



# **Fatalities Study: Children Ages 0-3**

## **January 2005-May 2014**



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**CT Department of Children and Families (DCF)**  
**Office for Research and Evaluation (ORE)**

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## Executive Summary

According to the National Center for Child Death Review, national statistics show that children under six (6) account for 86% of all maltreatment deaths, and infants account for 43% of these deaths". Fathers and mothers' boyfriends are most often the perpetrators in the abuse deaths. In neglect fatalities, mothers are more often the perpetrator. National studies report that it is difficult to predict a fatal abuse event, but studies have shown that such incidents are interrelated with poverty, domestic violence and substance abuse. During 2013, Connecticut experienced an increase in such deaths the majority of which were young children (ages 3 and under) and had some level of prior or current involvement with the Department of Children and Families (DCF).

Connecticut and National Maltreatment Data is below:

Calendar Year of Incident	Child Deaths Due to Maltreatment				
	DCF CT Number	DCF CT Rate*	NCANDS CT Number	NCANDS CT Rate*	NCANDS US Rate*
2005	N/A	N/A	9	1.08	1.94
2006	3	0.36	3	0.36	2.00
2007	4	0.49	4	0.49	2.28
2008	10	1.20	8	0.98	2.28
2009	6	0.73	4	0.50	2.30
2010	5	0.61	4	0.50	2.08
2011	9	1.10	8	1.00	2.11
2012	10	1.20	6	0.76	2.20
2013	16	2.00	N/A	N/A	N/A
2014	8		N/A	N/A	N/A

*\* All rates are shown as the number of child fatalities per 100,000 children in the relevant population (CT or US)*

While Connecticut has continued to be below the national rate for maltreatment related fatalities, DCF conducted a case-control study of 124 child fatalities involving ages birth to three years that occurred from January 1, 2005 through May 31, 2014 as a means to identify possible factors and employ strategies to reduce the risk for such deaths. The families of the 124 children had DCF involvement prior and/or at the time of the incident. The study examined family circumstances before and around the time of the fatalities and during the period under review for the control cases. The study compared child fatalities ages birth to three with children in placement, children in-home, and children in Family Assessment Response (FAR) cases within the same age range as the fatality cases. The purpose is to better understand the needs, service

delivery, and contributing factors to inform practice and intervention with in-home families. These comparisons allow greater exploration of the type and amount of services needed, and help inform the Department's case practice and decision making.

**Contextualizing Information:**

The State of Connecticut defines child abuse as "a non-accidental injury to a child which, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care." (Connecticut General Statutes § 46b-120(7)). Neglect is defined as "the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education." (Connecticut General Statutes § 46b-120(6)).

For the purpose of DCF data collection, child fatalities that include an associated substantiation of abuse and/or neglect are included in the count for maltreatment. Not all fatalities upon which the Department reports a maltreatment are due to a homicide or a crime. For example, from January 2014 – May 2014 there were eight (8) maltreatment deaths. Five of the deaths were accidents, 1 was undetermined and 2 were homicides. Thus, a fatality that was the result of an accident would be identified as maltreatment provided there was a substantiation.

**Results:**

The results from this study and its recommendations are based upon the Department's research on a universe of cases from the period of January 1, 2005 - May 31, 2014. While DCF's research identifies several risk factors in child fatality cases, these results may not be generalizable. Furthermore, the results neither imply nor should they be construed to represent that any identified factor is inherently correlative with fatality (e.g., behavioral health needs, etc.). These factors cannot be viewed in isolation; they are typically part of a broader constellation of issues that taken together increase the risk for fatality.

Simple and multiple logistical regressions were used to determine whether, based on DCF's universe for the period under review, the following factors had significant correlations. The number of "Not Applicable" and "Unable to determine" responses, however, prevented several variables from being compared.

Significant differences were not observed between fatality cases and controls among the following factors:

- Gender
- Race/Ethnicity
- Sufficient frequency and quality of the visits between caseworker and child
- Visit frequency in adherence with DCF policy.

Statistical significance was, however, determined for the following factors:

**Child Age:** Age is one of the most important factors associated with child fatalities. The older

the child is, the less likely the child is to die. Among the 124 children who died, 65% were less than 6 months of age; in comparison to the children who died at age 3.

**High Risk Newborn:** Children who were high risk newborns due to medical issues were more likely to die between ages 0-3, than those who were not high risk newborns.

**Assessment of Children's Sleeping Arrangements:** Sleeping arrangements were more likely to be assessed among fatality cases than controls. Although fatality cases were more likely to have sleeping arrangements assessed, reviewers expressed concern about documentation. Documentation was not consistently present or sufficient among both sample groups. For example, the documentation would state that the child has a crib without describing the sleep surface or whether items were present that pose a possible safety hazard.

**Assessment of Parents' Needs:** Where DCF made concerted efforts to conduct an initial and/or ongoing comprehensive assessment that accurately determined the needs of parents, were less likely to be fatality cases, compared to those where an agency did not make such an assessment. This suggests that an initial and/or ongoing comprehensive assessment may have a protective effect against child fatality. Given that half of the cases had these types of assessments conducted, it is recommended that the agency continues efforts to implement concrete actions to ensure comprehensive assessments for DCF involved families with children ages 0-3.

**Caseworker Visits with Parents:** Cases in which there was sufficient frequency of visits between the caseworker and parent were less likely to result in a fatality. This suggests that a sufficient frequency of parent-caseworker visitation may have a protective effect against child fatality. Therefore, it is recommended that efforts continue to ensure cases have a sufficient frequency of parent-caseworker visitation particularly for homes with children ages 0-3.

**Mental Health:** Where a parent had a mental health need, it was more likely to be a fatality case than those children whose parent did not have this need.

**Substance Abuse:** Parent substance abuse was more likely to result in a fatality case than those children whose parent did not have this need.

**Domestic Violence:** Cases in which domestic violence was identified, were less likely to result in a fatality case than those children whose parent did not have this need. Future research is needed to examine this finding. It may be that a domestic violence need results in greater scrutiny, judicial involvement and/or father or boyfriend's removal from the home or limited contact with a child, thereby reducing the likelihood of child fatality.

**Case History:** Fatality cases had more Child Protective Services (CPS) reports (substantiated and unsubstantiated) compared to the control cases.

**Causes of Death:** Most fatalities were due to SIDS 28.2% (35), followed by Medical Complications 12.1% (15), Unsafe Sleep 11.2% (14), and Physical Injury 8.1% (10).

The most significant finding is that unsafe sleeping was related to the death in 33.9% (42) of the fatalities. In 40% (14) of SIDS cases, unsafe sleep was also a factor. In 23.8% (10) of the cases

with unsafe sleep, the child was sleeping in a bed with an adult.

**Parents' Ages:** In fatality cases, most parents (33.1%) were between the ages of 20 and 24 years, with their mean age slightly younger than those in control cases.

**Perpetrators:** Most perpetrators in fatality cases were mothers and fathers living in the household (HH). Among the 124 fatalities, 49 children had a total number of 70 perpetrators. Of the 49 children, 28 had one perpetrator, and 21 had two perpetrators. Of the 70 perpetrators, 33 (47%) were mother HH, 17 (24%) were father HH and 20 (29%) were others. Given that most perpetrators were HH mothers and fathers, the percentages of their age ranges are similar to those of the parents.

### **Limitations:**

The review process tested the case review instrument with a small number of reviewers and did not conduct a pilot study after its development.

Another limitation is the percentage of "undetermined" and/or "not applicable" responses for many items, which may have affected results. With a large number of "undetermined" responses, the true results of the comparison between fatality cases and controls depend on the actual status ("yes" or "no") for those "undetermined" children. Also, although the reasons for selecting "not applicable" often are different from "undetermined", their impact on results is similar.

### **Current Initiatives:**

#### Legislation

Section 156. A bill that became effective October 1, 2013 states that DCF shall, within available appropriations, ensure that each child thirty-six months of age or younger who has been substantiated as a victim of abuse or neglect is screened for both developmental and social-emotional delays using validated assessment tools such as the Ages and Stages and the Ages and Stages-Social/Emotional Questionnaires, or their equivalents. The department shall ensure that such screenings are administered to any such child twice annually, unless such child has been found to be eligible for the birth-to-three program.

#### Policy

DCF Policy 44-12-8, Safe Sleep Environments, effective March 5, 2014 (new)

The policy can be accessed here: <http://www.ct.gov/dcf/lib/dcf/policy/pdf/44120800.pdf>

- The Social Worker shall, during each home or placement visit for an infant, ask to observe the infant's sleep environment.
- The Social Worker shall engage caregivers of infants in problem solving regarding safe sleep barriers.
- The Social Worker shall discuss any concerns with the caregiver and make recommendations for resolution. If a risk factor is identified during a visit and cannot be

resolved, the Social Worker shall immediately consult with the Social Work Supervisor as well as the pediatrician for the infant and any home visiting or parents' support services in place.

The policy also speaks to assistance with procuring equipment and the expected documentation regarding the discussions with the family. In addition, there is a practice guide that, "...provides DCF staff with evidence-based knowledge to assess the safety of an infant's sleep environment and to educate caregivers about how to create a safe infant sleep environment."

The practice guide can be accessed here:

[http://www.ct.gov/dcf/lib/dcf/policy/pdf/Safe Sleep - practice guide FINAL.pdf](http://www.ct.gov/dcf/lib/dcf/policy/pdf/Safe_Sleep_-_practice_guide_FINAL.pdf)

There are other DCF policies regarding infants and toddlers. More information regarding these four policies can be found in Appendix B.

DCF Policy # and Name	Purpose
34-2-6: "Critical Questions to Answer"	Includes questions to be asked during an investigation.
34-12-2 "High Risk Newborns"	Includes indicators and information to be obtained during an investigation.
34-12-3 "Disabled Infants with Life Threatening Conditions"	Offers definitions and outlines of the responsibilities of different departments within the agency.
33-7-15 "Save Haven for Newborns"	Allows for a parent or lawful agent of the parent may voluntarily surrender physical custody of an infant age thirty (30) days or younger to the nursing staff of a hospital emergency room

#### Programs/Assessments/Initiatives

Some of the Department's efforts and the programs utilized to improve practice with families caring for young children, as well as to address factors contributing to child fatalities are noted below:

#### Children Ages Birth to Three Years

- 24/7 Dads: Curriculum based parenting program for new fathers of young children.
- Access to Preschool for Children in DCF Care: According the budget implementer, section 132-133, "the DCF Commissioner, in consultation with the Office of Early Childhood, shall adopt policies and procedures that maximize the enrollment of eligible preschool-aged children in eligible preschool programs, and submit such policies and procedures to the joint standing committees of the General Assembly having cognizance of matters relating

to children, human services, education and appropriations by January 1, 2015.”<sup>1</sup>

- Baby Elmo Project: Connecticut Juvenile Training School (CJTS) implemented the Baby Elmo Program in 2013, making it only the third state in the country to establish this important program for juvenile justice committed males who are fathers. Youth who self-identify as fathers are offered the program which includes up to 10 training sessions, each on a particular topic related to relationships, communication, and development. The fathers have the opportunity to apply the concepts they have learned during semi-structured visits with their children. At CJTS, the rehabilitation staff takes the lead on this important program, with the support of clinical, medical, and residential staff. The focus of Baby Elmo is on building and maintaining a relationship between the teen parent and his child, as opposed to focusing on learning abstract parenting information.

The Department will be exploring an expansion of the Baby Elmo Project curriculum to serve all parenting adolescents. We will further be looking at strategies to support our adolescent population who may be at risk for becoming teen parents.

- Birth to Three System: Assists and strengthens the capacity of families to meet the developmental and health-related needs of infants and toddlers who have delays or disabilities.
- Child Abuse Pediatricians (CAPs) and Careline 8 Month Pilot Project: The provision of on-call, timely consultation by Child Abuse Pediatricians (CAPs) to Careline after hours and on weekends. The CAPs reviews a subset of non-accepted reports for infants younger than 12 months of age. Ongoing education and training of Careline and other DCF staff about appropriate recognition and disposition of high-risk injuries suggestive of abuse will be occurring.
- Child First Program: An evidence-based early intervention program for very young children and their families with significant mental health and child welfare needs. Serves families statewide for children birth to five years to specifically to address mother/child and parent/child attachment and bonding as well as parenting overall.
- Early Childhood Consultation Partnership (ECCP®): Statewide, evidence-based, mental health consultation program designed to meet the social and emotional needs of children birth to five in early care or education settings. Implemented by Advanced Behavioral Health, Inc. (ABH) and DCF.
- In 2015, the Department will be finalizing a transaction to expand an array of evidence based, substance use and recovery services for parents, caregivers and adolescents through Social Impact Financing. Investment in these services is crucial to addressing many of the challenges that have been identified in fatalities involving young children.

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<sup>1</sup> Early Childhood Alliance, (May 2014), Bills, <http://www.earlychildhoodalliance.com/bills>



- Family Based Recovery (FBR): A program for families affected by substance abuse. It provides in-home attachment-based parent-child therapy and contingency management substance abuse treatment. FBR treats mothers and fathers who are actively using substances or who have recent history of substance abuse that are also parenting a child under the age of 8.
- In November 2014 the Department, in partnership with DMHAS and other state and local partners, was awarded In-Depth Technical Assistance (IDTA) from the National Center on Substance Abuse in Child Welfare to implement a coordinated, statewide response to addressing fetal and neo-natal substance use disorders. With the IDTA, the partnering entities will be hiring a statewide coordinator to oversee this collaboration. In addition, with the IDTA, DCF will be implementing a pilot program in one or more hospitals to support families caring for substance exposed newborns.
- Maternal Infant Outreach Program (MIOP): Provides referrals, assessments and service coordination.
- Nurturing Families Network: A program for young children with substance abusing parents.
- Zero to Three (ZTT): A federal program for children 0-3 to provide increased visitation for young children placed in care and expedite reunification/permanency for these children

### Child Fatalities

- Medical screening guidelines were established to detect child abuse and neglect, as well as support ongoing educational sessions for the medical community. The Department will be collaborating with the Connecticut Hospital Association to create mandatory training for health care professionals working in pediatric medical settings and emergency departments.
- DCF in partnership with the Connecticut Hospital Association (CHA), as well as statewide child abuse pediatrician (CAP) consultants from Yale and CCMC, lead a broad-based multidisciplinary workgroup to identify best practices around the recognition and reporting in hospital settings of suspected abuse and neglect related injuries in children. The workgroup, focused initially in DCF's Region 3, has developed a blueprint of best practices in hospital settings to improve the recognition and reporting of suspected physical abuse. This blueprint will serve as a guiding framework for future collaboration with all hospitals statewide around the early identification, screening and detection of risk factors and injuries.
- A quality improvement/quality assurance review system has been developed to track cases in which a fatality has occurred. A system is in place to track child fatalities and critical incidents and conduct a case review. The case reviews examine items such as prior DCF history, SDM assessments reviews, risk factor review, and other case related information.

- DCF's Office for Research and Evaluation (ORE) is developing a case review system for all fatalities and will also collaborate with the Regions in order to combine these efforts.
- A public health campaign will be designed and developed to increase caregiver knowledge and raise public awareness of topics relevant to preventing child abuse and maltreatment. In May 2014, DCF secured technical assistance from Casey Family Programs and Prevent Child Abuse America to work with agencies to develop targeted messaging for a public health campaign to raise public awareness and caregiver knowledge around recurring issues that present in case fatalities, such as unsafe sleep and abusive head trauma. Through this technical assistance, DCF has been working with a broad coalition of stakeholders, including the Office of the Child Advocate, Office of Early Childhood, and pediatric and other medical professionals to design this campaign with an initial focus to target high risk populations and the general public around these issues.
- Since May 2014, DCF has been working in partnership with Cribs for Kids to provide portable cribs and safe sleep kits to high risk clients. Over 250 "safe sleep kits" have been distributed statewide since entering into this partnership.
- DCF will be participating in a research roundtable with the Casey Forum and the Federal Commission to Eliminate Child Deaths.
- DCF met with the Eckerd Foundation, a family service organization, who has worked with the state of Florida in response to child fatalities, to discuss a potential partnership. We are currently working with Eckerd to enter into an agreement to bring their Rapid Safety Feedback model to Connecticut. Casey Family Programs has offered to support the Department with the implementation of this approach.
- Child Fatality Tool Kit: This kit is being developed and is intended to be used to guide case practice during child death/near death events by DCF staff, DCF congregate care programs, and community providers. This guide will outline the steps that should be taken immediately following a fatality or near fatality. It will also address the psychological and emotional impact that these events may have on children, youth and their families as well as on staff.

### Data Collection

The Department's data collection system regarding fatalities has been enhanced, including the process by and breadth of information that is inputted.

