



SUBMISSION OF THE OFFICE OF THE CHILD ADVOCATE, IN SUMMARY OF OCA'S REPORT ON THE DEATHS OF INFANTS AND TODDLERS IN CONNECTICUT IN 2013

The Office of the Child Advocate is honored to present information to the Children's Committee regarding the sudden and unexpected deaths of very young children in the state during the last year. We offer the following as a brief summary of prefatory information, key findings and recommendations from this child death review report.

As a preliminary matter, OCA wants to thank the following people for their contribution to this report: Joan Kaufman, Ph.D., Karen Snyder, M.A., all of the members of the Child Fatality Review Panel, Ankeeta Shukla from Yale School of Public Health, and Felicia McGinniss from University of Connecticut School of Law. Many individuals contributed to the development of this report and their expertise and insight were invaluable and much appreciated.

INTRODUCTION

On July 31, 2013, The Office of the Child Advocate released a report analyzing the unexplained and unexpected deaths of infants and toddlers in Connecticut in 2013. The report was issued pursuant to OCA's obligation to review, investigate, and report regarding the efficacy of child-serving systems and develop recommendations for change. These duties also include investigating and reporting regarding the deaths of children involved with state-funded services.

INFANTS AND TODDLERS ARE THE MOST VULNERABLE TO SUDDEN AND UNEXPECTED DEATH WHETHER BY ACCIDENTAL MEANS OR CHILD ABUSE

Children 0-3, more than any other age group,, are more likely to die from unsafe sleep environments, child abuse or accidental injury. OCA prepared this report to promote transparency and accountability of the state's child death review process by providing the public with information related to the preventable deaths of our most vulnerable children.

OCA LOOKED AT ALL UNEXPECTED UNEXPLAINED DEATHS IN 2013 WHERE CHILDREN DID NOT DIE FROM NATURAL CAUSES

OCA reviewed all 82 fatalities of children age birth to three that came to the attention of the Office of the Chief Medical Examiner (OCME) in 2013. OCA's report outlines the findings from these reviews and recommendations to reduce child fatalities through health care reform and child welfare innovation.

- OCA reviewed child specific records, case files, medical examiner reports and pediatric records.
- OCA worked with consultant Dr. Joan Kaufman from Yale University in reviewing the data regarding child death pertinent to this report.
- OCA met with pediatricians to review common issues, strengths and barriers in providing well-child care for at-risk children.
- OCA consulted with various providers who assist in delivering services to at-risk children and their caregivers.
- OCA reviewed DCF Special Review Reports on the deaths of young children.
- OCA conducted an extensive 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.
- OCA reviewed 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.

INFANT TODDLER DEATHS IN 2013: THE NUMBERS

The 82 cases that were reported to OCA from the OCME were 44 natural deaths, 12 accidents, 10 homicides, and 16 undetermined infant and toddler deaths.

Depending on uniformity of definition, there are between 11 and 15 infant-toddler deaths due to maltreatment and/or homicide.

ROLE OF CHILD WELFARE AGENCY AND THE COMMUNITY IN PREVENTING AND RESPONDING TO CHILD ABUSE OR NEGLECT

In Connecticut, DCF is the lead agency for the prevention of child abuse and the protection of children who are victims of abuse or neglect. However, it is vital to underscore that prevention of child maltreatment and child fatalities cannot rest solely with DCF. It will take a collective effort, meaningful and strategic investment in family strengthening and child survival.

To prevent child abuse or neglect from occurring we need to support access to quality child care, effective primary care, supportive home-visiting and other community-based services that raise awareness and offer information and help to caregivers and their children.

We will need to continue to strengthen our investment in an early-child system of care that delivers a continuum of supports to parents and children together, from information and community services to intensive parent-child therapeutic programming. We will need to connect our community programs, including pediatric offices, to this community system of care. Families who need and want support should have ready access to proven, effective, community and home-based supports. These types of supports can be extremely cost-effective for the state and can markedly improve outcomes for children, including reducing incidence of abuse and neglect.

