuse or mental health challenges and were for out-patient treatment.

Child welfare records did not uniformly document the nature of communication between the agency and local providers or whether all providers and DCF had a common understanding of the needs of the family, the goals of the intervention, and how the measure of progress and rehabilitation would be appreciated within the family. Records often documented compliance with attendance or the results of drug screens, but how this information was incorporated into decision-making and case planning was variable.

Repeatedly, records did not seem to reflect cognizance of the level of risk for an infant in a home with a substance-abusing caregiver.

Given the level of risk in many of these homes, the treatment and visits must be designed to observe and do intensive work with the family by either the provider or DCF *most days of the week*. Families with repeat involvement with DCF often require intensive, trauma-informed therapeutic intervention as well as support for children in a developmentally appropriate manner. Parents have often experienced significant trauma, and the most appropriate interventions for these parents and their children will often be two-generational with a focus on both treatment and the parent-child relationship. We do not currently have the capacity to provide these services at the necessary scale.

The efficacy of traditional out-patient treatment must be evaluated as to whether and when it is a good fit for families with significant risk profiles and very young children in the home. Out-patient providers may not have opportunity to engage with the family in the home or to provide treatment in the normal environment. For many families, substance abuse treatment alone is unlikely to address the range of co-occurring issues and needs in the home the impact the safety and wellbeing of children.

The work of child protection and prevention requires a coordinated, teamed approach as opposed to a system of referrals or bifurcated care. Each family needs a comprehensive assessment of risks and strengths and a treatment plan that has a care coordination component addressing support, treatment, and collaboration. Treatment plans can include both traditional and non-traditional services, with a focus on outcomes, rather than just compliance with appointments. Duration of services must be equivalent to the need and the time it will take for families to benefit and transition, test for sustainable improvement, and address children's safety. *Duration of services must be tied to outcomes*. Progress for a family must be measured, in part, by improvement in parental capacity, judgment, and documented competencies over time.

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[29] The Triple P – Positive Parenting Program is a parenting and family support system designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers. *Triple P In a Nutshell*, TRIPLE P, http://www.triplep.net/glo-en/find-out-about-triple-p/triple-p-in-a-nutshell/ (last visited July 7, 2014).

[30] An intensive parent-child clinical intervention designed to improve parental capacity, children's developmental trajectories, and reduce incidences of abuse or neglect.

Collectively these cases speak to the critical need for highly skilled social work, effective trauma informed interventions for families, and rigorous quality assurance to support family preservation work.

How often are Cases Reviewed?

Most of the records indicate that social work case practice is reviewed regularly by the social work supervisor. Records do not indicate that supervisors routinely go into the field and meet with families or observe social work practice outside of the office.

Supervisors are often limited to information that is provided by the case worker. Typically, when an outside provider is being consulted, it is the case worker who makes the calls and then reports information to the social work supervisor.

Best practices in child welfare is an evolving standard, and we now know that "teaming", frequent reviews and active supervision are key elements for improving outcomes for children and families.[31] DCF in CT is moving towards a teaming model for many aspects of its work. This work, however, takes more time than referring a family for services and monitoring compliance. This is particularly true when children remain in the home with parents working to make progress with substance abuse or mental health treatment.

Ensuring quality social work and protecting children in the home will require caseloads that reflect the reality of the work we are asking social work teams to accomplish.

Quality Assurance

From a quality assurance standpoint, the cases present with varying strengths and concerns. Some of the cases reflect frequent visitation and use of evidence-based interventions. Other cases highlight significant quality assurance and case practice weaknesses, left uncorrected by supervision and management. The most recent Juan F. Federal Court Monitor's report highlighted concerns that DCF remains dramatically understaffed and over 200 social workers have caseloads at 100-150% of the existing caseload standards.[32] Moreover, few of the children who died in 2013 were the subject of court petitions (and the corresponding legal representation and judicial oversight) at the time of their deaths. At the core, the cases raise concerns regarding the quality of decision-making and case planning. We must prioritize an evaluation of our capacity to ensure that these elements are high skilled and comprehensive.

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[31] *See* CALF. DEPT. OF SOCIAL SERVICES ET AL., PATHWAYS TO MENTAL HEALTH SERVICES: CORE PRACTICE MODEL GUIDE 12–16 (2013), *available at* http://www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf ("teaming" is a necessary tool for child mental health and child welfare systems); U.S. DEPT. OF HEALTH & HUMAN SERVICES, FAMILY INVOLVEMENT IN THE IMPROVING CHILD WELFARE OUTCOMES THROUGH SYS. OF CARE INITIATIVE (2010), *available at* https://www.childwelfare.gov/management/reform/soc/communicate/initiative/evalreports/reports/FamilyInvolvement_Report.pdf (recommending the need for "teaming" and active supervision for families and children in the child welfare system); CHILDREN'S DEFENSE FUND ET AL., PROMOTING CHILD WELFARE WORKFORCE IMPROVEMENTS THROUGH FED. POLICY CHANGES 3–5 (2006), *available at* http://www.childrensrights.org/wp-content/uploads/2008/06/components_of_effective_child_welfare_workforce_august_2006.pdf (quality supervision is necessary for successful child welfare outcomes); MINN. DEPT. OF HUMAN SERVICES & CNTY. SOCIAL SERV. AGENCIES, PIP TIPS: ITEM 20 WORKER VISITS WITH PARENTS 3 (2004), *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_03840 ("regular supervisory case reviews that target frequency and quality of social worker visits with parents" must be conducted).