- Critical Incident Data Collection and Reporting Protocol: DCF's Risk Management Unit now maintains all critical incidents and collects all information related to each critical incident. They serve as the central repository and disseminator of data and information. This protocol covers a subset of the reasons for reporting Critical Incidents which include all: (1) Death of child (Child fatality); (2) Life-threatening or life altering condition/injury suspected to have been caused by child abuse or neglect; (3) Broken bones suspected to have been caused by child abuse or neglect to children under 6-years

of age; and (4) Serious injury of a child currently or previously DCF involved. The last two reasons were included because these types of incidents could become life threatening or fatal.

- DCF Electronic Case Management System: ORE and the DCF Division of Health and Wellness are developing a formal list of data collection elements to be considered for inclusion into the statewide electronic DCF system.
- Recognition of and Reporting Abuse/Neglect: Frontline providers can face significant barriers to reporting suspected abuse, including concerns that a diagnosis of abuse may be incorrect and result in adverse consequences due to reporting. As a means to address these barriers, DCF has reached out to various partners to improve the recognition of child abuse, especially for infants and young children where the symptoms may be more difficult to recognize. DCF, in partnership with Yale New Haven Children's Hospital (Yale) and Connecticut Children's Medical Center (CCMC), continues to offer expert education and consultation to the state's hospitals to effectively recognize abuse when a child is brought in with an injury.
- DCF Special Review Reports: The purpose of the Special Review is to provide an independent case analysis and timely systemic consultation in the aftermath of a child fatality or critical incident. The Special Review's emphasis on education and teaching is designed to generate practical feedback and information for professional learning, organizational development and staff support within and across helping systems. The multidisciplinary approach offers a consistent methodology that focuses on relevant fact-finding, and identification of key dimensions in case practice determined to be excellent, acceptable or in need of improvement.

### **Recommendations:**

The following recommendations are derived from an analysis of the study data, and both written and verbal feedback from the review team. The verbal feedback was obtained during a formal debriefing session held on August 12, 2014. An overarching theme that emerged was for the Department to cultivate broader community partnerships and invest in additional preventative programming. More detailed recommendations can be found later in this report:

**Enhancing Data Collection System:** No formal system exists for DCF to obtain information about fatalities after closing its cases. The Office for Research and Evaluation is currently enhancing the Critical Incident data collection system to include information that is collected during the CPS investigation.

**Working Collaborative with Hospital and Other Public Health Professional:** Continuing to work collaboratively with hospitals and other public health partners is important to impact the root causes of early childhood fatalities. Early screening and detection on needs in high risk families (e.g., young mothers, teen parents, un-treated behavioral health) must continue to be a focus of this work. In addition, the need to raise public awareness and enhance education around best

practices to mitigate some of the risk factors will be a key priority for collaboration with these partners.

**Working Collaboratively with Law Enforcement:** Continuing to work collaboratively with law enforcement is imperative in fatality cases. Information that only law enforcement can obtain may inform the determination of the CPS case disposition. "Therefore, it is important that law enforcement and CPS communicate and coordinate their efforts during the investigation."<sup>2</sup>

**Pre-Natal Care:** It is imperative that the agency continues to work collaboratively with hospitals and other community partners to help ensure that pregnant women receive appropriate pre-natal care, address any complications during their pregnancy or in utero exposure to drugs and/or alcohol.

**Documentation:** Reviewers noted documentation areas needing improvement. One area was observations of the parent/child relationships that could inform the caregivers' parenting skills, needs, and expectations of their children. Another area was discussions with parents about safe sleep beyond giving them the brochure. A third area was observations and assessments of the child, which is integral to adequately identifying needs and appropriate service provision. At times, observations of children included only information about the child's physical appearance without mention of the child's development. Next, providers' work with DCF families is important information that must be clearly documented in the electronic record. Last, information about the child's medical history or mother's pre-natal history which could help identify possible contributing factors was missing in fatality cases.

**Focusing on Prevention:** Research identifies factors associated with child maltreatment fatalities. This project identified factors that were statistically significant such as child's sleeping arrangement. Children's sleeping arrangements were more likely to be assessed among fatality cases than controls, suggesting that the agency is on the right track to prevent child fatality. Despite the agency's efforts, some children died, indicating the need for more innovative interventions to better prevent child fatalities; for example, an integrated system that examines cases with factors highly associated with child maltreatment fatalities in real time to ensure that they are assessed and addressed effectively. Continuing to expand the focus on prevention is an important component.

#### **Training Suggestions:**

**Child Development:** Continuing to ensure that specific child development training is available for DCF staff and required for provider staff that includes topics such as feeding times, forms of nutrients, child's motor skills, infant/toddler development stages (e.g., timeframes for crawling, reaching, sitting up, and so forth., eye-contact, sleeping patterns, and speech development).

**Engaging Families Who Have Experienced a Child Fatality:** Some reviewers expressed concerns about the response to families where a fatality occurred. "All too often, we as professionals are

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<sup>2</sup> Department of Justice, Walsh, Bill (August 2005), Investigating Child Fatalities: Portable Guides to Investigating Child Abuse. <https://www.ncjrs.gov/pdffiles1/ojdp/209764.pdf>

unprepared to deal with the emotions and feelings that surviving family members' experience when a child dies due to abuse or neglect. This may be due in part to our lack of training and/or experience in this area and may also be a result of our own issues related to abuse and death."<sup>3</sup> Evidence of initially offering grief counseling to the family was noted in some cases but there was typically no follow-up. Understanding the impact a death could have on a family and how they can be supported is important.

**Child Protective Service (CPS) Staff:** Allowing staff to express concerns about personal triggers related to case assignment is also important. The circumstances of a case may cause the staff to experience secondary trauma. A few examples were provided during the debriefing. Ensuring that fatality investigation cases are equally distributed among staff and the number assigned during a certain timeframe are other considerations.

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<sup>3</sup> National District Attorneys' Association (November 4, 2004), *Serving Those Left Behind: Crisis Intervention in Child Fatality Cases*, Volume 17. [http://www.ndaa.org/ncpca\\_update\\_v17\\_no4.html](http://www.ndaa.org/ncpca_update_v17_no4.html)

## Fatalities Study: Children Ages 0-3

### Section I: Purpose and Introduction

Families become involved with the Child Welfare System for various reasons, including allegations of abuse/neglect, requests for voluntary services, or juvenile justice. Many times families are in crisis, facing hardship, have economic challenges, struggling with substance abuse or mental health, experiencing domestic violence, or any combination of such factors. The trajectories of these families vary, occasionally leading to child fatalities in the most tragic cases. The causes of these fatalities range from unknown causes, medical issues to homicide by a caregiver. Younger children are most vulnerable due to their age and dependence on adults. According to the 2011 Child Welfare League of America Quality Improvement Report, more than four-fifths (82%) of children who died from maltreatment were under the age of 4 years; 42% were younger than 12 months.

The U. S. Department of Health and Human Services, Child Maltreatment 2012 report states, "While the national estimate and rate are lower for 2012 than for 2008, both the number and rate have been increasing since 2010." Similar to the national trend, Connecticut (CT) has experienced an increase in maltreatment deaths since 2010. The majority were very young children (ages 3 and under) from families with differing levels of prior or current involvement with the Department of Children and Families (DCF). An important change that came into effect on October 1, 2013 was that CT added criminal charges for failure to report or prohibiting the reporting of suspicion of child abuse and neglect. This change has likely resulted in more unexpected child deaths being reported to the Department. In response to these deaths, (referred to as critical incidents), DCF decided to conduct a case-control study of all fatalities of children ages 0 - 3 that occurred from January 1, 2005 through May 31, 2014.

This study examines the circumstances of the families prior to and around the time of the fatalities and during the period under review for the control cases. The design of the study compares child fatalities ages birth to three with children in placement, children in-home and children in Family Assessment Response (FAR) cases within the same age range. The purpose is to better understand the needs, service delivery, and contributing factors to inform practice and intervention with in-home families. These comparisons allow greater exploration of the type and amount of services needed, and help to inform DCF case practice and decision making.

In addition to the above noted statutory changes, another reason why there may have been an increase of child fatality reports in 2013 may be due to the collaborative work that DCF did with the medical community in the previous year. In 2012, DCF began working with the local medical community in order to improve the recognition and reporting of child abuse when a child presents in a medical setting with a traumatic injury. This came in response to the death of a 3 year old girl who died hours after being treated at a hospital for a head injury, which was later discovered to have been caused by physical abuse by her mother's boyfriend. It was at this point, DCF recognized a need to collaborate with the medical community in order assist them in better recognizing signs of abuse and neglect.

A multidisciplinary coalition was established, including representatives of child welfare, medical, advocacy and provider communities, in order to develop collaborative and proactive strategies that promote the early detection of child abuse. This resulted in a set of guidelines that provide medical personnel with a protocol to follow when a child presents in any clinical setting with a traumatic injury that may have been caused by abuse or neglect. This may have also been a contributor to the increased numbers of abuse/neglect reports received from medical staff. The number of hospital reporters has increased every year for the past three fiscal years. The proportion of reports increased from 2011-12 and 2012-13, but stayed the same for 2013 to 2014. Better training may also have led to more accurate reporting, as substantiation rates also jumped for these reporters between 2012 (30.3%) and 2013 (34.6%), though stayed about the same for 2014 (34.7%).

## Background

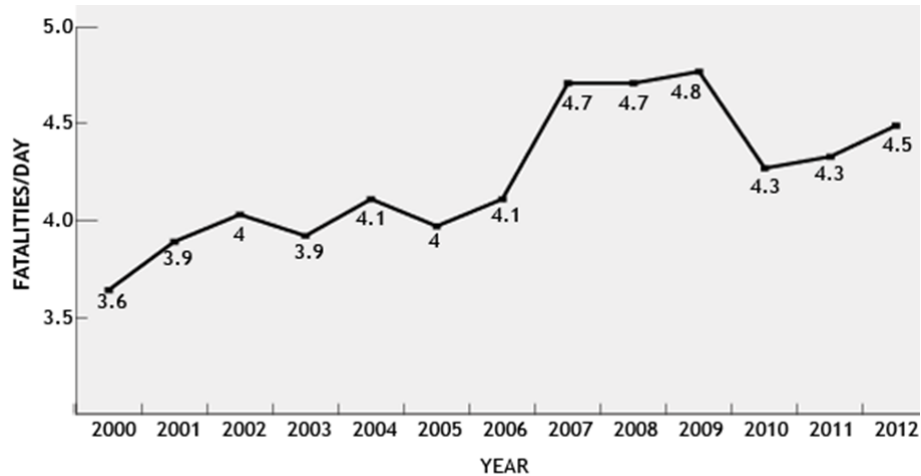
### **Contextualizing Information:**

The State of Connecticut defines child abuse as “a non-accidental injury to a child which, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care.” (Connecticut General Statutes § 46b-120(7)). Neglect is defined as “the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education.” (Connecticut General Statutes § 46b-120(6)).

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According to the U. S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2013) and the United States Government Accountability Office (2011), the children of our country are suffering from a hidden epidemic of child abuse and neglect. Yearly, more than six (6) million children are alleged to be abused or neglected in the more than three (3) million reports made to child protection agencies. The figure below demonstrates the fluctuating estimated number of child fatalities on a daily basis. The estimated number increased in 2007 then decreased in 2010. Since then, the numbers have been increasing.

Estimated child maltreatment fatalities per day:



Note: National data is likely to underestimate the number of children who died from maltreatment<sup>4</sup>

"National statistics show that children under six (6) account for 86% of all maltreatment deaths and infants account for 43% of these deaths."<sup>5</sup> Fathers and mothers' boyfriends are most often the perpetrators in the abuse deaths (fatal abuse). Whereas in neglect fatalities, mothers are more often the perpetrator. Fatal abuse is interrelated with poverty, domestic violence and substance abuse. National studies report that it is difficult to predict a fatal abuse event. In the U.S., studies find that the majority of child victims and their perpetrators had no prior contact with Child Protective Services (CPS) at the time of death, yet many children had previous injuries that were not reported to CPS systems.<sup>6</sup>

Douglas and McCarthy's research bolstered prior studies indicating that states with higher poverty levels and lower spending levels on social programs had higher fatalities rates. For each additional 1% of a state's population living in poverty, the fatality rate increases by 0.09 per 100,000 children. This study, which included an assessment of the efficacy of legislation to prevent child maltreatment fatalities, indicated that there was no change in the fatality rates in states with or without prevention-based legislation.

Klevens and Leeb's research supported earlier studies that indicated that more than half of the victims of child maltreatment fatalities are under one (1) year of age. Further, the two most common abuses resulting in such fatalities are abusive head trauma "shaken baby syndrome" and blunt force trauma typically in the abdominal area. The majority (44.7%) of perpetrators of these types of abuse are males known to the child/family, followed by mothers (20.5%).

<sup>4</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2013), Child Maltreatment 2012.  
<http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>

<sup>5</sup> National MCH Center for Child Death Review: Keeping Kids Alive, Fall 2013 Newsletter, A National Resource Center for Child Death Review

<sup>6</sup> Ibid



Vos Winkel and Ogdalsky's report regarding Connecticut fatalities from January 1, 2001 through January 1, 2011, indicates that fatalities of youth age 12 and under ruled as homicides are most often perpetrated by a family member or friend. 73% of these fatalities were children under the age of two (2), with the majority caused by blunt force trauma. Connecticut specific data on perpetrators of child homicide is similar to national data that the perpetrator is often a relative or involved with the child's family. Additionally, the perpetrator is most commonly the father, followed by paramours or former paramours.

Graham, Stepura, Baumann and Kern's research looked at predictive factors in households with child fatalities. Their research indicated that variables associated with neglect fatalities included: "families with a sole caretaker, a young victim, a high severity of past incidents, substance abuse, low income and high stress." Variables related to physical abuse fatalities included: "a young victim, a male victim, a history of past severe abuse toward children, and maladaptive beliefs about children. Additionally, substance abuse by a caregiver, mental incapacitation, history of violence toward others, poor parenting knowledge and skills, adolescent caregivers, and caregivers with high stress levels tended to be more proportionally associated with physical abuse fatalities."<sup>7</sup> Further, their research indicated that "the greater the distance in the relationship between the perpetrator and child (e.g., a biological parent versus a paramour), the higher the probability and severity of maltreatment."<sup>8</sup>

A closer review of these factors may be beneficial to the Department with respect to reducing child fatalities in Connecticut. These predictive factors may inform the enhancement of existing methods of intake, both traditional investigation and Family Assessment Response (FAR), to better identify households where the risk of child fatality is high.

## **Section II: Methodology**

### Case Control Study

It has been reported that the national rate of child fatalities was 2.2 deaths per 100,000 children (U.S. Department of Health and Human Services, 2013). Such a low fatality rate makes a longitudinal study extremely expensive and time-consuming. A case-control study is a type of observational evaluation used to identify factors that may contribute to a disease or outcome by comparing subjects who have that disease/outcome (the "cases") with other subjects who do not have the disease/outcome but are otherwise similar (the "controls") (Greenberg, 2004; Lewallen, 1998). This study design, originally developed in epidemiology, is widely applied in different fields, including the social sciences.

Case-control studies have specific advantages compared to other study designs such as

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<sup>7</sup> Graham, J. Christopher, Stepura, Kelly, Baumann, Donald J, and Kern, Homer (2010) Predicting Child Fatalities Among Less-Severe CPS Investigations, *Children and Youth Services Review*, 32, 274-280.

<sup>8</sup> Graham, J. Christopher, Stepura, Kelly, Baumann, Donald J, and Kern, Homer (2010) Predicting Child Fatalities Among Less-Severe CPS Investigations, *Children and Youth Services Review*, 32, 274-280.

longitudinal studies and randomized control trials. They are less costly and less time-consuming, and are particularly efficient for rare diseases or outcomes with a long latency period between factor and disease/outcome. Case-control studies, however, are subject to selection bias and inefficient for rare factors. In addition, information on factors is subject to observation bias. Balancing the advantages and limitations, a case-control study design was most appropriate for this project.

### Fatality Cases and Controls

The fatality cases in the present project included all Connecticut children with a history of DCF involvement who died between January 1, 2005 and May 31, 2014 in the age range of birth to three years (n = 124). DCF involvement was defined as the target child or the family having been served by DCF at any time point prior to the child's death.

One of the most important aspects in case-control studies is the selection of a comparable control group. The controls should be free of the outcome of interest, representative of the population at risk of the outcome, and be selected independently of the exposure of interest. Therefore, the controls should be randomly selected from the source population that produced the cases (Wacholder, 1992). This is not, however, always possible in practice. When a roster of source population is not available or creating the roster is extremely expensive, alternative controls such as neighborhood controls, hospital or disease registry controls, friend controls or relative controls are typically used. One important disadvantage of these alternative controls is that the exposures in the control group may be different from the population that produced the cases, which can lead to serious bias for the study.