It is important to note that children can die from abuse or neglect without ever coming to the attention of the child welfare agency.

DCF'S PROTECTIVE SERVICE ROLE FOR CHILDREN WHO ARE SUSPECTED OR SUBSTANTIATED VICTIMS OF ABUSE OR NEGLECT

Children that come to DCF's attention are, by definition, high need. They are often young, and are suspected or actual victims of abuse or neglect. DCF responds with guiding families to community assessments and services, or with more rigorous child protective service investigations, case planning, or foster care.

As DCF (as well as other states around the country) moves to increase "family preservation" efforts—removing fewer children into foster care and maintaining intact families-- it is essential to look at the quality and outcomes from our work.

It must be said that 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.

As part of OCA's child death review procedure and in keeping with OCA's statutory obligation to oversee and make recommendations regarding state agency practices, the report examined child protective service response to maltreated infants and toddlers who later died from abuse or neglect.

Some of the DCF-involved child deaths reviewed for this report raise questions and sometimes significant concerns regarding the efficacy of agency protocols for ensuring infant safety in high-risk homes.

Not all case records, however, reveal a clear 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.

Yet, a review of all cases provides important information regarding risk factors in families that may contribute to the preventable deaths of children.

KEY FINDINGS REGARDING FROM 2013 CHILD DEATH REVIEW

Unsafe Sleep and Sudden Infant Death

- Infants in Connecticut were more likely to die from unsafe sleeping conditions than from child abuse, car accidents, choking, drowning, falls, or any other source of accidental injury.
- In 2013, there were approximately 20 infants who died and who were found in unsafe sleep environments.

Accidents a Leading Cause of Death

- Fatality due to accidental causes or injury remains a leading manner of preventable death for infants and toddlers, both in Connecticut and across the nation.

2013 Saw an Unprecedented Rate of Infant-Toddler Homicide

- 2013 saw 10 homicides of children age birth to three, the highest number of reported homicides of young children in Connecticut since OCA and CFRP began collecting data on child deaths over a dozen years ago.
- The majority of alleged perpetrators were men. The majority of children died from child abuse.

Lack of Data Stymies Efforts to Trend and Track Progress

- Connecticut, like the majority of 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.
- Many states, including CT, may under-report maltreatment fatalities. This is in part because federal data is typically submitted by the child welfare agency alone, and may not include all relevant child fatalities.
- Federal reports, including a 2011 report from the Government Accountability Office confirms that state data submissions regarding maltreatment fatalities are “only a proportion of all child fatalities caused by abuse or neglect.”
- Federal reviewers conclude that there are several factors that complicate states’ ability to collect or even compare data from state to state.
 1. Challenges in child death investigation
 2. Over-reliance on CPS reporting
 3. Lack of uniformity regarding assessment, identification and determinations of abuse or neglect.

- The GAO reports that a peer-reviewed study of fatal child maltreatment in three states found that state child welfare records undercount child fatalities from maltreatment by from 55 percent to 76 percent.
- The GAO concludes that a clear picture of the extent of fatalities and near-fatalities of children is essential to understanding the risk factors leading to or associated with maltreatment. Without this data, states will be hampered in developing meaningful prevention strategies. "As a society, we should be doing everything in our collective power to end child deaths and near deaths." GAO Report, July 2011, Conclusion.

PART II of OCA Report: Opportunities to Strengthen DCF Response to High-Risk Infants

Of the 38 non-natural deaths of children in 2013, 21 children lived in families that had current or previous involvement with the Department of Children and Families. 9 of these deaths were associated with abuse or neglect.

Unsafe Sleep/Undetermined Deaths Where Families had Involvement with DCF

- N = 10.
- 7 out of these 10 children had at least one caregiver with a history of recent substance abuse or who admitted to using alcohol or other substances prior to sleeping with the baby.
- 5 of these children were prenatally exposed to substances.
- *The risk of sudden death due to unsafe sleep factors is higher in homes where a parent has untreated mental health issues or is actively substance abusing.*

Homicides, N=5

- 5 children were killed by child abuse. 2 children had cases open with DCF at the time of the fatality. A third child's case was closed the previous year after the infant was diagnosed with injuries consistent with child abuse.