[32] DCF COURT MONITOR'S OFFICE, *JUAN F. V. MALLOY* EXIT PLAN: QUARTERLY REPORT, CIVIL ACTION NO. 2:89 CV 859 (SRU) 5 (Jan. 2014–Mar. 2014), *available at* http://www.ct.gov/dcf/lib/dcf/positive_outcomes/pdf/2nd_qtr_report_2013_final_(2).pdf.

Records Review: Findings

Pediatric records were reviewed of 13 (of the 24) DCF involved children that died of preventable causes. Out of all documentation reviewed (handwritten notes, template forms, and electronic medical records), electronic medical records were found to be most informative in guiding more comprehensive age-appropriate evaluation of risks. Only one record utilized EPSDT and AAP forms for primary care encounters. Records indicated that all children reviewed received primary care with 2 indicating "no show" at an appointment. The majority of contacts regarding care were with the mother of the child. There was also great variability on documentation in pediatric case records.

Comparison of pediatric and child welfare records demonstrate that pediatric records rarely record multiple parental risk factors—such as, age, substance use, mental health concerns, multiple fathers of children, parenting demands of having several young children, parenting children with special needs, unemployment, domestic violence, and inadequate social network. Numerous records indicate lack of or absence of documentation regarding mental health issues—only 1 record was found to have reported "post-partum depression" despite the presence of mental health issues in 54% of mothers with child fatalities. Furthermore, records indicate no follow-up or referral regarding sexual abuse history in the household, teen parent support, maternal polysubstance abuse, maternal mental health issues, multiple missed pediatric specialty appointments, and pediatric emergency room visits. No documentation indicated counseling provisions for infant "fussiness" (N=3), reflux concern (N=2), special needs siblings (N=2), or parents. Only 1 record indicated provision of educational material to parent.

Social support networks have been shown to promote health and well-being outcomes. However, pediatric records do not reflect that social support network, home, or community-based parenting supports is explored. Rather, most records document home-based child care and do not show whether a pediatrician has access to social workers or nurses to assist with assessment, counseling, referral, and care coordination. Records demonstrate strained communication between pediatricians and DCF. One record indicated that while concern is raised by both DCF and pediatrician regarding missed pediatrician appointments, the follow-up is frail. Many times the provider is unaware of DCF involvement—only 3 records demonstrating overt awareness of DCF involvement, with only the aforementioned case documenting communication. There is, thus, little guidance or exploration of issues with the parents or the case plan.

Interviews with Pediatricians

OCA spoke with several pediatricians over the course of this review. Feedback was universal in that communication between pediatrics and DCF is suboptimal. Pediatricians reported receiving little or no information from DCF regarding child welfare concerns or service referrals that were initiated for a family. Pediatricians acknowledged the lack of a systematic approach to communication between providers working with at-risk or high risk families. They are often unaware of what programs exist and how to access them. Pediatricians also strongly recommended a "physician's line" at the DCF hotline/care line. Pediatricians indicated that it is difficult to call the hotline and wait times are too long.

In addition, pediatricians voiced significant concern with the current Medicaid health supervision structure and reimbursement schedule which they report allows for about 15 minutes for a pediatric well child encounter. Providers reported they are frequently challenged in having to address childhood illness issues during health supervision visits, further limiting their ability to assess for other issues and provide age-appropriate safety and wellness anticipatory guidance. An additional

reported barrier to consistent risk assessment screening was not having knowledge or access to an appropriate resource for the child or family when issues are identified.

Pediatrics Role in Child Maltreatment Prevention

The American Academy of Pediatrics (AAP) Position on the Pediatrician's role in Child Maltreatment Prevention provides the following:

> ***"It is the pediatrician's role to promote the child's well-being and to help parents raise healthy, well-adjusted children."***[33]

Pediatric practice has a significant focus on prevention, is concerned with the child and family, and providers typically have multiple encounters with families of young children over the first few years. Further, and most important for families with complex risks, taking a child to the pediatrician is universally accepted and without social stigma. Pediatric providers must have access to screening tools for children and families to help identify stressors and risks and assist with appropriate referrals. Pediatric primary care providers must be familiar with home and community resources and have timely access to needed resources. Research indicates that opportunities are often missed in the context of providing "health supervision."[34]

AAP has developed Bright Futures (BF) as the recommended standard of care for pediatric health supervision. Bright Futures is a national health care promotion and disease prevention initiative that uses a developmental based approach to address children's health needs in the context of family and community.[35] Bright Future prioritizes topics for discussion at each health supervision visit. Some states have adopted BF as the state's standard and others use the guidelines for training, age specific initiatives, and home visitation.[36]

SECTION III

Recommendations for Prevention of Child Fatalities Birth to Three

Unsafe Sleep Death Prevention

AAP/CDC Recommendations Regarding Safe Sleep[37]

- Always place babies on their backs to sleep, even for naps.
- Avoid stomach or side-sleeping for babies.
- Place baby on a firm sleep surface, such as a safety-approved crib mattress covered with a fitted sheet.
- Do not use pillows, blankets, or other soft surfaces.
- Cribs should be free of soft objects, toys or loose bedding.
- Do not use sleep positioners, even those marketed to avoid SIDS.
- Avoid letting baby overheat during sleep.

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[33] E.G. Flaherty, J. Stirling Jr., & Am. Acad. of Pediatrics: Comm. on Child Abuse and Neglect, *Clinical Report: The Pediatricians Role in Child Maltreatment Prevention*, 126 PEDIATRICS 833, 833–41 (2010).