Fortunately for this project, we have a roster of source population and thus the same number of controls was randomly selected from children age 3 years or younger whose family had a history of DCF involvement in the same year, according to the year of the child's death. We used frequency matching on the year of the child's death to select the control group, rather than individual matching on multiple factors for the following reasons. First, we are interested in examining a wide range of risk and protective factors of child fatalities. It would be hard to determine factors (i.e., strong confounders) that should be matched for cases and controls because strong confounders may be different for different risk and protective factors that are being studied. Second, over-matching is possible particularly when an inappropriate number of factors are matched. In addition to the difficulty of finding enough controls, over-matching makes cases and controls become increasingly similar with respect to the exposures of interest, and thus the study may not be able to detect a significant association between a factor and a disease/outcome, even if such an association actually exists. Moreover, once a factor has been matched, the role of this factor on the risk of fatality could no longer be examined.

### **Section III: Review Process**

Qualitative and quantitative case reviews were conducted on the full census of child fatalities ages birth to three with DCF involvement and random samples of children in placement and children in-home ages birth to three from the CY 2005 - May 2014. After identifying all of the cases in the census along with the control cases equaling two-hundred and forty eight, case

reviews were conducted by the Office for Research and Evaluation (ORE) and a review team that included staff from:

- Office of Administrative Case Review
- Area Office Quality Assurance/Improvement
- Court Monitor's Office
- Early Childhood
- Health and Wellness
- Therapeutic Foster Care
- Workforce Development Academy

Twenty-eight reviewers were randomly assigned cases from the two-hundred and forty eight sample cases (one-hundred twenty four fatalities and one-hundred twenty four control cases). The reviewers were intentionally selected from diverse workgroups across the agency in order to ensure an in-depth understanding of the cases reviewed.

ORE and the review team developed a case review instrument which they completed and entered into an electronic database. The sources of information included the electronic LINK record and the Significant Events and Critical Incidents Database. While these data sources are parts of the official case records, it is possible that other relevant information resides in the hard copy records and in the knowledge of staff involved with the cases. Future replication studies may include the review of other such data and information, in addition to that found in the electronic records.

#### **Section IV: Data Analysis**

Descriptive statistics were used to illustrate the characteristics of cases and controls including distribution of risk/protective factors; chi-square test and Student's t-test were used to compare group difference for categorical and continuous variables, respectively. When a chi-square test was inappropriate (i.e., more than 25% of the cells having expected counts less than 5), Fisher's exact test was used to compare differences for categorical variables.

An area of focus for the study was to examine the differences regarding need assessments and service delivery. Many subjects were not eligible for these or their status for assessments/services could not be determined due to the lack of recorded evidence. Therefore, many variables had a large percentage of "not applicable" or "undetermined", which were coded as different categories and were taken into account in the analysis. Those variables with an overall p-value (from the chi-square test or Student's t-test) of less than 0.20 were included in a logistic regression model building process. In logistic regressions, odds ratios (ORs) are commonly used to measure the associations between factors and outcomes. An OR is the ratio of the odds of a factor in the case group to the odds of a factor in the control group. It is important to calculate a confidence interval (CI) for each OR. A CI equal to 1.0 means that the association between the factor and outcome could have been found by chance alone and that the association is not statistically significant.

Given the large number of variables under investigation and the relatively small sample size, several steps were taken to build the logistic regression models for the study. First, dummy

variables were created for all variables with three or more categories (e.g., yes, no, not applicable). Second, a series of simple logistic regression models were conducted for those variables with a p-value (from a chi-square, Fisher's Exact Test or Student's t-test) less than 0.20. Simple logistic regression is commonly used to explore the association between one (dichotomous) outcome and one (continuous, ordinal, or categorical) exposure variable. Third, those variables with a p-value less than 0.20 between 'yes' (or 'needs identified') and 'no' (or 'needs not identified') from the simple logistic regression were included in the initial multiple logistic regression model. Multiple logistic regression is used to explore associations between one (dichotomous) outcome variable and two or more exposure variables. Fourth, a manual backward selection procedure was then used to sequentially eliminate the variables that did not remain significant between 'yes' (or 'needs identified') and 'no' (or 'needs not identified'). Considering that age is an important factor for child fatality, age is always included in all multiple logistic regression analysis. The significance level was defined as a two-tailed  $p < 0.05$ . SAS software, version 9.4 (SAS Institute Inc., Cary, North Carolina), was used to complete these analyses.

### **Section IVa: Descriptive Analysis**

The Department of Children and Families (DCF) serves tens of thousands of families on an annual basis. Families come to the attention of DCF by self-referral, referred by family members, community providers, and/or law enforcement. The DCF Careline, which receives the initial phone call, operates 24 hours a day, 365 days a year. In 2013, the DCF Careline received 89,355 calls, which resulted in 29,631 accepted reports for suspected abuse/neglect. In 2013, 34,704 unique families were served through DCF's various services, including those receiving Voluntary Services, Family Assessment Response (FAR), Probate, Family With Service Needs, Juvenile Justice, and Interstate Compact. This resulted in a total of 73,735 unique children being served by DCF during 2013.

The following table shows the number of CT child maltreatment fatalities from two separate data sources: the DCF Critical Incidents Database and the data DCF submits to the federal government's National Child Abuse and Neglect Data System (NCANDS) report. The NCANDS data, as specified by federal criteria, comes from CPS Investigation information. Such data tends to be limited to information available within a short window following the incident. For evaluative purposes, the Department considers the data from the Critical Incidents database to be more authoritative because DCF's Risk Management team conducts additional follow-up as additional facts and information are revealed over time in order to ensure the most accurate reporting.

Calendar Year of Incident	Child Deaths Due to Maltreatment				
	DCF CT Number	DCF CT Rate*	NCANDS CT Number	NCANDS CT Rate*	NCANDS US Rate*
2005	N/A	N/A	9	1.08	1.94
2006	3	0.36	3	0.36	2.00
2007	4	0.49	4	0.49	2.28
2008	10	1.20	8	0.98	2.28
2009	6	0.73	4	0.50	2.30
2010	5	0.61	4	0.50	2.08
2011	9	1.10	8	1.00	2.11
2012	10	1.20	6	0.76	2.20
2013	16	2.00	N/A	N/A	N/A
2014	8		N/A	N/A	N/A

\* All rates are shown as the number of child fatalities per 100,000 children in the relevant population (CT or US)

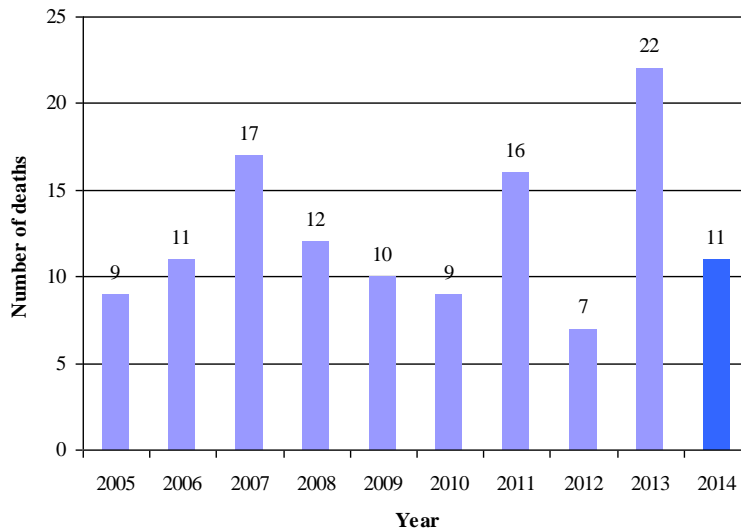
Of the eight (8) fatalities in 2014 attributed to maltreatment, five (5) were identified as accidents, one (1) was noted as undeterminable and two (2) were categorized to be homicides.

#### Trend of DCF-Involved Fatalities of Children Ages 0 - 3

It must be noted that the results from this study and its recommendations are based upon the Department's research on a universe of cases from the period of January 1, 2005 - May 31, 2014. While DCF's research identifies several risk factors in child fatality cases, these results may not be generalizable. Furthermore, the results do not imply or should be construed to represent that any identified factor is inherently correlative with fatality (e.g., behavioral health needs, etc.). These factors cannot be viewed in isolation; they are typically part of a broader constellation of issues that taken together increase the risk for fatality.

This study focusses on 124 cases for the period of January 2005 – May 2014 that involved a fatality of a children ages birth to three years. (Figure 1). A pattern was observed from 2005 to 2010. The number of deaths increased between 2005 and 2009 with a peak in 2007. In 2013, the number of deaths was 22, while in 2012 it was 7. As stated earlier there was an increase in 2012 – 2013, which might be attributed to the legislative change and community partnerships, resulting in more accurate reporting.

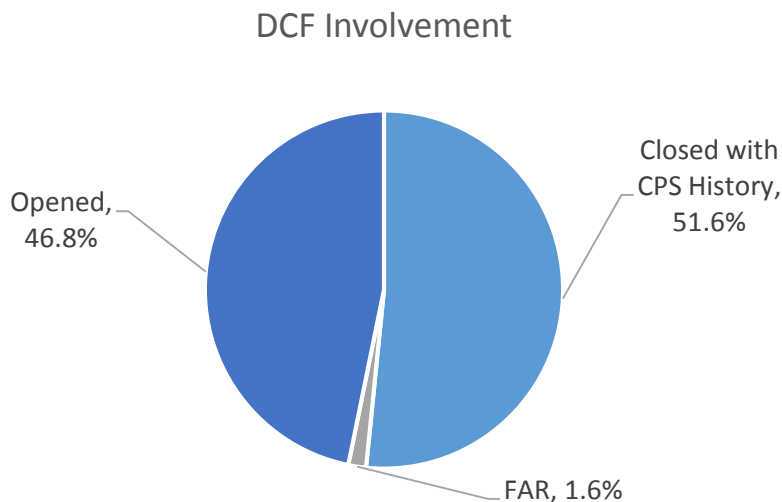
**Figure 1. Number of children whose family had a history of DCF involvement prior to their death between the ages of birth to three years by year, Jan 1, 2005 - May 31, 2014 (N = 124)**



Status of DCF Involvement Among Fatality Cases

Of the 124 children who died, 58 children (46.8%) were in cases that were open for services at the time of their death; 2 (1.6%) for Family Assessment Response (FAR) services; and 64 (51.6%) were closed, but had previous CPS history (Figure 2).

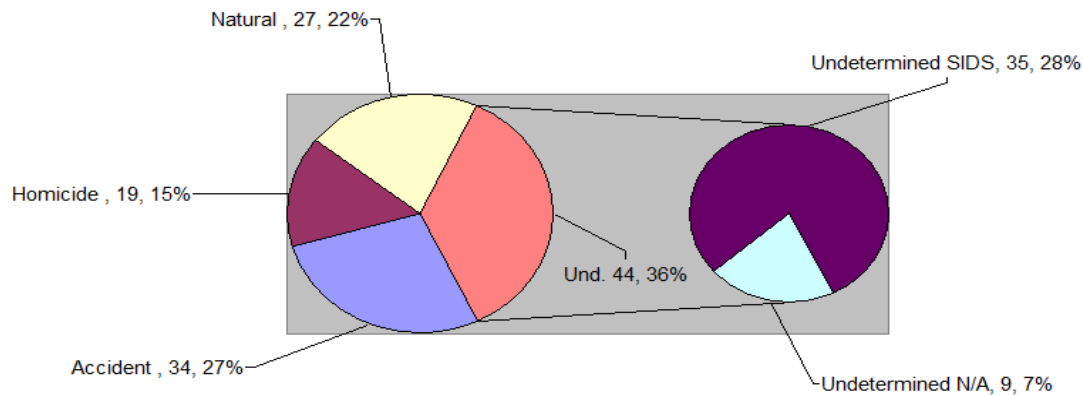
**Figure 2. Percent of children whose family had a history of DCF involvement prior to their death by status of involvement, Jan 1, 2005 - May 31, 2014 (N = 124)**



### Manner and Causes of Fatalities

Among the 124, the manner of death for 27% of children was determined to be an accident, 22% were natural causes, and 15% were homicide; the manner of death for 36% of the fatalities could not be determined (Figure 3). Among children whose death was an accident, 41% were due to unsafe sleeping and 21% due to accidental suffocation or strangulation in bed. Among children whose death was from natural causes, more than half (56%) were due to medical conditions. For children whose manner of death was homicide, 53% were caused by physical injury and 26% shaken baby.

**Figure 3. Manner of death for children whose family had a history of DCF involvement prior to their death between the ages of birth to three years, and number of SIDS deaths, Jan 1, 2005 - May 31, 2014 (N = 124)**



### SIDS (Sudden Infant Death Syndrome)

"SIDS is the leading cause of death among babies between 1 month and 1 year of age."<sup>9</sup> Among the 124 fatalities, the cause of death was determined to be SIDS for 35 (28%) of the children. The cause of SIDS is unknown. "More and more research evidence suggests that infants who die from SIDS are born with brain abnormalities or defects. These defects are typically found within a network of nerve cells that send signals to other nerve cells. The cells are located in the part of the brain that probably controls breathing, heart rate, blood pressure, temperature, and waking from sleep. At the present time, there is no way to identify babies who have these abnormalities, but researchers are working to develop specific screening tests."<sup>10</sup>

### Safe Sleep

A significant finding is that in 33.9% (42) of the fatalities, unsafe sleeping was related to the death.

<sup>9</sup> U.S. Department of Health and Human Services, Safe to Sleep, (2014), <http://www.nichd.nih.gov/sts/about/SIDS/Pages/causes.aspx>

<sup>10</sup> U.S. Department of Health and Human Services, Safe to Sleep, (2014), <http://www.nichd.nih.gov/sts/about/SIDS/Pages/causes.aspx>

In 40% (14) of the SIDS cases, unsafe sleep was also a factor. In 23.8% (10) of the cases in which unsafe sleep was a factor, the child was sleeping in a bed with an adult.

**Figure 4. Unsafe Sleep situations deaths for children whose family had current or prior history of DCF involvement, January 1, 2005 – May 31, 1014, (N=42)**

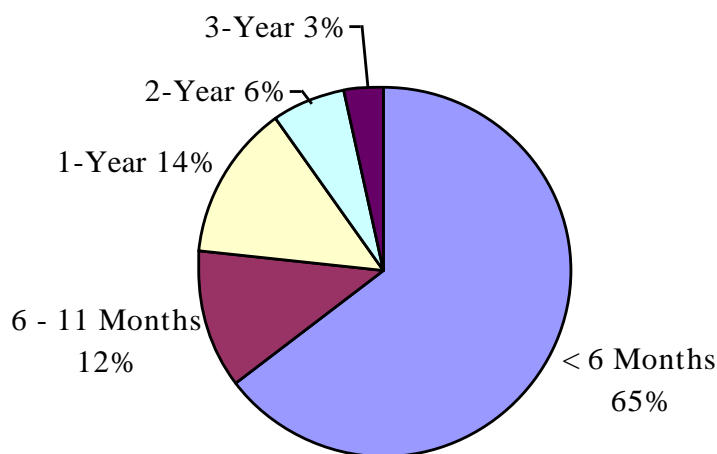
Situations	Frequency	
	#	%
Sleeping in a bed with adult	10	23.8%
Sleeping in a bed w/adult AND other minor children	6	14.3%
Sleeping in a bed alone	4	9.5%
Sleeping on couch/chair with adult	4	9.5%
Sleeping in car seat	2	4.8%
Sleeping in crib/basinet on stomach	2	4.8%
Sleeping in crib/basinet w/items that posed a safety hazard	2	4.8%
Sleeping with in a bed with adult under the influence	1	2.4%
Breast feeding at night, on sleeping and pain meds, mother was disoriented and missed bassinet, baby suffocated between bed and bassinet.	1	2.4%
Sleeping in a bed alone, caretaker under the influence of alcohol	1	2.4%
Sleeping in adult bed with other minor children	1	2.4%
Sleeping in crib with twin	1	2.4%
Seeping in crib but no mention of position or items	1	2.4%
Unable to Determine	6	14.3%
Total	42	100%

#### Age of Child at Time of Fatality

Age is one of the most significant factors associated with child fatality. Among the 124 children who died, 65% died less than 6 months after they were born; in comparison, 3% of children died at age 3 (Figure 5). Age can be a confounder, and should always be controlled for when examining the effect of other factors on child fatality.