DCF cases reviewed for this report (N=24, inclusive of 3 natural deaths) often did not include a court referral for parental neglect

- Few of the children's cases were referred to juvenile court; none of the children were removed and placed in foster care.

Risk Assessment/Case Planning Gaps

- DCF response to at-risk infants showed gaps in risk assessment, treatment planning, case follow up, and quality assurance.

- Many families had multiple previous contacts with DCF. History ranged from 1 prior report to 14.
- Parents/Caregivers' histories showed frequent histories of trauma, abuse or neglect, substance abuse, mental health challenges and family violence.
- DCF subject-matter specialists were inconsistently utilized in risk assessment or case planning.
- No cases showed application of DCF's current High Risk Newborn policy, even where infants were prenatally drug exposed.
- The key issue in some of the cases is that the intensity of the intervention, focused on treatment and safety, are not always consistent with the degree of risk in the home. It is unclear how the quality of improvement in parental capacity, judgment and decision-making are assessed.
- Case records did not consistently document nature of communication between DCF and local providers or whether providers and DCF had a common understanding of the needs of the family, the goals of the intervention, and how the measure of progress or rehabilitation would be measured.

Need to Increase Use of Evidence-based In-home Clinical Services

- Review of DCF case records often reveals an unmet need for trauma-informed, home-based services for high-need parents and their children.
- Approximately 1/3 of families' records documented referral and engagement with an in-home provider. Home visiting supports did not appear to be routinely offered for young or teenage parents.

DCF Goals Are Moving in a Positive Direction, Need Remains for Robust Review of Quality and Outcomes

- Reports from the Juan F. Federal Court monitor's office for the first quarter of 2014 echo many of the findings contained in OCA's report.
- Monitor's report notes progressive goals at DCF and positive efforts to reduce entry into foster care, eliminate unnecessary reliance on congregate care for children, and increase family-based care for all children. The Monitor notes that DCF is moving in the right direction.
- DCF achieved compliance with 15 out of 22 Outcome Measures, including reunification, adoption, re-entry into custody, training, and visitation in out-of-home cases. Juan. F. Report, 1st Quarter, 2014, pg. 11 (hereinafter Juan F.).

- DCF did not achieve compliance with 7 out of 22 Outcome Measures, including:
 - a. Completion of investigations;
 - b. Children's needs met;
 - c. Worker-child visitation for children still living in-home;
 - d. Treatment planning.
- The Monitor's report notes that "deficits in staffing and service resource levels is demonstrated by lowered levels of compliance [with outcome measures], problems with the *quality of investigations services and documentation in the case records...*" Juan F. Report, pg. 5
- Upon review of a sample of 54 cases, the court monitor noted "274 identifiable unmet needs [that] rose to the level of what reviewers felt had a significant negative impact on the health, safety or well-being of the children and families ... within the sample." Juan F Report pg. 7.
- Although DCF met its "repeat maltreatment" goal, the Monitor cautioned that verification of compliance with this goal "comes with a caveat" as the Monitor "did uncover issues with the Department's case practice related to Investigations." Juan F. Report, pg. 8.
- According to the monitor's report, "Children at ages two and three, and again at seven and eight appear to have a much higher rate of repeat maltreatment than children of other ages within the sample. Juan F. pg. 23. "Age may be a factor in cases with repeat maltreatment, or at least merits some consideration or weight in planning." Id.
- Reviewers for the federal court monitor wrote numerous comments expressing concern regarding gaps in the quality of early case assessment. Juan F. pp. 31 – 40.

Pediatric Records Often Sparse Regarding Child Welfare or Other Risk Issues

- Pediatric records rarely record awareness of multiple parental risk factors or document the existence or nature of parent counseling or referral.
- Pediatric records do not reflect that social support network, home, or community-based parenting supports are routinely explored.