[34] Steve Kairys & Tammy Piazza Hurley, Conference Presentation, *Getting Pediatric Practices to Prevent Child Abuse and Neglect, QUIIN & AAP* (2011), *available at* www2.aap.org/sections/.../PhaseII.ppt.

[35] Am. Acad. of Pediatrics, *Overview*, BRIGHT FUTURES, http://brightfutures.aap.org/about.html (last visited July 11, 2014).

[36] Am. Acad. of Pediatrics, *State Programs*, BRIGHT FUTURES, http://brightfutures.aap.org/integrate_state_program.html (last visited July 7, 2014).

[37] *New Infant Sleep Recommendations*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Oct. 18, 2011), http://www.cdc.gov/sids/parents-caregivers.htm.

- Increase education for parents on all risk factors related to the infant's sleep environment (including co-sleeping) and tobacco exposure. Case planning should include discussion and strategies regarding the common issues that may lead to co-sleeping such as concern regarding baby's sleep, parent's lack of sleep and exhaustion, infant fussiness, etc.

Strengthen Child Death Investigations

- Consider contemporaneous drug screens of care providers present when a child dies in a suspected Accident, Homicide, or in an Undetermined manner.
- Notify and dispatch police with emergency medical responders in cases involving children under the age of 1 year to facilitate securing the scene for the initial investigation when a child dies in a suspected Accident, Homicide, or in an Undetermined manner.
- Ensure death scene investigation across responding agencies is uniform and consistent with best practices.
- Utilize the Centers for Disease Control and Prevention (CDC) Sudden Unexplained Infant Death Investigation Protocol for all infant deaths.

Recommendations Regarding Service Delivery for Children and Parents

- According to a 2013 CT Voices for Children Publication, there are roughly 12,000 children born into poor families each year with one or more risk factors for abuse or neglect or poor child development.[38] About 5,000 of the children are born to first time parents[39] and roughly 2,200 are born to teens.[40] About 12% of the mothers received late or no prenatal care.[41]
- Evaluate need and bring appropriately to scale home-based programs, including, but not limited to, Nurturing Families Network,[42] Triple P Positive Parenting Program,[43] Circle of Security,[44] Parents as Teachers,[45] Nurse-Family Partnership,[46] Home-Based Early Head

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[38] CONNECTICUT VOICE FOR CHILDREN, BIRTHS TO MOTHERS WITH HUSKY PROGRAM AND MEDICAID COVERAGE: 2010 1, tbl. 4, tbl. 5 (2013).

[39] Id. at tbl. 4.

[40] *Id.* at 1, tbl. 4, tbl. 5.

[41] *Id.*

[42] Nurturing Families Network outcome data is based on comparative data from 3 studies of abuse and neglect rate for families identified at high risk using the Kempe Family Stress Checklist. The incidence of child abuse and neglect in the high-risk families identified by the Kempe participating in the Nurturing Families Network is 1.6% in 2006. TIMOTHY BLACK ET AL., CTR. FOR SOC. RESOURCE: UNIV. OF HARTFORD, NURTURING FAMILIES NETWORK 2007 ANNUAL OUTCOME EVALUATION REPORT 55–59 (2007). A two year study of prenatal mothers categorized into low and high-risk groups based on Kempe found that 22% of the high-risk mothers had abused or neglected their children versus 6% of the low-risk parents. Catherine Stevens-Simon, MD, & Joan Barrett, *A Comparison of the Psychological Resources of Adolescents at Low and High Risk of Mistreating Their Children*, 15 J. OF PEDIATRIC HEALTH CARE 299, (2001). Another two year study comparing medical charts two years after the children's birth to families defined at-risk on the Kempe and those defined as no risk found that 25% of the children in the at-risk group had been victims of abuse, neglect, or failure to thrive. The rate was 2% for the no-risk group. Solbritt Murphy et al., *Prenatal Prediction of Child Abuse and Neglect: A Prospective Study*, 9 CHILD ABUSE & NEGLECT 225, 225–27 (1985).

[43] A population-based trial of the Triple P system in the United States by Prinz, Sanders, Shapiro, Whitaker, & Lutzker demonstrated reductions in substantiated cases of child maltreatment, out of home placements, child hospitalizations, and emergency department visits due to child maltreatment- related injuries. Triple P is a public health initiative that can reach a large number of caregivers; utilizes a tiered approach from educational information and tips to clinical support for parents. Ronald J. Prinz et al., *Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial*, 10 PREVENTION SCIENCE 1 (2009).

[44] The Circle of Security is a relationship based early intervention program designed to enhance attachment security between parents and children. *About Us*, CIRCLE OF SECURITY INTERNATIONAL, http://circleofsecurity.net/ (last visited July 14, 2014).

[45] Parents for Teachers is a relationship based early intervention program that is designed to support and work with parents to support the healthy development of their children. *What We Do*, PARENTS AS TEACHERS, http://www.parentsasteachers.org/about/what-we-do (last visited July 22, 2014).

Start,[47] and dyadic clinical interventions such as, but not limited to, services provided by Child First,[48][49] Intensive Family Preservation,[50] and Family Based Recovery,[51] which are all evidence-based or promising practices (in different ways) to support families, improve developmental outcomes, and improve parental functioning.

- Ensure that quality and intensity of in-home service matches the need. Not all home visiting programs are evidence-based for the same populations. Some families need educational support, some need crisis stabilization, and others need intensive, clinical, trauma-informed interventions, substance-abuse treatment, or treatment for maternal depression. Services must match families' needs.
- Ensure that all maltreated infants and toddlers that come to the attention of DCF have access to parent-child treatment supports.

