

**STATE OF CONNECTICUT
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REPORT RELEASE

JULY 31, 2014

**Office of the Child Advocate Releases Report:
CHILD FATALITIES: CHILDREN BIRTH TO THREE 2013**

The Office of the Child Advocate is releasing a report analyzing the unexplained and unexpected deaths of infants and toddlers in Connecticut in 2013. The report is being 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.

Children 0-3, unlike older children, are more likely to die from unsafe sleep environments, child abuse or accidental injury. OCA submits 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 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. This report outlines the findings from these reviews and recommendations to reduce child fatalities through health care reform and child welfare practice innovation.

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.

Of the 38 non-natural deaths, the majority of children lived in families that had current or previous involvement with the Department of Children and Families. 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.

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 the report 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 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. 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.

Recommendations emanating from this report fall into two categories: 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. 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.

Summary of Findings:

1. 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.
2. 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.
3. 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.
4. 2013 saw 10 homicides of children age 0 to 3--the highest number of reported homicides of young children in Connecticut since OCA and CFRP began collecting data on child deaths. Five (5) of the children lived in families with open or previous DCF involvement.
5. Connecticut struggles to collect and report data regarding preventable infant and toddler deaths, particularly those that are associated with concerns of possible abuse or neglect.
6. Review of DCF-involved children and families reveals the need for a heightened agency response and the development of specific practice protocols that will ensure infant safety in high-risk homes.
7. The majority of DCF-involved families where a child died an "undetermined" death (N=10) included at least one caregiver with a history of recent substance abuse. Five of these same children were prenatally exposed to substances. Undetermined deaths often correlate to the presence of unsafe sleep environments. 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.
8. Review of DCF case records often reveals an unmet need for trauma-informed, home-based services for high-need parents and their children.
9. Pediatric records rarely record awareness of multiple parental risk factors or document the existence or nature of parent counseling or referral.
10. Pediatric records do not reflect that social support network, home, or community-based parenting supports are routinely explored.
11. Records and interviews demonstrate strained communication between pediatricians and DCF.

Recommendations for infants and toddlers include:

- Strengthen the quality and uniformity of child death investigations by all relevant agencies.
- Ensure information about child death reviews, including causes and recommendations for prevention are public.
- Scale up evidence-based and trauma-informed parent-child programs that will support better outcomes for children and improve parental functioning.

- Ensure that all maltreated infants and toddlers that come to the attention of DCF have access to effective parent-child treatment supports.
- Ensure that pediatric offices have capacity to offer developmental and mental health screening for children and their caregivers, and are connected to a continuum of home and community-based resources.
- Given the implications of Adverse Childhood Experiences (ACES) data for health and well-being, our infrastructure development should include focus on increased access to a therapeutic continuum of pre-natal and home visiting services.
- 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.
- Target home and community-based interventions for fathers and male partners to increase parental capacity, judgment, and knowledge of child development.
- Educate male caregivers regarding shaken baby syndrome and fatal child abuse syndrome.
- Increase access to effective substance abuse and domestic violence services for families with very young children.
- Develop a DCF-child welfare practice model specific to children birth to three—inclusive of 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 DCF caseload standards and case worker credentialing requirements reflect 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.
- Evaluate and publicly report regarding the efficacy of state-funded child welfare and related services for abused, neglected and at-risk infants and toddlers.

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