KEY RECOMMENDATIONS FOR CHILD SURVIVAL

Recommendations emanating from this report fall into two categories:

1. The first category includes things the community and health care systems can do to improve interventions for parents and children and prevent maltreatment before it occurs.
2. The second category are actions that DCF can take to specialize its approach to our most at-risk children: infants and toddlers who are suspected victims of abuse or neglect.

We must know how many children die from accidental causes or maltreatment

- Better develop Connecticut's knowledge and baseline data regarding the number of children who die in unexpected ways, including maltreatment so as to enable the state to track progress with public health reforms and prevention strategies.

Transparency and Accountability for State Investment and Child Survival

- Ensure information about child death reviews, including causes and recommendations for prevention are public, and regularly reviewed so as to inform strategic investment in prevention and treatment strategies.

Invest in Proven and Effective Child Abuse, Child Fatality Prevention Services

- Connecticut is home to several evidence-based parent-child programs that will support better outcomes for children and improve parental functioning, but many programs do not currently have capacity to serve all the parents and children that need them.
- Connecticut must continue to build its continuum of two-generational supports, from home visiting to trauma-informed child-parent psychotherapy. Programs are not one-size fits all, and must be appropriate to level of risk and need in the home.
- Early intervention and treatment is cost-effective; and parents who experience trauma and present with significant mental health and substance abuse issues often need intensive, frequent psychotherapeutic intervention.
- Target home and community-based interventions for fathers and male partners to increase parental judgment and knowledge of child development, essential to reducing the risk of child abuse.
- Ensure all community providers, include in-home service providers are providing counseling regarding safe sleep and shaken baby and documenting problem solving and counseling efforts.

- Collect and report data regarding clinical or other support services that are provided to at-risk parents and young children, with an emphasis on treatment and longitudinal outcomes.

Support Pediatricians' Capacity to Provide Preventative Well-Child Care for young children.

- Ensure that pediatric offices have capacity to offer developmental and mental health screening for children and their caregivers—including maternal depression—and that pediatricians are connected to a continuum of home and community-based resources that will help families.
- Pediatric offices must have access to affordable/reimbursable care coordination not just for children with complex, or chronic disease but for families and children as needed to support a multidisciplinary approach to children's health and well-being.

Increase access to effective substance abuse and domestic violence services for families with very young children.

- Substance abuse and family violence afflicted many families in the case records that OCA reviewed. Ensuring access to high quality services, that can be delivered either in the community or *in the home*, and that includes a relationship, two-generational therapeutic approach, is critical to treating caregivers and protecting children.

Further Innovate Child Welfare's Family Preservation Efforts for Infants and Toddlers.

- Develop a DCF-child welfare practice model specific to children birth to three—include an effective *high risk infant policy*--with appropriate case loads, expert social work and clinical supervision.
- 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.
- Ensure that all maltreated infants and toddlers that come to the attention of DCF have access to proven parent-child treatments and support services.
- DCF caseload standards must be appropriate to children's needs.
- Case workers must be appropriately credentialed for the intensity and complexity of child welfare practice for families with infants and toddlers.

- Require training for all levels of DCF staff, foster parents, court personnel, relevant service providers, and biological parents about the developmental needs of infants and toddlers and the impact of trauma or maltreatment on infants and toddlers.
- Every DCF office must have access to expertise in early childhood issues; needs of children, heightened risk, developmentally-appropriate case planning.
- Consider a special department within each DCF area office that can work with or plan for families that have very young children (age 0 to 1, or 0 to 2).
- Evaluate and publicly report regarding the value and effectiveness of state-funded child welfare services for abused, neglected and at-risk infants and toddlers, with attention to outcomes, disaggregated by age.

INFANT AND TODDLER DEATHS IN 2013

BABY G

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 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.

BABY J

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.

BABY M

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.

BABY J

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.

BABY T

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.

BABY CS

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.

BABY C

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.

TODDLER KJ

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.

BABY O

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.

BABY A

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.

BABY N

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.

BABY J

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 AB

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 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.