Note: Home-visiting or home-based treatment programs begin at about $11 per day, significantly less than the cost of future treatment and state child welfare intervention.[52]

- Ensure that pediatric offices are connected to early childhood/early intervention systems of care.
- The Casey Family Programs recommends the integration and coordination of services with "federally-funded home visiting programs in states." These "targeted and universal home-visiting initiatives in states provide an opportunity to maximize prevention efforts, share resources, and coordinate the service array that families receive. Making these linkages explicit and developing enhancements to the home-visiting model to most effectively serve the child welfare population could have a large impact on families being served through these separate funding streams."[53]

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[46] The Nurse-Family Partnership is an evidence-based model that provides in home nursing support to low-income, first-time parents. The public health nurse visits the home and establishes a relationship with the mother from the start of the pregnancy until the baby turns two. *What We Do*, NURSE-FAMILY PARTNERSHIP, http://www.nursefamilypartnership.org/about/what-we-do (last visited July 22, 2014).

[47] "Early Head Start is a comprehensive, two-generation federal initiative aimed at enhancing the development of infants and toddlers while strengthening families." Background Information on Early Head Start Home-Based Model, U.S. Dep't of Health & Human Services, Administration for Children and Families, http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start/program-options/home-based/ProgramModelOve.htm (last visited July 22, 2014). "In addition to home-based, the range of EHS program options includes center-based, Family Child Care, combination of center- and home-based, and locally designed options." *Id.*

[48] Child FIRST, a clinical parent-child program used by DCF works with very at-risk caregivers. Reports show that almost all of parents served have experienced trauma in their lives and over 80 percent of children were reported to have experienced at least one traumatic event. D.I. Lowell et al., *A Randomized Controlled Trial of Child First: A Comprehensive, Home-Based Intervention Translating Research into Early Childhood Practice*, 82 CHILD DEVELOPMENT 193, 196–99 (2011) (on file with author). Almost 50% of children served were identified with developmental issues. *Id.* Evaluation data shows that a significant percentage of children and families showed clinically significant improvement in multiple domains, including developmental gains, decreases in maternal depression and parenting stress, and improvement in the parent-child relationship. *Id.* at 200–04.

[49] Child First only covers 52% of the towns in CT. Each affiliate agency has long waiting lists, in spite of triaging to lower levels of service whenever possible. Increased capacity is desperately needed for every program.

[50] IFP incorporates evidence-based strategies to affect family change (crisis intervention, motivational interviewing, parent education, skill building, and cognitive behavioral therapy). *Intensive Family Preservation Service and Intensive Family Reunification Services*, INSTITUTE FOR FAMILY DEVELOPMENT (2013), http://www.institutefamily.org/programs_IFPS.asp.

[51] FBR works with parents of young children where parents have very recent substance abuse. *Yale University: Family-Based Recovery*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, http://captus.samhsa.gov/grantee/capt-client/sts/yale-university-family-based-recovery (last visited June 27, 2014).

[52] An $11 per day figure is the estimate for the cost of Nurturing Families Network home visiting program. Cost per day figures increase based on clinical nature of a service, frequency, and duration of program.

[53] CASEY FAMILY PROGRAMS, MAKING THE CASE FOR EARLY CHILDHOOD INTERVENTION IN CHILD WELFARE 11 (2013), *available at* http://www.casey.org/Resources/Publications/pdf/EarlyChildhoodIntervention.pdf.

- Examine funding streams, both state and federal, to determine where clinical and preventative parent-child supports fit into the state's Medicaid, private insurance, and employer-sponsored healthcare plans.
- Ensure capacity to provide effective substance abuse and domestic violence services for families with very young children, requiring collection, and reporting of outcome data.[54]
- Support and facilitate strong partnership between the Office of Early Childhood, DCF, and other state-agency partners working with the birth to three population to ensure there is a "web of concrete services for infants, toddlers, and families."[55]

Recommendations to Improve Pediatric Support and Inter-Agency Communication for Children and Families

- Explore restructuring of health supervision schedule for the birth to three population—increasing frequency of contact.
- Adjust reimbursement to increase allowable time and increase frequency of contact for health supervision/anticipatory guidance for children birth to three.
- Examine technological tools and protocols to promote improved communication with child welfare agency.

Highlighting Implications of CT State Innovation Model (SIM) for Children's Well-Being Care

As the CT SIM rightly focuses on improving health care delivery and outcomes through better prevention or management of chronic disease or costly health issues, it is imperative that we consider and fully optimize the SIM framework to improve children's health outcomes, beginning with pre-natal development and infancy.

- Examine how increased access to trauma-informed, dyadic treatment and prevention programs for parents with young children fits into the Statewide Innovation Model for advanced primary care.
- Given the implications of Adverse Childhood Experiences data for health and well-being,[56] our infrastructure development should include focus on increased access to a therapeutic continuum of pre-natal and home visiting services. By considering these programs as Community Health Providers within the SIM framework, an opportunity may be created to further develop and bring to scale critical and cost-efficient early intervention partners.[57]
- Home visiting can also work to ensure developmental screening of young children, a cost efficient and effective mechanism for identifying children in need of additional support services. National data confirms that many children eligible for early intervention services do not receive them.[58]

Primary Care Transformation and Pediatric Well-Being Care

- Pediatric care providers must have the resources to facilitate screening so that every child is

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[54] CT currently has multiple Evidence-Based Programs that focus on trauma recovery. Cognitive Behavioral Therapy and Dialectical Behavioral Therapy can also assist individuals struggling with a history of family violence. DCF currently has an evidence-based intervention that it is partnering with CCADV.