**Figure 5. Percent by age, of children whose family had current or prior DCF involvement at the time of their death, Jan 1, 2005 - May 31, 2014 (N = 124)**



Manner of Death by Age Range

"Research indicates that very young children (ages 4 years and younger) are the most frequent victims of child fatalities. NCANDS data for 2012 demonstrated that children younger than 1 year accounted for 44.4% of fatalities; children younger than 4 years accounted for over three-fourths (77%) of fatalities."<sup>11</sup> Similarly, the study indicated that 95 (77 %) of the children in the fatality group were under the age of one year, the highest percentage belonging to the group less than 6 months old. Undetermined was the most common manner of death for children less than 6 months old. SIDS cases are included in that figure. Of the 44 undetermined deaths, 35 (80%) were listed as SIDS. (Figure 6)

**Figure 6. Number of children and manner of death by age range at time of death. (N = 124)**

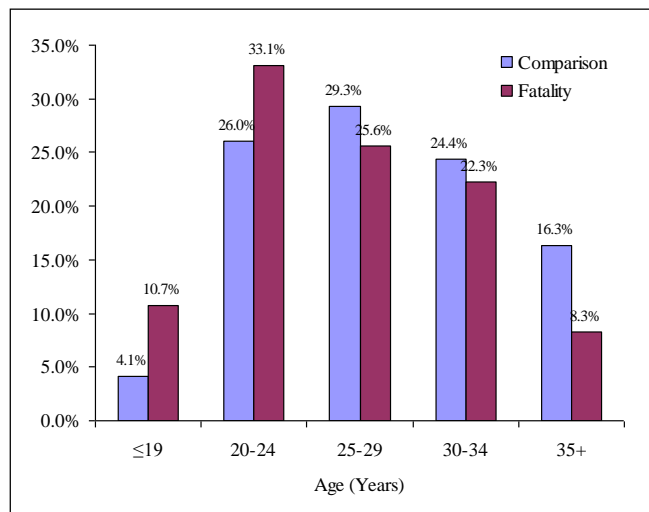
Manner of Death	Less than 6 Months	6-11 Months	12-23 Months	24-35 Months	36-47 Months	Total #	Total %
Accident	21	2	6	3	2	34	27.4%
Homicide	7	2	7	1	2	19	15.3%
Natural	19	3	2	3	0	27	21.8%
Undetermined	33	8	2	1	0	44	35.5%
<b>Total #</b>	<b>80</b>	<b>15</b>	<b>17</b>	<b>8</b>	<b>4</b>	<b>124</b>	<b>100%</b>
<b>Total %</b>	<b>64.5%</b>	<b>12.1%</b>	<b>13.7%</b>	<b>6.5%</b>	<b>3.2%</b>		

<sup>11</sup> Children's Bureau, (2012) Child Abuse and Neglect Fatalities 2012: Statistics and Interventions, <https://www.childwelfare.gov/pubs/factsheets/fatality.pdf>

Parent Age<sup>12</sup>

The parents in the 124 fatality cases, were at a higher rate than in the control cases, under the age of 25 years. At a rate two times greater than the comparison cases, (4.1%) parents where a fatality occurred were under the age of 20 years (10.7%).

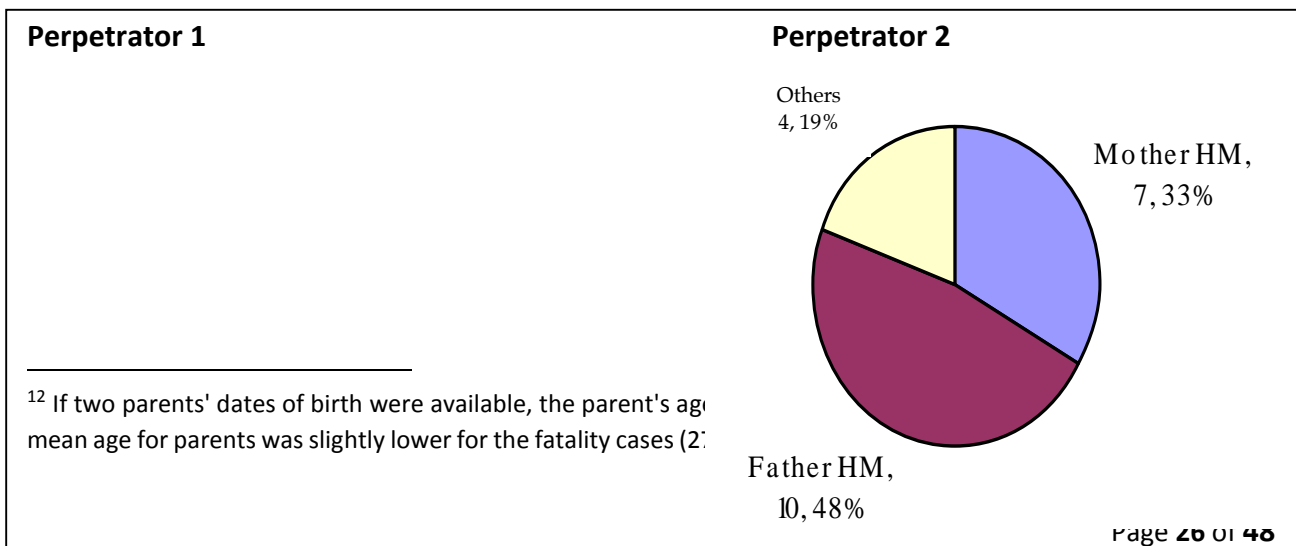
**Figure 7. Parents' age ranges whose family had a history of DCF involvement prior to their child's death, Jan 1, 2005 - May 31, 2014 (N = 124)**

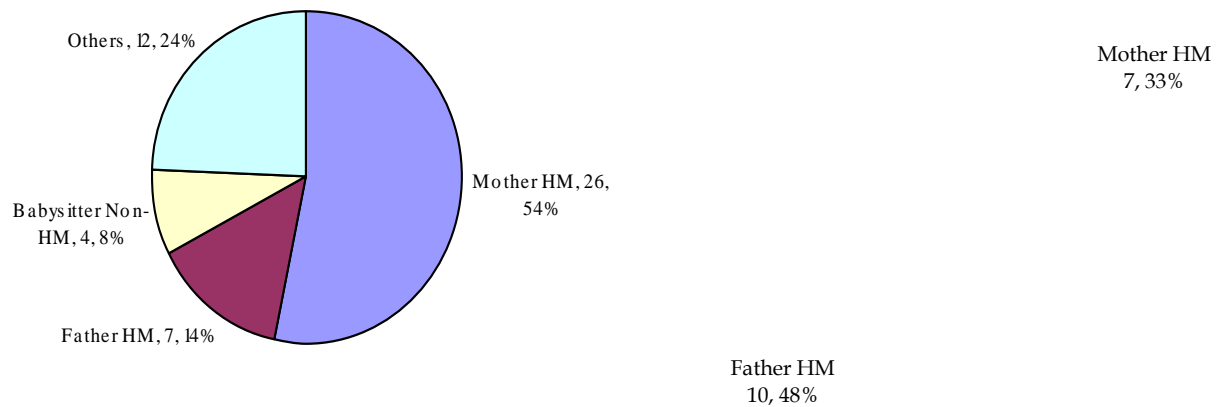


Perpetrators

Perpetrators are defined as individuals who DCF substantiated allegations of abuse and neglect at the completion of the investigation report regarding the child's death. Perpetrators were documented only for the fatality cases. The majority of perpetrators were mothers and fathers living in the home. Therefore, perpetrators' age ranges are similar to that noted above for parents.

**Figure 8. Percentages of substantiated perpetrators in fatality cases, Jan 1, 2005 - May 31, 2014 (N = 124)**





**Section IVb: Logistic Regression Analysis**

Target Child<sup>13</sup> Demographic and Contextual Factors

Table 1 presents the comparison demographics and contextual factors between fatality cases and controls. Compared to the control children who died were 17.5 months younger ( $p < 0.0001$ ) and had more substantiated reports during the PUR ( $p = 0.005$ ). Except for these two factors, the two groups of children had similar distributions of other demographic and contextual factors. For example, the two groups had similar gender ( $p = 0.31$ ), racial/ethnic composition ( $p = 0.61$ ) and family structure ( $p = 0.82$ ). It should be noted that the differences between fatality cases and controls for the number of unsubstantiated reports during the PUR ( $p = 0.06$ ) and ever having a child legally removed from home ( $p = 0.05$ ) were close to the statistical significance level.

Table 2 presents results from the simple and multiple logistic regression models, which examined demographic and contextual factors associated with child fatality. As stated earlier in the Methodology section, only factors with a  $p < 0.20$  from the overall chi-square test or t-test were included in the logistic regression model building process. Thus, simple logistic regression was conducted for four factors: age, number of substantiated reports, number of unsubstantiated reports, and ever having a child legally removed from home. Results from the multiple logistic regression show that three factors (except ever having a child legally removed from home) remained significantly associated with child fatality. With every month’s increase in age, children, ages 0-3 were 10% less likely to die (OR, 0.90; 95% CI, 0.88-0.93).

Summary of Table 1 and 2:

- The older the child, the less likely the child is to die between ages 0-3 years.

<sup>13</sup> **Target Child** for the control case is defined as a randomly selected child in a case open during the same year as the matched fatality case, between birth to three years old during that year.

- Families of fatality cases had more reports of abuse/neglect; both substantiated and unsubstantiated
- No gender disparity was associated with child fatality was observed.
- No racial/ethnic disparity associated with child fatality was observed.

**Table 1. Comparisons of demographics and contextual factors between fatalities and controls, January 2005 - May 2014 (N = 248)**

Demographics and contextual factors	Fatalities (n = 124)	Controls (n = 124)	p-value
Age in months (mean ± s.d.)	7.8 ± 10.1	25.3 ± 14.8	<0.0001
Sex			0.31
Female	46.0%	52.4%	
Male	54.0%	47.6%	
Race/ethnicity			0.61
Non-Hispanic White	25.8%	30.6%	
Non-Hispanic African American	32.3%	35.5%	
Hispanic	29.0%	22.6%	
Other	12.9%	11.3%	
Substantiated reports during PUR			0.005
0	41.9%	58.9%	
1	41.9%	35.5%	
2 or more	16.1%	5.6%	
Unsubstantiated reports during PUR			0.06
0	26.6%	39.5%	
1	45.2%	41.9%	
2 or more	28.2%	18.6%	
Child in placement at any time during PUR			0.80
No	93.5%	92.7%	
Yes	6.5%	7.3%	
Child in placement at the end of PUR			0.55
No	94.4%	96.0%	
Yes	5.6%	4.0%	
Family structure			0.82
Two-parent	21.8%	25.8%	
Single female parent alone	39.5%	38.7%	
Blended family	20.2%	21.8%	
Single female parent with unrelated partner	9.7%	6.4%	
Other	8.9%	7.3%	
Number of siblings/other foster children living in home/placement w/target child			0.66
0	33.1%	30.6%	
1	28.2%	31.4%	

Demographics and contextual factors	Fatalities (n = 124)	Controls (n = 124)	p-value
2	15.3%	19.4%	
3 or more	23.4%	18.6%	
Ever had a child legally removed from care			0.05
No	71.9%	82.5%	
Yes	28.1%	17.5%	
Parents/guardians ever on the central registry			0.50
No	65.3%	69.4%	
Yes	34.7%	30.6%	

**Table 2. Logistic regression analysis for demographics and contextual factors on child fatality, January 2005 - May 2014 (N = 248)**

Demographics and contextual factors	Odds ratio (95% confidence interval)	
	Simple logistic regression <sup>a</sup>	Multiple logistic regression <sup>b</sup>
Age in months (mean ± s.d.)	0.91 (0.88-0.93)	0.90 (0.88-0.93)
Substantiated reports during PUR (treated as a continuous variable)	1.86 (1.26-2.74)	2.66 (1.57-4.52)
Unsubstantiated reports during PUR (treated as a continuous variable)	1.51 (1.07-2.13)	2.32 (1.45-3.71)
Ever had a child legally removed from care		—
No	Reference group	
Yes	1.84 (0.996-3.409)	

<sup>a</sup> Simple logistic regression analysis was conducted for all variables with an overall p-value (from the chi-square test or Student's t-test) less than 0.20.

<sup>b</sup> Only variables with a p-value less than 0.20 from the simple logistic regression analysis were included in the multiple logistic regression model building process. Age was also controlled for in the multiple logistic regression.

### Target Child Risk Factors

Table 3 presents preliminary comparison results of child's factor between fatality cases and controls. Significant differences were observed for factors including the child being a high risk newborn due to medical issues, drug exposed, alcohol exposed, born premature, child with concerns at birth, child up-to-date with immunizations, child with chronic medical conditions, and child ever being placed in a medically complex foster home (Table 3). For example, 13.7% of the fatality cases were for high risk newborns due to medical issues, while only 0.8% of the controls were for high risk newborns. It should be noted that the significance may not only be caused by different proportions of child factors between cases and controls, but by different proportions of undetermined or not applicable responses. For instance, the percentage of children in the undetermined category differed greatly for being a high risk newborn, 26.6% among cases versus 62.1% among controls. Further logistic regression would determine if the

percentages of child factors between cases and controls were different, taking into consideration potential confounders.

Table 4 presents results from the simple and multiple logistic regressions to examine child risk factors associated with child fatality. In simple logistic regression, a child being a high risk newborn due to medical issues, born drug exposed, born premature, and a child having medical concerns with his or her birth were more likely to die between ages 0-3 years than those children without the corresponding factors. In multiple logistic regression, only the factor of a child being a high risk newborn due to medical issues remained significant. Children who were high risk newborn were 24 times (OR, 23.57; 95% CI, 2.29-242.90) more likely to die between the ages 0-3, compared to those who were not high risk newborn. Given the high percentages of undetermined, the result may have changed if the undetermined category could have been known. Therefore, efforts will be made to reduce the percentage of children in the undetermined category in future research.

#### Summary of Table 3 and 4:

- Children who were high risk newborns due to medical issues were more likely to die between ages 0-3 than those who were not high risk newborn.
- Simple logistic regression analysis based on our data universe suggests that there are a variety of factors associated with fatalities in young children. This includes children born drug exposed and children born premature. No significance, however was observed in multiple logistic regression. This is possibly because the high risk newborn status was caused by the child being born drug exposed or prematurely.
- Future research should address the undetermined problem for factor status.

**Table 3. Comparisons of child risk factors between fatalities and controls, January 2005 - May 2014 (N = 248)**

Child factor	Fatalities (n = 124)	Controls (n = 124)	p-value
Child seen by community providers other than by pediatrician			0.44
No	59.7%	54.8%	
Yes	40.3%	45.2%	
Child a high risk newborn due to medical issues			<0.0001
No	59.7%	37.1%	
Yes	13.7%	0.8%	
Undetermined	26.6%	62.1%	
Child born drug exposed			<0.0001
No	49.2%	31.5%	
Yes	17.7%	2.4%	
Undetermined	33.1%	66.1%	
Child born alcohol exposed			<0.0001 <sup>a</sup>
No	60.5%	33.1%	
Yes	0.8%	0.8%	
Undetermined	38.7%	66.1%	
Child born premature			<0.0001
No	47.6%	30.7%	
Yes	23.4%	2.4%	
Undetermined	29.0%	66.9%	
Concerns with child at birth			<0.0001
No	42.7%	28.2%	
Yes	29.0%	4.8%	
Undetermined	28.2%	66.9%	
Child with up-to-date with immunizations			0.04
No	8.9%	4.8%	
Yes	56.4%	71.8%	
Undetermined	34.7%	23.4%	
Child with any chronic medical conditions			0.03
No	59.7%	56.4%	
Yes	18.5%	9.7%	
Undetermined	21.8%	33.9%	
Child with developmental delays			0.56
No	56.4%	50.0%	
Yes	12.1%	15.3%	
Undetermined	31.5%	34.7%	
Child at birth child ever being placed in a medically complex foster home			0.009 <sup>a</sup>
No	54.8%	37.1%	
Yes	0.8%	0.8%	
N/A	44.4%	62.1%	

<sup>a</sup> P-value was obtained from the Fisher's Exact Test due to the number of cells that have expected counts less than 5.

**Table 4. Logistic regression analysis for child risk factors on fatality, January 2005 - May 2014 (N = 248)**

Child factor	Odds ratio (95% confidence interval)	
	Simple logistic regression <sup>a</sup>	Multiple logistic regression <sup>b</sup>
Child a high risk newborn due to medical issues		—
No	Reference group	Reference group
Yes	10.56 (1.36-81.96)	23.57 (2.29-242.90)
Undetermined	0.27 (0.15-0.46)	0.54 (0.28-1.04)
Child born drug exposed		—
No	Reference group	
Yes	4.69 (1.32- 16.72)	
Undetermined	0.32 (0.19-0.55)	
Child born alcohol exposed		—
No	Reference group	
Yes	0.55 (0.03-8.97)	
Undetermined	0.32 (0.19-0.54)	
Child born premature		—
No	Reference group	
Yes	6.23 (1.77-21.88)	
Undetermined	0.28 (0.16-0.49)	
Concerns with child at birth		—
No	Reference group	
Yes	3.96 (1.51-10.39)	
Undetermined	0.28 (0.16-0.50)	
Child with up-to-date with immunizations		—
No	Reference group	
Yes	0.43 (0.15-1.22)	
Undetermined	0.81 (0.27-2.43)	
Child with any chronic medical conditions		—
No	Reference group	
Yes	1.81 (0.84-3.92)	
Undetermined	0.61 (0.34-1.09)	
Child at birth child ever being placed in a medically complex foster home placement		—
No	Reference group	
Yes	0.68 (0.04-11.09)	
N/A	0.48 (0.29-0.80)	



<sup>a</sup> Simple logistic regression analysis was conducted for all variables with an overall p-value (from the chi-square test or Student's t-test) less than 0.20.