[55] ZERO TO THREE ET AL., A CALL TO ACTION ON BEHALF OF MALTREATED INFANTS AND TODDLERS 20 (2011), *available at* http://www.zerotothree.org/public-policy/federal-policy/childwelfareweb.pdf.

[56] *See generally* J.P. Shonkoff et al., *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS 232 (2012) (discussing the correlation between child fatalities and adverse childhood experiences).

[57] *See* THE PEW CENTER ON THE STATES, MEDICAID FINANCING OF EARLY CHILDHOOD HOME VISITING PROGRAMS: OPTIONS, OPPORTUNITIES, AND CHALLENGES (2012) (describing how to fund home visiting services under state EPSDT or preventative service plans; or through braiding Medicaid and MIECHV and other grant funding).

[58] S.A. Rosenberg et al., *Prevalence of Developmental Delays and Participation in Early Intervention Services for Young Children*, 121 PEDIATRICS 1503, 1503–09 (2008).

appropriately matched to specialty providers and community health improvement programs.

- Screening should address (but not be limited to) infant mental health, early childhood development, and caregiver depression.
- Pediatric offices must have access to affordable/reimbursable care coordination not just for children with significant, complex, or chronic disease but for families and children as needed to support a holistic and multidisciplinary approach to children's health and well-being.

Transparency of Quality Assurance and Child Fatality Reviews

- Hold an annual public hearing on child fatalities, including a focused discussion on infant-toddler deaths, to highlight prevention as a critical public health priority.
- Collect and report data regarding child fatalities causes, addressing both "maltreatment" and familial risk factors that increase risk for child mortality.[59]
- Ensure Child Fatality Review Panel has resources and staffing to provide multidisciplinary recommendations regarding child death prevention, in accordance with best practices and national recommendations.[60]
- Support and strengthen DCF's internal capacity to review child fatalities and develop operational priorities emerging therefrom. DCF internal findings may be shared with the Child Fatality Review Panel.

Fatherhood/Father-Figure Engagement

- Target home and community-based interventions for fathers and male partners to increase parental capacity, judgment, and knowledge of child development.
- Engage males with education regarding shaken baby syndrome and fatal child abuse syndrome.
- Support males around infant crying and sleep patterns, providing information, coping, and soothing strategies.
- Ensure child welfare agencies, contracted providers, and other community providers continue to expand engagement efforts with fathers and male partners, conducting comprehensive assessments and targeting interventions to increase caregiver capacity.

CHILD WELFARE: Workforce Development

- Ensure that supervisors and managers evaluate case workers in the field.
- Support and strengthen DCF efforts to ensure that supervisors have training in clinical supervision, so that they can expertly assist front line social workers in identifying and interpreting information about families and children that implicate risk and safety.
- Ensure DCF has an adequate number of Area Regional specialists to ensure appropriate expertise is brought to bear for families in the areas of domestic violence, behavioral health, substance abuse, and early childhood development.[61]

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[59] *See generally* Emily Putnam-Hornstein et al., *Racial and Ethnic Disparities: A Population-Based Examination of Risk Factors for Involvement with Child Protective Services*, 37 CHILD ABUSE & NEGLECT 33 (2013) (arguing that data collection must address "maltreatment as a factor); FP Rivara & B. Johnston, *Effective Primary Prevention Programs in Public Health and their Applicability to the Prevention of Child Maltreatment*, 92 CHILD WELFARE 119 (2013) (discussing the need for collection and reporting of child fatality data that includes "maltreatment" and family risk factors); Patricia G. Schnitzer et al., *Advancing Public Health Surveillance to Estimate Child Maltreatment Fatalities: Review and Recommendations*, 92 CHILD WELFARE 77 (2013) (describing the need for improved data collection and reporting for child fatality causes).

[60] *See* Schnitzer et al., *supra* note 59, at 94 (recommending that the role of child fatality review boards be strengthened and increased to serve in reviewing and reporting deaths and state cross-disciplinary training and technical assistance be provided); THE NATIONAL CENTER FOR CHILD DEATH REVIEW ET AL., A PROGRAM MANUAL FOR CHILD DEATH REVIEW 16, 53 (2005), *available at* http://www.childdeathreview.org/finalversionprotocolmanual.pdf (factors that contribute to successful child fatality review boards include appropriate funding, training, and membership).

- Implement caseload standards that correspond to complexity and intensity of birth to three child protection work.
- Examine the professional requirements for child welfare staff working with families and children.
    - The Child Welfare League of America in a recent comprehensive child fatality report commissioned in Massachusetts by Governor Deval Patrick strongly recommended that DCF case workers be licensed social workers at the time of hire or within 6 months of hire.[62]
    - The CWLA recommended that supervisors, managers, and directors all have clinical, professional licenses in social work and related fields.[63]
    - The National Association of Social Workers practice standards provide that child welfare caseworkers "shall hold a BSW or MSW degree" from an appropriate educational institution.[64]
- Require training for all levels of agency staff, foster parents, court personnel, and biological parents about the developmental needs of infants and toddlers and the impact of trauma or maltreatment on infants and toddlers.[65]
- Maximize federal funding for child welfare training to offset costs for professional development.[66]

<u>CHILD WELFARE: Heightened Practice and Quality Assurance Protocols for Children Birth to Three</u>[67]

- Increase investment in services for young children and early intervention programs and increase engagement and referrals for families, *"even when no immediate, actionable safety threats are present,"* but where there may be *repeat referrals* to child welfare. [68]
- Support and ensure quality implementation of DCF's recently issued practice guide regarding "safe sleep" practices for infants.
- Ensure child protection policies adequately appreciate the mortality risk for infants in homes with substance abusing parents.
- Ensure safe sleeping and other safe parenting strategies are reinforced through frequent monitoring, support from home visitors, and other home-based clinical or medical providers.
- Integrate sleeping concerns into safety-assessment.
- Consider heightened protocols regarding investigation of abuse/neglect cases where there are infants and toddlers in the home. For example, families that have experienced multiple CPS investigations or where there are young parents may be flagged for heightened review.[69]

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[61] Casey Family Services notes that while expertise may develop over time, systems should also "consider the use of early childhood . . . specialists" to aid in case planning. CASEY FAMILY PROGRAMS, *supra* note 53, at 12.

[62] *Id.* at 46.

[63] *Id.*

[64] NAT'L ASS'N OF SOCIAL WORKERS, STANDARDS FOR SOCIAL WORK PRACTICE IN CHILD WELFARE 13 (2013), *available at* http://www.naswdc.org/practice/standards/childwelfarestandards2012.pdf

[65] CHILD TRENDS & ZERO TO THREE, CHANGING THE COURSE OF INFANTS AND TODDLERS: A SURVEY OF STATE CHILD WELFARE POLICIES AND INITIATIVES 26 (2013); ZERO TO THREE ET AL., *supra* note 55, at 10 (recommending the "recruitment of front-line workers and supervisory staff with training in child development").

[66] *Fact Sheet, Title IV-E Child Welfare Training Program*, NAT'L ASS'N OF SOCIAL WORKERS (2004), http://www.naswdc.org/advocacy/updates/2003/081204a.asp.

[67] Younger children "account for the majority of children who die or are seriously injured due to maltreatment." CHILD WELFARE LEAGUE OF AMERICA, *supra* note 1, at 31 (citations omitted). Studies also show that "boys are slightly more likely than girls to die from maltreatment-related incidents." *Id.* (citations omitted).

[68] Jennifer Sheldon-Sherman et al., *Extent and Nature of Child Maltreatment-Related Fatalities: Implications for Policy and Practice*, 20 VA. J. SOC. POL'Y & L. 41, 51 (2013).

- Reform and widespread implementation of a DCF "High Risk Newborn" Policy should be considered, with duration of the policy extending at least the first six months of baby's life. [70]
- Ensure expedited schedule for case reviews, visits, and court hearings for infants and toddlers.[71]
- Support and expand opportunities for collaborative decision-making/child welfare "teaming" for children age birth to three that includes providers and pediatricians.
- Consider DCF legal consult in all high risk newborn/infant cases.
- Develop a policy for incorporating the pediatric provider into the family/child's case planning process.
- Consider policy requirement for a case planning conference that includes service providers prior to termination of DCF supervision.
- Ensure child protection workers recognize the importance of a family's DCF history during the risk assessment and case planning process.

CHILD WELFARE AND COMMUNITY: How Good is Our Work?

- The state must collect and report quantitative and qualitative information about case practice *and* outcomes for children birth to three.
- DCF Quality Assurance processes should include individuals and stakeholders from within and outside the agency to review case practice, case outcomes, and develop operational priorities.[72] Currently, much of the in-depth, quality-assurance case reviews are conducted by the Juan F. Federal Court Monitor's Office.
- Quality Assurance and operational plans should be publicly reported and publicly available.
- Child Trends and Zero To Three—two nationally-focused non-profit agencies working on child wellbeing policies—recommend, and several states provide, increased data collection that is disaggregated within the maltreated infant and toddler population in order to follow, track trends, and review outcomes.[73]

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[69] Massachusetts recently implemented a new protocol requiring DCF to "screen in" at the hotline any report regarding a child five years of age or younger and where there are young parents or a parent of any age with a history of substance abuse, domestic violence, or mental health challenges. CHILD WELFARE LEAGUE OF AMERICA, *supra* note 1, at 31.

[70] "Social Worker shall provide or arrange for intensive in-home supervision of the infant and services to begin within three days of discharge from the hospital. In-home visits shall occur at least twice a week for at least four weeks. In-home supervision and services may be provided . . . as appropriate." DCF Policy Manual 36-5 (2014).

[71] ZERO TO THREE & CHILD TRENDS, CHANGING THE COURSE FOR INFANTS AND TODDLERS (2013), *available at* http://www.childtrends.org/wp-content/uploads/2013/09/changing-the-course-for-infants-and-toddlers-FINAL.pdf. DCF currently supports two pilot sites in New Haven and Milford that house a Safe Babies Court Team/Zero to Three Project to model best practices in case planning for infants and toddlers.

[72] *See* TEIJA SUDOL, QUALITY ASSURANCE SYSTEMS IN CHILD WELFARE, NATIONAL RESOURCE CENTER FOR FAMILY-CENTERED PRACTICE AND PERMANENCY PLANNING 2 (2009), *available at* http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/Sudol_QASystemsInfoPack_5%205%2009.pdf (quality assurance must include internal and external stakeholders); CTR. FOR THE STUDY OF SOCIAL POLICY, IMPROVING THE PERFORMANCE AND OUTCOMES OF CHILD WELFARE THROUGH STATE PROGRAM IMPROVEMENT PLANS (PIPS) 18–19 (2003), *available at* http://www.cssp.org/publications/child-welfare/child-welfare-misc/improving-the-performance-and-outcomes-of-child-welfare-through-state-program-improvement-plans-pips.pdf (quality assurance programs must utilize expertise of stakeholders in the community); *see generally* NAT'L CHILD WELFARE RES. CTR. FOR ORGANIZATIONAL IMPROVEMENT, A FRAMEWORK FOR QUALITY ASSURANCE IN CHILD WELFARE (2002), *available at* http://muskie.usm.maine.edu/helpkids/rcpdfs/QA.pdf (detailing the need for internal and external individual and stakeholder involvement in quality assurance programs).