<sup>b</sup> Only variables with a p-value (yes vs. no) less than 0.20 from simple logistic regression analysis were included in the multiple logistic regression model building process. Age was also controlled for in multiple logistic regression.

### Assessments

Table 5 presents preliminary comparison results of child assessments between fatalities and controls. Significant differences were observed for all assessments included in Table 5. For example, in 25.0% and 10.5% of fatality cases, sleeping arrangement were assessed by the agency during some visits and during all visits, respectively; in comparison, these percentages were 47.6% and 4.0%, respectively among controls. In addition, 41.1% of fatality cases were in the not applicable category, while only 1.6% of controls were in this category.

Results from simple logistic regression in Table 6 suggest that the majority of significant differences in the previous table were caused by variance in the not applicable category between cases and controls. Impacted assessment variables include agency making concerted efforts to conduct ongoing formal/informal comprehensive assessments to determine target child's needs, agency conducting an initial assessment that accurately determined all risk and safety concerns for the child, agency conducting ongoing assessments that accurately determined all of the risk and safety concerns for the target child, and agency developing an appropriate safety plan with the family, continually monitoring and updating the safety plan regarding the target child when safety concerns were present. Results from multiple logistic regression show that among the assessments conducted, only those of a child's sleeping arrangement remained significant. Children whose sleeping arrangement were assessed during all visits were 8 times (OR, 7.81; 95% CI, 1.82-33.49) more likely to be a fatality case than those whose sleeping arrangement were not assessed. Although cause and effect could not be established in this study, it is unlikely that more assessments of sleeping arrangement could cause child fatality. The association may be explained by the fact that the agency usually is more likely to assess sleeping arrangements for children with safety concerns, and those children are more likely to die than those without any safety concern.

#### Summary of Table 5 and 6:

- Children's sleeping arrangements were more likely to be assessed among fatality cases than controls, suggesting that the agency is on the right track to prevent child fatality. Despite the agency's efforts, some children still died, suggesting that more additional interventions might be needed to better prevent child fatality.
- No other significant differences were observed for assessments between cases and controls once age and sleeping arrangement assessment were controlled for.

**Table 5. Comparisons of child assessments between fatalities and controls, January 2005 - May 2014 (N = 248)**

Assessments	Fatalities (n = 124)	Controls (n = 124)	p-value
Agency making concerted efforts to conduct ongoing formal/informal comprehensive assessments to assess target child's needs			<0.0001
No	15.3%	26.6%	
Yes	36.3%	64.5%	
N/A	48.4%	8.9%	
The agency conducted an initial assessment that accurately assessed all risk and safety concerns for the child			< 0.0001
No	5.6%	8.1%	
Yes	50.8%	91.1%	
N/A	43.6%	0.8%	
The agency conduct ongoing assessments that accurately assessed all of the risk and safety concerns for the target child			0.047
No	12.9%	9.7%	
Yes	31.5%	46.8%	
N/A	55.6%	43.5%	
If safety concerns were present, the agency developed an appropriate safety plan with the family, continually monitored and updated the safety plan regarding the target child			0.002
No	10.5%	10.5%	
Yes	27.4%	48.4%	
N/A	62.1%	41.1%	
Agency assessed child's sleeping arrangement			< 0.0001
No	23.4%	46.8%	
Yes, during some visits	25.0%	47.6%	
Yes, during all visits	10.5%	4.0%	
N/A	41.1%	1.6%	
Safe sleeping was discussed with parents /caretakers			< 0.0001
No	41.1%	74.2%	
Yes	19.4%	17.7%	
N/A	39.5%	8.1%	

**Table 6. Logistic regression analysis for child assessments, January 2005 - May 2014 (N = 248)**

Assessment	Odds ratio (95% confidence interval)	
	Simple logistic regression	Multiple logistic regression <sup>a</sup>
Agency making concerted efforts to conduct ongoing formal/informal comprehensive assessments to assess target child's needs		—
No	Reference group	
Yes	0.98 (0.50-1.91)	
N/A	9.47 (4.03-22.28)	
The agency conducting an initial assessment that accurately assessed all risk and safety concerns for the child		—
No	Reference group	
Yes	0.80 (0.29-2.20)	
N/A	77.14 (8.54-697.09)	
The agency conducting ongoing assessments that accurately assessed all of the risk and safety concerns for the target child		—
No	Reference group	
Yes	0.50 (0.22-1.18)	
N/A	0.96 (0.42-2.20)	
If safety concerns were present, the agency developed an appropriate safety plan with the family, continually monitored and updated the safety plan regarding the target child		—
No	Reference group	
Yes	0.57 (0.24-1.36)	
N/A	1.51 (0.65-3.52)	
Agency assessed child's sleeping arrangement		
No	Reference group	Reference group
Yes, during some visits	1.05 (0.56-1.96)	1.22 (0.58-2.55)
Yes, during all visits	5.20 (1.69-16.00)	7.81 (1.82-33.49)
N/A	51.00 (11.59- 224.36)	68.14 (11.82-392.92)
Safe sleeping was discussed with parents /caretakers		—
No	Reference group	
Yes	1.97 (1.01-3.85)	
N/A	8.84 (4.13-18.92)	

<sup>a</sup> Simple logistic regression analysis was conducted for all variables with an overall p-value (from the chi-square test or Student's t-test) less than 0.20.

<sup>b</sup> Only variables with a p-value (yes vs. no) less than 0.20 from the simple logistic regression

analysis were included in the multiple logistic regression model building process. Age was also controlled for in the multiple logistic regression.

### Visitation

Table 7 presents preliminary comparison results of child visitation between cases and controls. Significant differences were observed for all visitation included in this table.

Simple logistic regression results in Table 8 suggest that the significant differences in the previous table were caused by the differences of not applicable category between cases and controls. Multiple logistic regression results further confirmed. Child visitation (yes vs. no) was not significantly associated with child fatality when age was controlled for in multiple logistic regression. Results also show that the children who died were less likely to have a visitation because of 'not applicable', which limits our ability to interpret these data in a valid manner.

Summary of Table 7 and 8:

- There were no significant differences (yes vs. no) between fatality cases and controls regarding sufficient frequency and quality of the visits between caseworker and child, and the visit frequency in adherence with DCF policy.

**Table 7. Comparisons of child visitation between fatalities and controls, January 2005 - May 2014 (N = 248)**

Visitation	Fatalities (n = 124)	Controls (n = 124)	p-value
Frequency of the visits between caseworker and child was sufficient			< 0.0001
No	14.5%	16.1%	
Yes	37.9%	83.1%	
N/A	47.6%	0.8%	
Quality of the visits between caseworker and child was sufficient to address issues			< 0.0001
No	16.1%	25.8%	
Yes	37.1%	72.6%	
N/A	46.8%	1.6%	
Frequency of the visit between social worker and child in adherence with DCF policy			< 0.0001
No	14.5%	16.1%	
Yes	37.9%	83.1%	
N/A	47.6%	0.8%	

**Table 8. Logistic regression analysis for child visitation on child fatality, January 2005 - May 2014 (N = 248)**

Assessment/needs/services	Odds ratio (95% confidence interval)	
	Simple logistic regression <sup>a</sup>	Multiple logistic regression <sup>b</sup>
Frequency of the visits between caseworker and child was sufficient		—
No	Reference group	
Yes	0.51 (0.25-1.05)	
N/A	64.44 (8.08-514.20)	
Quality of the visits between caseworker and child was sufficient to address issues		—
No	Reference group	
Yes	0.82 (0.42-1.59)	
N/A	46.40 (10.19- 211.35)	
Frequency of the visit between social worker and child in adherence with DCF policy		—
No	Reference group	
Yes	0.51 (0.25-1.05)	
N/A	65.56 (8.22-522.93)	

<sup>a</sup> Simple logistic regression analysis was conducted for all variables with an overall p-value (from the chi-square test or Student's t-test) less than 0.20.

<sup>b</sup> Only variables with a p-value (yes vs. no) less than 0.20 from the simple logistic regression analysis were included in the multiple logistic regression model building process. Age was also controlled for in the multiple logistic regression.

### Needs/Services

Table 9 presents preliminary comparison results of child identified needs and services provided between fatality cases and controls. Significant differences were observed for non-routine medical assessment/examination; dental needs; Early Headstart Program; Child First; Positive Parenting; hospitalization during the PUR; emergency department visits during the PUR; Area Office Area Resource Group (ARG) nurse consulted; agency having collateral contacts with medical providers; agency having contacts with daycare providers; agency having contacts with individuals who had regular contact with target child; appropriate ARG being consulted; and a legal consult being conducted.

Simple logistic regression results in Table 10 suggest that some significant differences in the previous table were caused by the variance of not applicable and/or undetermined category between cases and controls. Multiple logistic regression results show that among the needs and services identified or provided, only hospitalization history during the PUR remained significant. Children who had a hospitalization history for any reason during the PUR were 5 times (OR, 4.53, 95% CI, 1.65-12.43) more likely to be a fatality case than those children without a hospitalization history.

## Summary of Table 9 and 10:

- Children who died between the ages of birth to three were more likely to have history of hospitalization during the PUR than those in the controls.
- The status of needs/services also could not be determined for a relatively large proportion of children. Results may be changed if the undetermined category can actually be determined, depending on the category that each child belongs. Therefore it is recommended that important needs must always be documented, regardless whether the relevant services are delivered.

**Table 9. Comparisons of needs/services between fatalities and controls, January 2005 - May 2014 (N = 248)**

Needs/services	Fatalities (n = 124)	Controls (n = 124)	p-value
Agency making concerted efforts to provide appropriate services to meet all of the target child's identified needs			0.30
No	4.8%	8.1%	
Yes	29.0%	34.7%	
N/A	66.1%	57.3%	
Well-child check (Routine)			0.52
Need not identified	56.5%	52.4%	
Need identified	43.6%	47.6%	
Medical assessment/examination (other than routine)			0.002
Need not identified	71.8%	87.9%	
Need identified	28.2%	12.1%	
Occupational and/or Physical Therapy			0.20
Need not identified	94.4%	97.6%	
Need identified	5.6%	2.4%	
Sexual Abuse Assessment/Examination			1.00 <sup>a</sup>
Need not identified	99.2%	98.4%	
Need identified	0.8%	1.6%	
Dental <sup>a</sup>			0.0003
Need not identified	96.8%	83.1%	
Need identified	3.2%	16.9%	
Birth to Three			0.54
Need not identified	87.9%	90.3%	
Need identified	12.1%	9.7%	
Daycare			0.81
Need not identified	91.9%	92.7%	
Need identified	8.1%	7.3%	

Needs/services	Fatalities (n = 124)	Controls (n = 124)	p-value
Developmental assessment (other than birth-3)			0.82
Need not identified	91.9%	91.1%	
Need identified	8.1%	8.9%	
Completed MDE			0.57
No	5.9%	4.1%	
Yes	3.4%	5.7%	
N/A	90.7%	90.2%	
In Early Headstart Program			0.02 <sup>a</sup>
No	44.4%	54.8%	
Yes	1.6%	4.8%	
N/A	36.3%	19.4%	
UTD	17.7%	21.0%	
In Child First			0.01 <sup>a</sup>
No	49.2%	60.5%	
Yes	0	1.6%	
N/A	29.8%	14.5%	
UTD	21.0%	23.4%	
In a Positive Parenting Program			0.03 <sup>a</sup>
No	53.2%	57.3%	
Yes	0.8%	4.8%	
N/A	25.8%	13.7%	
UTD	20.2%	24.2%	
In Help Me Grow			0.06
No	51.6%	61.3%	
Yes	0	0	
N/A	26.6%	14.5%	
UTD	21.8%	24.2%	
In Nurturing Families Network			0.22 <sup>a</sup>
No	52.4%	62.1%	
Yes	2.4%	1.6%	
N/A	23.4%	13.7%	
UTD	21.8%	22.6%	
Hospitalized during the PUR			< 0.0001
No	55.7%	54.8%	
Yes	29.8%	6.5%	
UTD	14.5%	38.7%	
Had ER visits during the PUR			0.003
No	62.9%	50.0%	
Yes	16.9%	10.5%	
UTD	20.2%	39.5%	
ARG nurse consulted			< 0.0001
No	9.1%	12.2%	
Yes	28.9%	6.5%	

Needs/services	Fatalities (n = 124)	Controls (n = 124)	p-value
N/A	62.0%	81.3%	
Agency had collateral contacts w/medical providers			< 0.0001
No	14.5%	10.5%	
Yes	66.9%	88.7%	
N/A	18.6%	0.8%	
Agency had contacts w/daycare providers			0.01
No	9.7%	15.3%	
Yes	6.4%	16.1%	
N/A	83.9%	68.6%	
Agency had contacts w/individuals who had regular contact w/target child			< 0.0001
No	9.7%	18.5%	
Yes, with some	34.7%	55.6%	
Yes, with all	25.0%	20.2%	
N/A	30.6%	5.6%	
There were appropriate ARG consulted			0.0008
No	5.6%	21.0%	
Yes, some	18.5%	11.3%	
Yes, all	33.1%	21.0%	
N/A	42.7%	46.8%	
A legal consult was conducted			0.02
No	37.1%	21.8%	
Yes	22.6%	22.6%	
N/A	40.3%	55.6%	
Neglect petitions was filed in regards to target child			0.69
No	51.6%	49.2%	
Yes	14.5%	12.1%	
N/A	33.9%	38.7%	

<sup>a</sup> P-value was obtained from the Fisher's Exact Test due to the number of cells that have expected counts less than 5.



**Table 10. Logistic regression analysis for needs/services on child fatality, January 2005 - May 2014 (N = 248)**

Needs/services	Odds ratio (95% confidence interval)	
	Simple logistic regression <sup>a</sup>	Multiple logistic regression <sup>b</sup>
Medical assessment/examination (other than routine)		—
Need not identified	Reference group	
Need identified	2.86 (1.47-5.57)	
Dental		—
Need not identified	Reference group	
Need identified	0.16 (0.05-0.49)	
In Early Headstart Program		—
No	Reference group	
Yes	0.41 (0.08-2.12)	
N/A	2.32 (1.26-4.27)	
UTD	1.05 (0.54-2.04)	
In a Positive Parenting Program		—
No	Reference group	
Yes	0.18 (0.02-1.53)	
N/A	2.03 (1.03-3.99)	
UTD	0.90 (0.48-1.68)	
Hospitalized during the PUR		
No	Reference group	Reference group
Yes	4.56 (1.98-10.50)	4.53 (1.65-12.43)
UTD	0.37 (0.20-0.70)	0.45 (0.21-0.93)
Had ER visits during the PUR		—
No	Reference group	
Yes	1.28 (0.60-2.77)	
UTD	0.41 (0.23-0.73)	
ARG nurse consulted		—
No	Reference group	
Yes	5.97 (2.00-17.80)	
N/A	1.02 (0.44-2.35)	
Agency had collateral contacts w/medical providers		—
No	Reference group	
Yes	0.55 (0.25-1.18)	
N/A	16.61 (1.98-139.14)	
Agency had contacts w/daycare providers		—
No	Reference group	
Yes	0.63 (0.21-1.89)	
N/A	1.94 (0.89-4.22)	

Needs/services	Odds ratio (95% confidence interval)	
	Simple logistic regression <sup>a</sup>	Multiple logistic regression <sup>b</sup>
Agency had contacts w/individuals who had regular contact w/target child		—
No	Reference group	
Yes, with some	1.19 (0.54-2.65)	
Yes, with all	2.38 (0.99-5.70)	
N/A	10.40 (3.58-30.21)	
There were appropriate ARG consulted		—
No	Reference group	
Yes, some	6.10 (2.10-17.73)	
Yes, all	5.86 (2.22-15.43)	
N/A	3.39 (1.36-8.47)	
A legal consult was conducted		—
No	Reference group	
Yes	0.59 (0.29-1.19)	
N/A	0.43 (0.23-0.77)	

Note. Although "In Child First" and "In Help Me Grow" were significant in Table 9, Table 10 includes neither variable in the logistic regression model due to unreliable estimates.

<sup>a</sup> Simple logistic regression was conducted only for variables with a p-value (from the overall test) less than 0.20.

<sup>b</sup> Only variables with a p-value (from the simple logistic regression) for the category "yes" vs. "no" or "need identified" vs. "need not identified" less than 0.20 were included in the multiple logistic regression model building process. Age was always controlled in the multiple logistic regression.

### Parent and Sibling Assessments

Table 11 presents preliminary comparison results of parent and sibling assessments between cases and controls. Significant differences were observed for assessments including the agency making concerted efforts to conduct an initial and/or ongoing comprehensive assessment that accurately determined the needs of parents, the agency having identified concern regarding parent and child relationship, and agency having conducted an initial assessment to assess risk and safety concerns for other minor children in home.

Table 12 presents both simple and multiple logistic regression results. The other ratio for the agency making concerted efforts to conduct an initial and/or ongoing comprehensive assessment was 0.41, and a 95% confidence interval was 0.19-0.86. In other words, where the agency made concerted efforts to conduct an initial and/or ongoing comprehensive assessment that accurately assessed the needs of parents the children were 59% less likely to be a fatality case, compared to those where the agency did not make such an assessment.

Summary of Table 11 and 12:

- Children for whom the agency made concerted efforts to conduct an initial and/or ongoing comprehensive assessment that accurately determined the needs of the parents were less likely to be fatality cases, compared to those for whom the agency did not make such an assessment. This suggests that an initial and/or ongoing comprehensive assessment may have a protective effect on child fatality. It is recommended that the agency continue to focus on the completion of such assessments for cases that involve children age birth to three years.

**Table 11. Comparisons of Parent and Sibling Assessments between Fatalities and Controls, January 2005 - May 2014 (N = 248)**

Parent and sibling assessment	Fatalities (n = 124)	Controls (n = 124)	p-value
The agency made concerted efforts to conduct an initial and/or ongoing comprehensive assessment that accurately assessed the needs of parents			0.0007
No	28.2%	23.4%	
Yes	51.6%	71.0%	
N/A	20.2%	5.6%	
There was information in LINK regarding parents and the child's relationship			0.16
No	63.7%	54.8%	
Yes	36.3%	45.2%	
There was identified concern regarding parent and child relationship			0.0001
No	64.2%	85.1%	
Yes	14.7%	13.8%	
N/A	21.1%	1.1%	
The agency addressed concerns with parents			0.05
No	14.5%	11.3%	
Yes	15.3%	6.4%	
N/A	70.2%	82.3%	
Agency conducted initial assessment to assess Risk & Safety concerns for other minor children in home			0.006
No	6.5%	4.0%	
Yes	54.8%	74.2%	
N/A	38.7%	21.8%	
Agency conducted ongoing assessments to assess Risk & Safety concerns for other minor children in home			0.86
No	8.9%	7.3%	
Yes	36.3%	38.7%	
N/A	54.8%	54.0%	

## UTD

**Table 12. Logistic regression analysis of parent and sibling assessments on child fatality, January 2005 - May 2014 (N = 248)**

Overall assessment for parents	Odds ratio (95% confidence interval)	
	Simple logistic regression <sup>a</sup>	Multiple logistic regression <sup>b</sup>
The agency made concerted efforts to conduct an initial/ongoing comprehensive assessment that accurately assessed the needs of parents		—
No	Reference group	Reference group
Yes	0.60 (0.34-1.09)	0.41 (0.19-0.86)
N/A	2.96 (1.12-7.82)	2.07 (0.61-7.01)
There was information in LINK regarding parents and the child's relationship		—
No	Reference	
Yes	0.69 (0.42-1.15)	
There was identified concern regarding parent and child relationship		—
No	Reference	
Yes	1.42 (0.61-3.29)	
N/A	24.26 (3.17-185.99)	
The agency addressed concerns with parents		—
No	Reference group	
Yes	1.85 (0.63-5.45)	
N/A	0.66 (0.31-1.41)	
Agency conducted initial assessment to assess Risk & Safety concerns for other minor children in home		—
No	Reference group	
Yes	0.46 (0.15-1.47)	
N/A	1.11 (0.33-3.74)	

<sup>a</sup> Simple logistic regression analysis was conducted for all variables with an overall p-value (from the chi-square test or Student's t-test) less than 0.20.

<sup>b</sup> Only variables with a p-value (yes vs. no) less than 0.20 from the simple logistic regression analysis were included in the multiple logistic regression model building process. Age was also controlled for in the multiple logistic regression.

Parent visitation

Table 13 presents preliminary comparison results of parent visitation between cases and

controls. About 48% of cases had a sufficient frequency<sup>14</sup> of visits between caseworker and the parent; 21% cases were not applicable. In comparison, 77% of the controls had a sufficient frequency of visits between caseworker and the parent, while only 1% of the controls were not applicable.

Table 14 presents logistic regression results. Children whose parent had a sufficient frequency of visits between caseworker and parent were 63% less likely to be fatality cases than those whose parent did not have a sufficient frequency (OR, 0.37; 95% CI, 0.18-0.77).

Summary of Table 13 and 14:

- Children whose parent had a sufficient frequency of visits between caseworker and parent were less likely to be fatality cases than those whose parent did not have sufficient visits. This suggests that sufficient frequency of parent visitation may have a protective effect on child fatality. Therefore, it is recommended that interventions should continue to occur to boost the worker-parent visitation rate among cases with children age 0-3 whose family has DCF involvement.

**Table 13. Comparisons of visitation for parents between fatalities and controls, January 2005 - May 2014 (N = 248)**

Visitation	Fatalities (n = 124)	Controls (n = 124)	p-value
Frequency of visits between caseworker and parent was sufficient			<0.0001
No	31.4%	21.8%	
Yes	47.6%	77.4%	
N/A	21.0%	0.8%	
Quality of visits between caseworker and parent was sufficient			< 0.0001
No	26.6%	25.8%	
Yes	52.4%	73.4%	
N/A	21.0%	0.8%	

**Table 14. Logistic regression analysis of visitation for parents on child fatality, January 2005 - May 2014 (N = 248)**

Overall assessment for parents	Odds ratio (95% confidence interval)	
	Simple logistic regression <sup>a</sup>	Multiple logistic regression <sup>b</sup>

<sup>14</sup> The case reviewer determined whether or not the frequency of visitation was sufficient based on what was necessary to ensure the child's safety, permanency and well-being considering the family's circumstances. This would be a minimum of once per month for parents of children who are in foster care and twice a month for parents whose children reside in the home with the parents.

Frequency of visits between caseworker and parent was sufficient		
No	Reference group	Reference group
Yes	0.43 (0.24-0.77)	0.37 (0.18-0.77)
N/A	18.00 (2.30-140.76)	16.75 (1.64-171.25)
Quality of visits between caseworker and parent was sufficient		
No	Reference group	—
Yes	0.69 (0.39-1.24)	
N/A	25.21 (3.23-196.95)	

<sup>a</sup> Simple logistic regression analysis was conducted for all variables with an overall p-value (from the chi-square test or Student's t-test) less than 0.20.

<sup>b</sup> Only variables with a p-value (yes vs. no) less than 0.20 from the simple logistic regression analysis were included in the multiple logistic regression model building process. Age was also controlled for in the multiple logistic regression.

### Parent needs/services

Table 15 presents preliminary comparison results of parent needs/services between cases and controls. Significant differences were observed for substance abuse (need identified among 51% cases and 31% controls,  $p = 0.001$ ), domestic violence (need identified among 18% cases and 29% controls,  $p = 0.04$ ), mental health (need identified among 51% cases and 32% controls,  $p = 0.003$ ), and safety concerns regarding neighborhood ( $p = 0.003$ ).

Results from the simple logistic regression analysis show that substance abuse (OR, 2.34; 95% CI, 1.39-3.93), domestic violence (OR, 0.53; 95% CI, 0.29-0.96) and mental health (OR, 2.17; 95% CI, 1.30-3.63) were significantly associated with child fatality (Table 16). In the multiple logistic regression analysis while mental health and substance abuse are closely related, these two variables were included in two separate models. Results from the two models show that substance abuse, domestic violence and mental health remained significant.

The likelihood of death between age 0-3 for children whose parent had a mental health need or substance abuse need were more than twice higher than for those children whose parent did not have such a need. When the parents had untreated mental health or substance abuse problems, they were less able to protect the child from their own symptoms and from other sources of harm.

Children whose parent had a domestic violence need were less likely to be fatality case than those whose parent did not have a domestic violence need. It seems contradictory to the intuition of the consequence of domestic violence. Although we could not exclude the possibility of observing the association by chance, since many characteristics/factors have been examined, it is not unexplainable. It is possible that those (mainly women) who suffer from domestic violence may be more likely to carefully look after their children, and more likely to protect their children from any other potential risks. In addition, these parents who have a domestic violence need usually receive corresponding services addressing this issue. A component of child safety may have been incorporated into these services. More study is needed to examine this

possibility.

Summary of Table 15 and 16:

- Children whose parent had a mental health need or a substance abuse need were more likely to be a fatality case than those children whose parent did not have this issue.
- Children whose parent had a domestic violence need were less likely to be a fatality case than those children whose parent did not have this need. Additional study is needed to examine this finding. It may be that a domestic violence need results in multi-system (e.g: judicial) involvement, greater scrutiny, and/or father or boyfriend's removal from the home or limited contact with child thereby reducing the likelihood of child fatality.

**Table 15. Comparisons of needs/services for parents between fatalities and controls, January 2005 - May 2014 (N = 248)**

Overall assessment for parents	Fatalities (n = 124)	Controls (n = 124)	p-value
The agency made concerted efforts to provide services to meet all identified needs of parents			0.97
Need not identified	22.6%	21.8%	
Need identified	47.6%	49.2%	
N/A	29.8%	29.0%	
Agency developed appropriate safety plan w/family and continually monitor/update as needed for other minor children in home			0.16
No	15.3%	8.1%	
Yes	27.4%	33.9%	
N/A	57.3%	58.1%	
Substance abuse			0.001
Need not identified	49.2%	69.4%	
Need identified	50.8%	30.6%	
Domestic violence			0.04
Need not identified	82.3%	71.0%	
Need identified	17.7%	29.0%	
Mental health			0.003
Need not identified	49.2%	67.7%	
Need identified	50.8%	32.3%	
Medication management			0.17
Need not identified	80.7%	87.1%	
Need identified	19.3%	12.9%	
Parenting education			0.79
Need not identified	62.1%	63.7%	
Need identified	37.9%	36.3%	

Overall assessment for parents	Fatalities (n = 124)	Controls (n = 124)	p-value
<b>Parent stressors</b>			
Obtaining and/or maintaining employment			1.00
No	47.5%	47.1%	
Yes	22.5%	22.3%	
UTD	30.0%	30.6%	
Obtaining substantial food			0.11
No	63.9%	52.9%	
Yes	5.9%	12.4%	
UTD	30.2%	34.7%	
Obtaining or maintaining housing			0.72
No	52.9%	48.4%	
Yes	21.9%	22.1%	
UTD	25.2%	29.5%	
Paying for utilities			0.36
No	55.1%	45.9%	
Yes	10.2%	13.1%	
UTD	34.7%	41.0%	
Safety concerns regarding neighborhood			0.003 <sup>a</sup>
No	69.5%	49.6%	
Yes	2.5%	2.4%	
UTD	28.0%	48.0%	
A move from one residence to another			0.36
No	48.3%	50.4%	
Yes	36.7%	29.3%	
UTD	15.0%	20.3%	

<sup>a</sup> P-value was obtained from the Fisher's Exact Test due to the number of cells that have expected counts less than 5.

**Table 16. Logistic regression analysis of parent needs/services on child fatality, January 2005 - May 2014 (N = 248)**

Overall assessment for parents	Odds ratio (95% confidence interval)		
	Simple logistic regression <sup>a</sup>	Multiple logistic regression A <sup>b</sup>	Multiple logistic regression B <sup>b</sup>
Agency developed safety plan w/family and monitor for other children in home		—	—
No	Reference		
Yes	0.43 (0.18-1.04)		
N/A	0.52 (0.23-1.19)		
Substance abuse			Not in model B
Need not identified	Reference	Reference	
Need identified	2.34 (1.39-3.93)	2.15 (1.13-4.12)	



Domestic violence			
Need not identified	Reference	Reference	Reference
Need identified	0.53 (0.29-0.96)	0.45 (0.21-0.95)	0.41 (0.19-0.90)
Mental health			
Need not identified	Reference	Not in model A	
Need identified	2.17 (1.30-3.63)	2.47 (1.28-4.76)	
Medication management			
Need not identified	Reference	—	—
Need identified	1.62 (0.81-3.23)		
Parent stressors			
Obtaining substantial food			
No	Reference	—	—
Yes	0.39 (0.15-1.02)		
UTD	0.72 (0.41-1.26)		
Safety concerns regarding neighborhood			
No	Reference	—	—
Yes	0.74 (0.15-3.81)		
UTD	0.42 (0.24-0.71)		

<sup>a</sup> Simple logistic regression analysis was conducted for all variables with an overall p-value (from the chi-square test or Student's t-test) less than 0.20.

<sup>b</sup> Only variables with a p-value (yes vs. no) less than 0.20 from the simple logistic regression analysis were included in the multiple logistic regression model building process. Age was also controlled for in the multiple logistic regression. Considering that mental health and substance abuse are closely related, these two variables were included in two separate multiple logistic regression models.

## Section V: Legislation and DCF Initiatives, Programs, and Policies

The Department has made and continues to make efforts to improve practice for all families it serves, particularly those with young children. Policy enhancements, new initiatives and practice guidance have and are being implemented to address the needs of families with infants and toddlers.

### Legislation

Implementer Bill: Section 156. A bill that became effective October 1, 2013 states that DCF shall, within available appropriations, ensure that each child thirty-six months of age or younger who has been substantiated as a victim of abuse or neglect is screened for both developmental and social- emotional delays using validated assessment tools such as the Ages and Stages and the Ages and Stages-Social/Emotional Questionnaires, or their equivalents. The department shall ensure that such screenings are administered to any such child twice annually, unless such child has been found to be eligible for the birth-to-three program.

### DCF Policies

DCF Policy 44-12-8, Safe Sleep Environments, effective March 5, 2014 (new)

The policy can be accessed here: <http://www.ct.gov/dcf/lib/dcf/policy/pdf/44120800.pdf>

- The Social Worker shall, during each home or placement visit for an infant, ask to observe the infant's sleep environment.
- The Social Worker shall engage caregivers of infants in problem solving regarding safe sleep barriers.
- The Social Worker shall discuss any concerns with the caregiver and make recommendations for resolution. If a risk factor is identified during a visit and cannot be resolved, the Social Worker shall immediately consult with the Social Work Supervisor as well as the pediatrician for the infant and any home visiting or parents' support services in place.

The policy also speaks to assistance with procuring equipment and the expected documentation regarding the discussions with the family. In addition, there is a practice guide that, "...provides DCF staff with evidence-based knowledge to assess the safety of an infant's sleep environment and to educate caregivers about how to create a safe infant sleep environment."

The practice guide can be accessed here:

[http://www.ct.gov/dcf/lib/dcf/policy/pdf/Safe Sleep - practice guide FINAL.pdf](http://www.ct.gov/dcf/lib/dcf/policy/pdf/Safe_Sleep_-_practice_guide_FINAL.pdf)

There are other DCF policies regarding infants and toddlers. More information regarding these four policies can be found in Appendix B.

<b>DCF Policy # and Name</b>	<b>Purpose</b>
34-2-6: "Critical Questions to Answer"	Includes questions to be asked during an investigation.
34-12-2 "High Risk Newborns"	Includes indicators and information to be obtained during an investigation.
34-12-3 "Disabled Infants with Life Threatening Conditions"	Offers definitions and outlines of the responsibilities of different departments within the agency.
33-7-15 "Save Haven for Newborns"	Allows for a parent or lawful agent of the parent may voluntarily surrender physical custody of an infant age thirty (30) days or younger to the nursing staff of a hospital emergency room

#### Programs/Assessments/Initiatives

Some of the Department's efforts and the programs utilized to improve practice with families caring for young children, as well as to address factors contributing to child fatalities are noted below:

Children Ages Birth to Three Years

- 24/7 Dads: Curriculum based parenting program for new fathers of young children.
- Access to Preschool for Children in DCF Care: According to the budget implementer, section 132-133, “the DCF Commissioner, in consultation with the Office of Early Childhood, shall adopt policies and procedures that maximize the enrollment of eligible preschool-aged children in eligible preschool programs, and submit such policies and procedures to the joint standing committees of the General Assembly having cognizance of matters relating to children, human services, education and appropriations by January 1, 2015.”<sup>15</sup>
- Baby Elmo Project: Connecticut Juvenile Training School (CJTS) implemented the Baby Elmo Program in 2013, making it only the third state in the country to establish this important program for juvenile justice committed males who are fathers. Youth who self-identify as fathers are offered the program which includes up to 10 training sessions, each on a particular topic related to relationships, communication, and development. The fathers have the opportunity to apply the concepts they have learned during semi-structured visits with their children. At CJTS, the rehabilitation staff takes the lead on this important program, with the support of clinical, medical, and residential staff. The focus of Baby Elmo is on building and maintaining a relationship between the teen parent and his child, as opposed to focusing on learning abstract parenting information.

The Department will be exploring an expansion of the Baby Elmo Project curriculum to serve all parenting adolescents. We will further be looking at strategies to support our adolescent population who may be at risk for becoming teen parents.