[73] ZERO TO THREE & CHILD TREND, *supra* note 71, at 27; ZERO TO THREE ET AL., *supra* note 55, at 7 (must respond to the needs of infants and toddlers through "program administration, research, data collection, and analysis, as well as the provision of ongoing services").

- Support and expand existing efforts to ensure programs and strategies for maltreated infants and toddlers are continuously evaluated so the data can be used to measure outcomes of the programs to increase evidence-informed and evidence-based practices.[74]

New DCF Initiatives to Reduce Maltreatment

DCF provided information to the OCA regarding the agency's recent initiatives for maltreatment prevention.[75] These efforts include "[DCF's] enhanced supervision model … the [DCF] Safe Sleep campaign… [and the integration of that work] with [DCF] local nurses to assure social workers are educated on safe sleep. Integrating clinical RRGs into [DCF's] practice and case formulation are all examples of how [DCF has] learned from these tragedies to improve practice."[76] DCF is also addressing barriers for individuals and entities who are reporting suspected abuse. One of DCF's new initiatives includes providing "education and ongoing support to assist mandated reporters in recognizing possible abuse and reporting suspected abuse to DCF."[77]

DCF is also working with Yale and Connecticut Children's Medical Center to "offer expert education and consultation" for the recognition of child abuse.[78] DCF's Region 3 is putting together a collaborative of stakeholders to "develop a blueprint of best practices to improve the recognition and reporting of suspected physical abuse." In May 2013, DCF began to work with Casey Family Programs and Prevent Child Abuse America to bring together multiple partners and "develop messaging for a public health campaign" regarding child maltreatment prevention.[79] DCF's Office for Research and Evaluation is now launching a study to analyze fatalities of children birth to three over a 9 year period. DCF will review and repeat this evaluation on a yearly basis."[80]

Conclusion

Reducing preventable child fatalities will require a coordinated, strategic partnership between state and local agencies that prioritizes children's safety and recognizes that children's "wellness" is inextricably bound to the health and wellbeing of their families.

Connecticut lost over 3 dozen infants and toddlers due to what are largely considered preventable causes. The majority of children lived in families with multiple stressors or risk factors, including poverty, repeated involvement with the child welfare system, substance abuse, mental health challenges, and a history of family violence. The preventable nature of these tragedies requires us to strengthen and expand our work to ensure that all of Connecticut's children may survive and thrive. This work will require a reimagining of our state's model for children's wellness, and necessarily will require expansion of innovative programming that supports children's health and well-being through work with both the parent and child.

Finally, we must subject our work with the state's most vulnerable children to the highest level of scrutiny and transparency. DCF's recent endeavor to annually review its work with abused and neglected children age birth to three is a critical step forward in this regard. Work to review and prevent child fatalities must be public.

OCA looks forward to partnering with all stakeholders for a continuing discussion regarding child fatality prevention.

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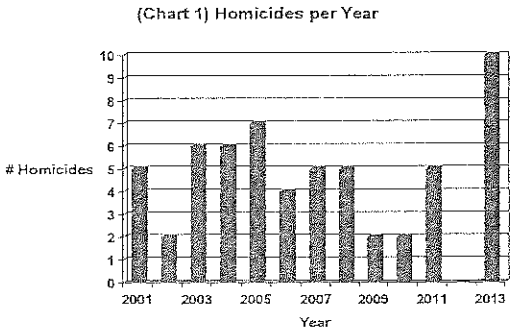
[74] CASEY FAMILY PROGRAMS, *supra* note 53, at 13.
[75] Letter from Joette Katz, *supra* note 19.
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*

APPENDIX

Office of the Child Advocate
Connecticut Child Fatality Review Panel
Public Health Alert
Infant and Toddler Homicides

In 2013 Connecticut experienced an unprecedented number of infant and toddler homicides. Ten infants and toddlers were killed by people who knew them, and most of the alleged perpetrators were in a caregiving role. Fatal child abuse or neglect is the physical injury or negligent treatment of a child by a person who is responsible for the child's well-being. More than 2,000 children die each year from child abuse and neglect in the United States. Most deaths result from fatal head trauma such as when an infant's head is violently shaken, slammed against a surface, or struck by a caregiver, or from fatal abdominal injury, when a child's abdomen is struck, leading to internal bleeding. Connecticut, similar to the rest of the country, sees a higher incidence of child maltreatment fatalities in boys. Biological parents account for up to 63% of perpetrators of fatal child abuse and neglect. Men (usually mother's boyfriends or fathers) are the most common perpetrators of fatal abuse and, therefore, need to be especially targeted in prevention efforts. Strangers are responsible only for a small fraction of child homicides.



Child Homicide in Connecticut

Between January 1, 2001 and December 31, 2013 there were 57 homicides of children from birth through three years of age. Thirty-eight (67%) were boys and nineteen (33%) were girls. Over 75% of these young children sustained fatal child abuse associated with head and/or abdominal trauma. Forty-six (81%) of the children were under two years old. Connecticut experienced an unprecedented number of child homicides for young children in 2013. There were no homicides of infants and young children three years old and under in 2012.