- Birth to Three System: Assists and strengthens the capacity of families to meet the developmental and health-related needs of infants and toddlers who have delays or disabilities.
- Child Abuse Pediatricians (CAPs) and Careline 8 Month Pilot Project: The provision of on-call, timely consultation by Child Abuse Pediatricians (CAPs) to Careline after hours and on weekends. The CAPs reviews a subset of non-accepted reports for infants younger than 12 months of age. Ongoing education and training of Careline and other DCF staff about appropriate recognition and disposition of high-risk injuries suggestive of abuse will be occurring.
- Child First Program: An evidence-based early intervention program for very young children and their families with significant mental health and child welfare needs. Serves families statewide for children birth to five years to specifically to address mother/child and parent/child attachment and bonding as well as parenting overall.
- Early Childhood Consultation Partnership (ECCP®): Statewide, evidence-based, mental

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<sup>15</sup> Early Childhood Alliance, (May 2014), Bills, <http://www.earlychildhoodalliance.com/bills>

health consultation program designed to meet the social and emotional needs of children birth to five in early care or education settings. Implemented by Advanced Behavioral Health, Inc. (ABH) and DCF.

- In 2015, the Department will be finalizing a transaction to expand an array of evidence based, substance use and recovery services for parents, caregivers and adolescents through Social Impact Financing. Investment in these services is crucial to addressing many of the challenges that have been identified in fatalities involving young children.
- Family Based Recovery (FBR): A program for families affected by substance abuse. It provides in-home attachment-based parent-child therapy and contingency management substance abuse treatment. FBR treats mothers and fathers who are actively using substances or who have recent history of substance abuse that are also parenting a child under the age of 8.
- In November 2014 the Department, in partnership with DMHAS and other state and local partners, was awarded In-Depth Technical Assistance (IDTA) from the National Center on Substance Abuse in Child Welfare to implement a coordinated, statewide response to addressing fetal and neo-natal substance use disorders. With the IDTA, the partnering entities will be hiring a statewide coordinator to oversee this collaboration. In addition, with the IDTA, DCF will be implementing a pilot program in one or more hospitals to support families caring for substance exposed newborns.
- Maternal Infant Outreach Program (MIOP): Provides referrals, assessments and service coordination.
- Nurturing Families Network: A program for young children with substance abusing parents.
- Zero to Three (ZTT): A federal program for children 0-3 to provide increased visitation for young children placed in care and expedite reunification/permanency for these children

### Child Fatalities

- Medical screening guidelines were established to detect child abuse and neglect, as well as support ongoing educational sessions for the medical community. The Department will be collaborating with the Connecticut Hospital Association to create mandatory training for health care professionals working in pediatric medical settings and emergency departments.
- DCF in partnership with the Connecticut Hospital Association (CHA), as well as statewide child abuse pediatrician (CAP) consultants from Yale and CCMC, lead a broad-based multidisciplinary workgroup to identify best practices around the recognition and reporting in hospital settings of suspected abuse and neglect related injuries in children. The workgroup, focused initially in DCF's Region 3, has developed a blueprint of best practices in hospital settings to improve the recognition and reporting of suspected physical abuse. This blueprint will serve as a guiding framework for future collaboration

with all hospitals statewide around the early identification, screening and detection of risk factors and injuries.

- A quality improvement/quality assurance review system has been developed to track cases in which a fatality has occurred. A system is in place to track child fatalities and critical incidents and conduct a case review. The case reviews examine items such as prior DCF history, SDM assessments reviews, risk factor review, and other case related information.
- DCF's Office for Research and Evaluation (ORE) is developing a case review system for all fatalities and will also collaborate with the Regions in order to combine these efforts.
- A public health campaign will be designed and developed to increase caregiver knowledge and raise public awareness of topics relevant to preventing child abuse and maltreatment. In May 2014, DCF secured technical assistance from Casey Family Programs and Prevent Child Abuse America to work with agencies to develop targeted messaging for a public health campaign to raise public awareness and caregiver knowledge around recurring issues that present in case fatalities, such as unsafe sleep and abusive head trauma. Through this technical assistance, DCF has been working with a broad coalition of stakeholders, including the Office of the Child Advocate, Office of Early Childhood, and pediatric and other medical professionals to design this campaign with an initial focus to target high risk populations and the general public around these issues.
- Since May 2014, DCF has been working in partnership with Cribs for Kids to provide portable cribs and safe sleep kits to high risk clients. Over 250 "safe sleep kits" have been distributed statewide since entering into this partnership.
- DCF will be participating in a research roundtable with the Casey Forum and the Federal Commission to Eliminate Child Deaths.
- DCF met with the Eckerd Foundation, a family service organization, who has worked with the state of Florida in response to child fatalities, to discuss a potential partnership. We are currently working with Eckerd to enter into an agreement to bring their Rapid Safety Feedback model to Connecticut. Casey Family Programs has offered to support the Department with the implementation of this approach.
- Child Fatality Tool Kit: This kit is being developed and is intended to be used to guide case practice during child death/near death events by DCF staff, DCF congregate care programs, and community providers. This guide will outline the steps that should be taken immediately following a fatality or near fatality. It will also address the psychological and emotional impact that these events may have on children, youth and their families as well as on staff.

### Data Collection

The Department's data collection system regarding fatalities has been enhanced, including the

process by and breadth of information that is inputted.

- **Critical Incident Data Collection and Reporting Protocol:** DCF's Risk Management Unit now maintains all critical incidents and collects all information related to each critical incident. They serve as the central repository and disseminator of data and information. This protocol covers a subset of the reasons for reporting Critical Incidents which include all: (1) Death of child (Child fatality); (2) Life-threatening or life altering condition/injury suspected to have been caused by child abuse or neglect; (3) Broken bones suspected to have been caused by child abuse or neglect to children under 6-years of age; and (4) Serious injury of a child currently or previously DCF involved. The last two reasons were included because these types of incidents could become life threatening or fatal.
- **DCF Electronic Case Management System:** ORE and the DCF Division of Health and Wellness are developing a formal list of data collection elements to be considered for inclusion into the statewide electronic DCF system.
- **Recognition of and Reporting Abuse/Neglect:** Frontline providers can face significant barriers to reporting suspected abuse, including concerns that a diagnosis of abuse may be incorrect and result in adverse consequences due to reporting. As a means to address these barriers, DCF has reached out to various partners to improve the recognition of child abuse, especially for infants and young children where the symptoms may be more difficult to recognize. DCF, in partnership with Yale New Haven Children's Hospital (Yale) and Connecticut Children's Medical Center (CCMC), continues to offer expert education and consultation to the state's hospitals to effectively recognize abuse when a child is brought in with an injury.
- **DCF Special Review Reports:** The purpose of the Special Review is to provide an independent case analysis and timely systemic consultation in the aftermath of a child fatality or critical incident. The Special Review's emphasis on education and teaching is designed to generate practical feedback and information for professional learning, organizational development and staff support within and across helping systems. The multidisciplinary approach offers a consistent methodology that focuses on relevant fact-finding, and identification of key dimensions in case practice determined to be excellent, acceptable or in need of improvement.

## **Section VI: Study Limitations**

A possible study limitation was the expedited review process that tested the case review instrument using a small number of reviewers. While not necessarily dispositive of an issue, the small tester pool could influence the inter-rater reliability.

Another possible limitation is the high percentage of "undetermined" and/or "not applicable" responses for many items, which may have affected results. For example, in the case group,

there was a 33% case status for the question, "was target child born drug exposed", could not be determined; while this "undetermined" category doubled in the control group, reaching to 66%. If the percentage of "undetermined" category is low, the effect of missing data on results may be minimal. The "undetermined" category, however, is high such as in the present project, the true results of the comparison between cases and controls really depend on the actual status ("yes" or "no") for those "undetermined" children. For instance, if all "undetermined" children is actually in the "yes" category, the rate of child born drug exposed would be 50.8% in the case group vs. 68.5% in the control group; while if all "undetermined" children is actually in the "no" category, the rate of child born drug exposed would be 17.7% in the case group vs. 2.4% in the control group. Therefore, the best way to increase the validity of the results is to make maximum efforts to reduce the percentage in the "undetermined" category.

Although the reasons that produce a "not applicable" often are different from "undetermined", their effect on results is similar. If a group of subjects has a much higher "not applicable" category than the other group, this item may not be appropriate to be included for comparison. In the present study, we treated "not applicable" and "undetermined" as separated categories and included them in the analysis by creating a dummy variable for each of them. This allows us to have a maximum number of subjects in the analysis and also balance the sample size of the case and control group.

### **Methodology Recommendation for Future Research**

As noted, the present review found high percentages of the "undetermined" and "not applicable" categories for many factors/services/need assessments, which may have biased results of the study. In future research, concrete efforts will be made to reduce the percentages of these two categories. In order to address the "undetermined" issue, ORE plans to review fatality cases and controls in an ongoing manner. More specifically, a thorough review will be conducted at the end of the third month of the death of a child. Meanwhile, a DCF-involved child will be randomly selected as a control and his/her record will be reviewed at the similar time as the fatality case. This rolling review will allow the Department to have sufficient time to address the "undetermined" issue since the majority of the "undetermined" issue comes from the control part. For example, the reviewer can seek the answer from multiple resources, including directly from the social worker.

Regarding the "undetermined" issue, the percentage of "not applicable" is more difficult to reduce because it mainly comes from fatality cases. If there is a large sample of fatality cases, we can exclude cases that are "not applicable" for factors/services/need assessments from the study. Every fatality case, however, should be included in the study since the number of fatality cases is small. This situation allows the Department to continue to use the frequency matching design, rather than the individual matching. The latter design would yield a higher percentage of "not applicable" answers than the frequency matching design because under individual matching, the controls are more similar to the fatality cases (fatality cases having more "not applicable" category). Although statistical techniques (e.g., dummy variables and multiple imputations) can be used to address the "not applicable" issue, it should be noted that they are not the best way to reduce the percentage of "not applicable" category.

## **Section VII: Recommendations**

The following study recommendations are derived from an analysis of the data as well as written and verbal feedback from the review team. The verbal information was obtained during a formal debriefing session held on August 12, 2014. An overarching theme that emerged was for the Department to cultivate broader community partnerships and invest in additional preventative programming. More detailed recommendations can be found later in this report:

### **Enhancing Data Collection System**

A system is not in place to obtain information about fatalities after DCF closed its cases. The cause of a child death may not be determined until after case closure. Therefore, some deaths may be undetermined when DCF closes the case and no longer has contact with the family. "The autopsy will determine the official cause of death (blunt force trauma, drowning, etc.) and manner of death (natural, accidental, homicide, suicide, undetermined)." <sup>16</sup> Further work is needed to develop a system for the Department to obtain and document this information.

As noted, ORE is currently enhancing the Critical Incident data collection system to better include information that is collected during the Child Protective Services (CPS) investigation.

### **Working Collaborative with Hospital and Other Public Health Professional**

Continuing to work collaboratively with hospitals and other public health partners is important to impact the root causes of early childhood fatalities. Early screening and detection on needs in high risk families (e.g., young mothers, teen parents, un-treated behavioral health) must continue to be a focus of this work. In addition, the need to raise public awareness and enhance education around best practices to mitigate some of the risk factors will be a key priority for collaboration with these partners.

### **Working Collaboratively with Law Enforcement**

Continuing to work collaboratively with law enforcement regarding fatalities is imperative. Although CPS staff are trained in a number of areas, there is information that can only be obtained by law enforcement that may inform the determination of the CPS case disposition. "The role of CPS is to determine whether maltreatment was involved in the child's death, identify the responsible party, and then take appropriate action to protect any surviving siblings. CPS does not determine whether anyone committed a crime. CPS personnel are not trained as criminal investigators nor are they trained to collect evidence or interrogate suspected offenders. Therefore, it is important that law enforcement and CPS communicate and coordinate their efforts during the investigation."<sup>17</sup>

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<sup>16</sup> Ibid.

<sup>17</sup> Department of Justice, Walsh, Bill (August 2005), Investigating Child Fatalities: Portable Guides to Investigating Child Abuse. <https://www.ncjrs.gov/pdffiles1/ojdp/209764.pdf>



### Pre-Natal

It is important that the agency continues to work collaboratively with hospitals and other community partners to help ensure that DCF involved pregnant women receive appropriate pre-natal care, address any complications during their pregnancy or in utero exposure to drugs and/or alcohol. The State of Connecticut Office of The Child Advocate published a report of their review of eighty-two fatalities of children birth to three that occurred during 2013. The report stated, "...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 pre-maturity."<sup>18</sup>

### Visitation

Children whose parent had a sufficient frequency of visits between caseworker and parent were less likely to be fatality cases than those whose parent did not. This suggests that sufficient frequency of parent visitation may have a protective effect on child fatality. Therefore, it is recommended that interventions should continue to be taken to boost the worker-parent visitation rate among cases with children age 0-3 whose family has DCF involvement.

### Documentation

Several of the reviewers noted that some of the electronic case records did not contain the necessary documentation to make determinations in the review. In 2013, DCF authored *A Special Review Summary Report*, a compilation of twenty critical incidents and child fatalities assessed from January 2011 to November of 2013. This report also stated, "Several of the cases ...highlighted the importance of clear and concise documentation of casework activities; in order to support an integrated continuity of care, and an accurate account of transactions with clients and the provider network."<sup>19</sup>

### Parent/Child Relationship

"Research suggests that the parent-child relationship may be key to understanding fatal child maltreatment."<sup>20</sup> It is important to observe, assess and document the parents' interaction with their children. This can inform the caretakers' parenting skills, their needs, and the expectations they have of their children. Reviewers sometimes found that either there was no information about the parent/child relationship or when documented, it was not sufficient.

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<sup>18</sup> State of Connecticut Office of The Child Advocate, (July 2014), Child Fatality Report: Children Birth to Three (2013), [http://www.ct.gov/oca/lib/oca/Final\\_OCA\\_Infant\\_Toddler\\_Fatality\\_Report.pdf](http://www.ct.gov/oca/lib/oca/Final_OCA_Infant_Toddler_Fatality_Report.pdf)

<sup>19</sup> State of Connecticut Department of Children and Families, Special Review Report: From Symptoms to Systems, Covering January 2011 through November 2013.

<sup>20</sup> Douglas, Emily M. (2013), Case, Service and Family Characteristics of Households that Experienced a Child Maltreatment Fatality in the United States, *Child Abuse Review*, 22, 311-326.

### Safe Sleep

Reviewers noted that although the safe sleep brochure was provided to families, there was no evidence regarding the reasons why parents are choosing particular sleeping arrangements. For example, asking why the parents have chosen to co-sleep with their children as opposed to just discussing the dangers of co-sleeping.

### Observation/Assessment of Child

It is important for DCF workers to document information regarding observations of the child's physical presentation, motor skills, response to the environment, interacting with the infant, ensuring that there are observations of the child when awake. In some of the cases, there was very limited information about the target child such as, "Child was free of marks and bruises. Child was appropriately dressed." In one case, a reviewer noted that the social worker was able to provide a comprehensive assessment of his interaction with the child because he made it clear that he played with the child and documented the child's behaviors, motor skills, eye contact, etc.

### Needs and Services

The status of needs/services also could not be determined for some of the children. Therefore it is recommended that important needs are documented, regardless whether or not the relevant services are delivered.

### Provider Information

Service providers working with DCF families should produce and provide regular written reports to the agency. Workers should request such reports if they are not being regularly provided, and then scan and/or summarize and document them in the LINK electronic record. Providers also need to ensure they are creating and submitting timely robust reports about their interaction and observations with clients in common.

### Training Suggestions

Continuing to ensure that there is training for DCF workers and provider staff regarding what to expect when there is an infant in the home is important. Training areas for inclusion might be feeding times and forms of nutrients, child's motor skills, infant/toddler development stages such as timeframes for crawling, reaching, sitting up, etc., eye-contact, sleeping patterns, speech development

### Engaging Families Regarding Fatalities

Some of the reviewers expressed concerns about the response to families when a fatality occurred. "All too often, we as professionals are unprepared to deal with the emotions and feelings that surviving family members' experience when a child dies due to abuse or neglect. This may be due in part to our lack of training and/or experience in this area and may also be a

result or our own issues related to abuse and death."<sup>21</sup> It was noted that there was evidence of initially offering grief counseling to the family, but no documented follow-up. Some families may refuse services soon after a fatality due to their own grieving process. There was also a lack of information regarding the deceased child's medical history or mother's pre-natal history. This may be due to the social worker's hesitance to probe the family because of the tragedy. One social worker documented that she had not asked the family questions about the child's past due to the "sensitive nature of the case." Another question that was raised worth exploring is, what impact does a child's death have on a family? The example was given in one of the cases in which an infant had died and after that the mother felt that she had to have her other children sleep in the bed with her because she was afraid something would happen to them. There are also possible cultural considerations that need to be explored. It is important to understand the impact a death can have on a family and how they can be supported.

#### Engaging CPS Staff Regarding Fatalities

Similar to working with families in which a fatality occurred, is the issue of supporting staff. It is important to allow staff to express their concerns regarding personal triggers when it comes to case assignment. The circumstances of a case may cause the staff to experience secondary trauma. A few examples were provided during the debriefing in which fatalities had been assigned to social workers who had experienced a child's death. It is important to note that the assigning staff was not aware of this before the assignment. This is not to say that such information has to be divulged or that the assigned staff would be negatively impacted, but it is important for staff to be provided a vehicle and support to address any possible considerations. Ensuring that fatality cases are equally distributed so that staff aren't assigned more than one fatality case during a certain timeframe may also be a strategy the Department adopts.