In 2013, the suspected perpetrators in all ten infant and children homicides were known to the children. Four were fathers, four were mother's boyfriends, and two brothers were killed by their grandmother. Two of these homicides had an open case with the Department of Children and Families (DCF) at the time of death, and three other cases had a history with DCF. DCF has developed several initiatives with Pediatric Child Abuse Specialists that focus on multidisciplinary education, training, case consultation and real time assessment and intervention.

In the United States, deaths due to child abuse and neglect may be vastly underreported due to inadequate investigations, lack of information-sharing between medical personnel (first responders and emergency department personnel), police investigators, child protective service agencies, the medical examiner's office, and reporting systems that fail to capture the contribution of maltreatment as a cause of death. The use of statewide child fatality review teams that perform child fatality surveillance may address this issue as Child Fatality Review Teams (CFRTs) may be able to more accurately determine the cause and manner of death.

To examine the global issues related to child abuse deaths, a federal commission has been charged with making recommendations to the President and Congress. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), is a federal advisory committee established by the Protect Our Kids Act of 2012, Public Law 112-275. According to the enabling legislation, the commission's work includes an examination of best practices in preventing child and youth fatalities that are caused due to negligence, neglect, or a failure to exercise proper care; the effectiveness of federal, state, and local policies and systems aimed at collecting accurate and uniform data on child fatalities; the current barriers to preventing fatalities from child abuse and neglect, how to improve child welfare outcomes; trends in demographic and other risk factors that are predictive of or correlated with child maltreatment, such as age of the child, child behavior, family structure, parental stress, and poverty; methods of prioritizing child abuse and neglect; and methods of improving data collection and utilization, such as increasing interoperability among state and local and other data systems.

Perpetrators

Male caregivers are more likely to be the perpetrators of fatal injuries to young children. Some of these men reported that they fatally injured the infant or child because they lost patience when the child would not stop crying. Male caregivers are less likely to accompany mothers and their children to well-child care appointments and therefore may be missing important information about child development. Fatherhood initiatives are key to ensuring that male caregivers have critical information about early childhood developmental milestones.

GUIDELINES FOR PARENTS AND CAREGIVERS

Talk to *your* child's pediatrician about crying and things you might do to soothe your baby. Ensure that every caregiver of your child understands that:

- ✓ Infant crying is a normal part of development.
- ✓ Crying can be *a way* for *the* baby to communicate (they are hungry, need a diaper change, or want to be held).
- ✓ Sometimes children cry for no reason.
- ✓ Babies can cry often and for long periods of time.
- ✓ Sometimes it is hard to console a crying a baby.
- ✓ Crying is not a reflection of your parenting skills.
- ✓ Crying will not hurt the child.
- ✓ Listening to a baby cry can be very challenging.
- ✓ If a caregiver gets frustrated, *they should* put the baby in a safe place (crib, bassinette, pack and play), take a break, and call someone for help.
- ✓ Shaking a baby can cause brain damage resulting in serious mental and physical disabilities and even death.
- ✓ *NEVER SHAKE A BABY*

GUIDELINES FOR PEDIATRICIANS AND HOSPITALS, CASEWORKERS, IN-HOME SERVICE PROVIDERS, AND CHILDCARE PROVIDERS

1. Medical providers, child care workers, case workers, and in-home service providers should provide guidance for caregivers regarding the role of crying in infants as part of normal development. These facts about normal infant crying include infants can be difficult to console even in the absence of illness, that crying is not harmful to infants, that shaking an infant can cause brain damage resulting in serious mental and physical disabilities or even death (6) and a safety plan for when caregivers get frustrated with infant crying (take a break, put the baby down on his/her back in a safe place, call someone for help).

2. Hospitals should institute practice policies that encourage guidance in planning for the child's safety when intractable crying becomes an issue during encounters within the hospital or health care system (e.g. well infant visits, sick visits, Emergency Department visits, subspecialty care visits).
3. This guidance should be provided to ALL CAREGIVERS of the infant or child.

RECOMMENDATIONS FOR LAW ENFORCEMENT

1. Request that the Governor's Task Force on Justice for Abused Children establish dedicated funding for child death review training.

RECOMMENDATIONS FOR POLICYMAKERS

1. Devise legislation to encourage or require reimbursement to primary care providers for the time spent counseling families regarding infant and child crying and a safety plan for crying similar to what has been done successfully in other states such as Washington for oral primary care (*www.innovations.ahrq.gov).*
2. Devise legislation that mandates parent training on the dangers of shaking infants and alternatives for maintaining their baby's safety during episodes of prolonged crying is delivered by health care providers at discharge from the newborn hospital (similar to what is done in states like New York about Shaken Baby Syndrome *(www.ncsl.org/research/human-services/shaken-baby-syndrome-prevention-legislation.aspx)*
3. Devise legislation that provides support for evidence based fatherhood programs that teach fathers and other male caregivers to become capable caregivers of infants and children.
4. Support efforts by the Office of the Child Advocate and the Child Fatality Review Panel to report annual to the Connecticut General Assembly the number of infant and toddler homicides.
5. Connect home visitation and clinical home-based services to pediatrics. Home visitation programs provide essential supports and education to new parents.

RESOURCES

1. National Center on Shaken Baby Syndrome (Enjoy Your Baby), (3 Things Every Dad Should Know), *www.dontshake.org*
2. Enjoy Your Baby: *www.parenting.com*
3. Prevent Child Abuse: *www.preventchildabuse.org*
4. Connecticut Parenting: *www.ctparenting.com*

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