### **Section VIII: Conclusion**

Ensuring that children and families are receiving appropriate support and services requires collaboration among several entities. Ongoing assessments are necessary in order to determine the appropriate services and support needed by the families. The findings can influence not only practice and policies within a department but also legislation and national efforts.

Congruent with statewide and national research, some of the findings of this study identify some potential risk factors associated with child fatalities. Age of the child, as well as that of the parents are factors in child fatality cases. Therefore staff training about best practices for cases involving infants and toddlers is important. Programming targeting young families is imperative. These recommendations will assist the Department in better assessing the needs of children and families and aid in determining the service provision needed to better support these families.

While documentation was an identified area for improvement, it is important to not necessarily

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<sup>21</sup> National District Attorneys' Association (November 4, 2004), *Serving Those Left Behind: Crisis Intervention in Child Fatality Cases*, Volume 17. [http://www.ndaa.org/ncpca\\_update\\_v17\\_no4.html](http://www.ndaa.org/ncpca_update_v17_no4.html)

request *more* information but rather the *right* information in order to inform practice and case decisions. Further examination of sub sets of the sample groups within this study may yield more significant results due to the limitations presented earlier.

Finally, the Department's focus on exploring these cases more closely will inform practice, policies and procedures to improve e outcomes for children and families.

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## **Section X: Appendices**

### **Appendix A**

#### **Birth to Three Instrument and Guide**

1. Reviewer Name:

2. Date of Review:

3. LINK Case ID:

4. LINK Case Name:

5. Target Child's Name:

6. Child Person ID:

7. Was child in placement at any time during PUR ? Yes No

7a. What was child's placement status at end of PUR?

- Foster Care
- Residential, etc
- Not in Placement

8. Parent 1 Name:

- For a Fatality Case, this would be the child's parent/guardian, primary caretaker.
- For a Comparison Case This is the person you have identified with whom the child was residing the last 3 months of the PUR.)

9. Parent 1 Person ID: (refers to whom you identified in Q8)

9a. Parent 1 Relationship: (refers to whom you identified in Q8)

Mother

Father

Step-mother

Step-father

Mother's Partner (Male)

Mother's Partner (Female)

Father's Partner (Female)

Father's Partner (Male)

Grandmother

Grandfather

Aunt

Uncle

Sibling

Other \_\_\_\_\_

10. Parent 2 Name:

- For a Fatality Case, this would be the child's parent/guardian, primary caretaker.
- For a Comparison Case This is the person you have identified with whom the child was residing the last 3 months of the PUR.)

11. Parent 2 Person ID: (refers to whom you identified in Q10)

11a. Parent 2 Relationship: (refers to whom you identified in Q10)

Mother

Father

Step-mother

Step-father

Mother's Partner (Male)

Mother's Partner (Female)

Father's Partner (Female)

Father's Partner (Male)

Grandmother

Grandfather

Aunt

Uncle

Sibling

Other \_\_\_\_\_

12. Perpetrator 1 Relationship: FOR FATALITY CASES ONLY! If Comparison case or no perpetrator, choose N/A. (HM = Household Member)

The perpetrator may or may not be different from the parent

Mother HM

Father HM

Babysitter HM

Step-mother HM

Step-father HM

Mother's Partner (Male) HM

Mother's Partner (Female) HM

Father's Partner (Female) HM

Father's Partner (Male) HM

Grandmother HM

Grandfather HM

Aunt HM

Uncle HM

Sibling HM

Other HM \_\_\_\_\_

Mother Non-HM

Father Non-HM

Babysitter Non-HM

Step-mother Non-HM

Step-father Non-HM

Mother's Partner (Male) Non-HM

Mother's Partner (Female) Non-HM



Father's Partner (Female) Non-HM  
 Father's Partner (Male) Non-HM  
 Grandmother Non-HM  
 Grandfather Non-HM  
 Aunt Non-HM  
 Uncle Non-HM  
 Sibling Non-HM  
 Foster Parent  
 Residential Facility Staff  
 Other Non-HM \_\_\_\_\_  
 N/A

13. Perpetrator 1 Name: FOR FATALITY CASES ONLY! If Comparison case or no perpetrator, enter N/A.

14. Perpetrator 1 Person ID: FOR FATALITY CASES ONLY! If Comparison case or no perpetrator, enter 000000.

15. Perpetrator 2 Relationship: FOR FATALITY CASES ONLY! If Comparison case or no perpetrator, choose N/A. (HM = Household Member)

The perpetrator may or may not be different from the parent

Mother HM  
 Father HM  
 Babysitter HM  
 Step-mother HM  
 Step-father HM  
 Mother's Partner (Male) HM  
 Mother's Partner (Female) HM  
 Father's Partner (Female) HM  
 Father's Partner (Male) HM  
 Grandmother HM  
 Grandfather HM  
 Aunt HM  
 Uncle HM  
 Sibling HM  
 Other HM \_\_\_\_\_  
 Mother Non-HM  
 Father Non-HM  
 Babysitter Non-HM  
 Step-mother Non-HM  
 Step-father Non-HM  
 Mother's Partner (Male) Non-HM  
 Mother's Partner (Female) Non-HM  
 Father's Partner (Female) Non-HM  
 Father's Partner (Male) Non-HM

Grandmother Non-HM  
Grandfather Non-HM  
Aunt Non-HM  
Uncle Non-HM  
Sibling Non-HM  
Foster Parent  
Residential Facility Staff  
Other Non-HM \_\_\_\_\_  
N/A

16. Perpetrator 2 Name: FOR FATALITY CASES ONLY! If Comparison case or no perpetrator, enter N/A.

17. Perpetrator 2 Person ID: FOR FATALITY CASES ONLY! If Comparison case or no perpetrator, enter 000000.

18. Type of Case:

- Fatality
- Comparison Case

19: At time of death (for fatality case) or on last day of PUR (for a comparison case), case status:

- Opened
- Closed with CPS History
- Closed with no CPS History
- FAR

20. At time of death (for fatality case) or on last day of PUR (for a comparison case), number of siblings/other foster children living in home/placement w/target child?

21. Did either individual whom you identified as the parent(s) EVER have a child legally removed from their care? (This information should be in the case plan, investigation protocol or narratives. If you can not determine either way, choose UTD.)

- Yes (no TPR)
- Yes with TPR
- No
- UTD

## CHILD

For the questions with an "\*" after it (Q22aCRF-Q22fCRF), you may have to review past the 2 year PUR if we were involved with the family in order to obtain information regarding the Target Child.

22. Was child seen by community providers other than by pediatrician during the PUR?

- Yes
- No

22aCRF. Was target child born a high risk newborn due to medical issues?\*

- Yes
- No
- UTD

22bCRF. Was target child born drug exposed?\*

- Yes
- No
- UTD

22cCRF. Was target child born alcohol exposed?\*

- Yes
- No
- UTD
- 

22dCRF. Was target child born premature?\*

- Yes
- No
- UTD

22eCRF. Were there concerns with target child at birth?\*

- Yes
- No
- UTD

22fCRF. Was the target child up-to-date with immunizations?\*

- Yes
- No
- UTD
- N/A Parents declined immunizations

22gCRF. Did target child have any chronic medical conditions during the PUR?

- Yes
- No
- UTD

22hCRF. Did target child have any developmental delays during the PUR?

- Yes
- No
- UTD

22iCRF. Was target child placed in a medically complex foster home placement during the PUR?

(Look under the "Placement Icon" in link to determine if any of the placements during the PUR for the TARGET CHILD were listed as medically complex.)

- Yes
- No
- N/A

#### ASSESSMENTS/NEEDS/SERVICES FOR CHILD

23. Did agency make concerted efforts to conduct ongoing formal/informal comprehensive assessments to assess target child's needs? (See "Term Guidance and Tips" at beginning of guide for more information regarding underlined terms.)

- Yes
- No
- N/A

23a. Did the agency make concerted efforts to provide appropriate services to meet ALL of the target child's identified needs?

- Yes
- No
- N/A

The following questions speak to whether or not the agency made concerted efforts to address the identified need. If the reviewer determines that the agency made concerted efforts to meet the need, choose "Met." Please refer to the beginning of the document for guidance regarding "Concerted Efforts."

23aCN. Well-Child Check (Routine): Met Not Met N/A

23aCB. If not met, what was primary barrier? (Choose primary barrier)

23bCN. Medical Assessment/Examination (Other than Routine): Met Not Met N/A

23bCB. If not met, what was primary barrier? (Choose primary barrier)

23cCN. Occupational and/or Physical Therapy: Met Not Met N/A

23cCB. If not met, what was primary barrier? (Choose primary barrier)

23dCN. Sexual Abuse Assessment/Examination: Met Not Met N/A

23dCB. If not met, what was primary barrier? (Choose primary barrier)

23eCN. Dental: Met Not Met N/A

23eCB. If not met, what was primary barrier? (Choose primary barrier)

23fCN. Birth to Three: Met Not Met N/A

23fCB. If not met, what was primary barrier? (Choose primary barrier)

23gCN. Daycare: Met Not Met N/A

23gCB. If not met, what was primary barrier? (Choose primary barrier)

23hCN. Developmental Assessment (Other than B-3): Met Not Met N/A

23hCB. If not met, was primary barrier? (Choose primary barrier)

23iCN. Other UNMET need: (If none, enter N/A)

23iCB. If not met, what was primary barrier? (Choose primary barrier)

**Drop down Barriers**

- a. N/A - Need was met or not a need
- b. Parent/Guardian refused service
- c. Whereabouts of parent/guardian/caretaker unknown
- d. Hours of operation (Alt. hours needed) a barrier
- e. Gender-specific service not available
- f. Specific service not available in the primary language of parent
- g. Transportation
- h. Service deferred pending completion of another
- i. Waiting list
- j. Delay in service by provider (not due to waiting list)
- k. Referred service unwilling to engage client
- l. Financing
- m. Delay in referral by DCF
- n. Delay due to medical insurance
- o. Reviewer determined that it was a need but it was not identified by the agency
- p. Unable to be determined
- q. Other \_\_\_\_\_

**VISITS WITH CHILD**

23VF. During the period under review, was the FREQUENCY of the visits between the caseworker (or other responsible party) and the target child sufficient to address issues pertaining to the safety, permanency, and well-being of the child.

Yes No N/A

Guidance  
 Visits were to have been conducted by Social Workers or Social Work Supervisors. Although case aides have frequent contact with children and families, these visits would not be considered in the determination of the answer to this question. Visits should be occurring in the child's home.  
 Base your determination on the frequency necessary to ensure the child's safety, permanency, and well-being and **not based on state policy** requirements regarding caseworker contacts or

visits with the child. For example, if state policy is that the caseworker should visit the child at least once a month, and you determine that given the circumstances of the case (for example, there are safety concerns), the caseworker should visit more frequently, then the answer to question A should be No. If the typical pattern of visits is less than once a month, the answer to question A should be No unless you determine that there is a substantial justification for a Yes answer.

Although visits can occur in the community (outside of the home) the reviewer should use their professional judgment whether the social worker visits of the child IN THE HOME were sufficient.

N/A - This would be used in cases in which there was no time allotted to conduct visits such as in cases where the agency became involved due to a child's death.

Frequency Guidance:

CIP: While the child is in foster care that child is to be visited once/month.

In-home: Child is to be seen twice a month.

FAR: Child is to be seen within 5 days of that date in which the family was initially contacted.

Initial family contact can be via phone or face to face.

Investigation to On-going services: Child is to be seen 1/week for the first four weeks after the case is transferred from investigation to on-going services.

23VQ. During the period under review, was the quality of the visits between the caseworker and the child(ren) sufficient to address issues pertaining to the safety, permanency, and well-being of the target child? (See further clarification on quality of visits on pg. 5) Yes No N/A

Guidance

Although case aides have frequent contact with children and families, these visits would not be considered in the determination of the answer to this question.

Did we observe the child in the home or outside of the home, consider duration and whether or not there are descriptions of child. Did we discuss the child's well being with the caretaker?

The worker is not required to view child alone in that verbal communication between the worker and child is not possible due to the age of the child.

23VPol. Was the frequency of the visit between the social worker and the child in adherence with DCF policy?

Yes No N/A

Policy Standards:

CIP: While the child is in foster care that child is to be visited once/month.

In-home: Child is to be seen twice a month.

FAR: Child is to be seen within 5 days of that date in which the family was initially contacted.

Initial family contact can be via phone or face to face.

Investigation to On-going services: Child is to be seen 1/week for the first four weeks after the case is transferred from investigation to on-going services.

**RISK AND SAFETY**

23RSa. If the case was opened during the period under review, did the agency conduct an initial assessment that accurately assessed all risk and safety concerns for the target child? If the case was opened prior to the PUR, choose N/A.

Yes No N/A

**Guidance**

“Risk” is defined as the likelihood that a child will be maltreated in the future.

An assessment of safety is made to determine whether a child is in a safe environment. A safe environment is one in which there are no threats that pose a danger or, if there are threats, there is a responsible adult in a care-giving role who demonstrates sufficient capacity to protect the child.

Risk and Safety assessment may be demonstrated in a variety of ways. They may be formal or informal. In many ways, they may seem similar to the formal/informal assessments of needs. The reviewer should look for case documentation that indicates that the safety and/or risk factors for the target child were assessed. This can occur formally through tools, evaluations, reports and informally through visits, conversations, observations, and etcetera.

These include, but are not limited to: Structured Decision Making Assessments (SDM)

SDMs if during the years since the agency policy incorporated

SDMs Refer to the formal and informal assessment lists below

SDM Assessments can be found in Link under the "Assessment" Icon

23RSb. During the period under review, did the agency conduct ongoing assessments that accurately assessed all of the risk and safety concerns for the target child?

Yes No N/A

**Guidance**

Determine whether ongoing assessments (formal or informal) were conducted during the period under review. If the agency conducted an initial assessment of risk and safety at the onset of the case, but did not assess for risk and safety concerns on an ongoing basis (for example, when there were new allegations of abuse or neglect, changing family conditions, new people coming into the family home or having access to the children, changes to visitation, upon reunification, or at case closure) then the answer should be No.

If the only activity during the PUR was a Family Assessment Response (FAR) or an Investigation in which allegations were unsubstantiated, it could be that there weren't any risk or safety concerns identified therefore ongoing assessments may not have been deemed necessary.

Note that in some cases, the issue of ongoing assessments may not be relevant because the case was opened for a very short period of time (for example, if the case was opened shortly before the end of the period under review and during the initial assessment the agency determined that there were no risk or safety concerns, then it may be reasonable to conclude that the agency would not have conducted a second risk and safety assessment during the period under review). In this case, determine whether the agency conducted ongoing assessments of both risk and safety and, if not, whether it should have, given the time frame and circumstances of the case. If you believe that ongoing assessments were not necessary, this question may be answered Not Applicable.

If a case was closed during the period under review, determine whether the agency conducted a risk and safety assessment before closing the case if deemed necessary based on the circumstances of the case.

23RSc. During the period under review, if safety concerns were present, did the agency: (1) develop an appropriate safety plan with the family and (2) continually monitor and update the safety plan as needed, including monitoring family engagement in any safety-related services regarding the target child?

Yes No N/A

#### Guidance

Safety plan” refers to a plan that describes strategies developed by the agency and family to ensure that the child is safe. Safety plans should address safety threats and how those will be managed/addressed by the caregiver, caregiver capacity to implement the plan and report safety issues to the agency, and family involvement in implementation of the plan. Safety plans may be a separate from or integrated into the case plan.

PARENT 1 - Please make sure you refer to timeframe and accurate individual according to the guidance in the beginning of this document. There is also clarification regarding the underlined terms.

24. During the period under review, did the agency make concerted efforts to conduct a formal or informal initial and/or ongoing comprehensive assessment that accurately assessed the parent 1 needs? Yes No N/A

The following questions are asking if the agency made concerted efforts to meet the individual's needs.

24a. Did agency make concerted efforts to provide appropriate services to Parent 1 to meet ALL identified needs? Yes No N/A

The following questions speak to whether or not the agency made concerted efforts to address the identified need. If the reviewer determines that the agency made concerted efforts to meet the need, choose "Met." Please refer to the beginning of the document for guidance regarding



"Concerted Efforts."

24aPN. Substance Abuse: Met Not Met N/A

24aPB. If not met, what was primary barrier? (Choose primary barrier)

24bPN. Domestic Violence: Met Not Met N/A

24bPB. If not met, what was primary barrier?

24cPN. Mental Health (Other than maternal Depression): Met Not Met N/A

24cPB. If not met, what was primary barrier? (Choose primary barrier)

24dPN. Maternal Depression: Met Not Met N/A

24dPB. If not met, what was primary barrier? (Choose primary barrier)

24ePN. Medication Management: Met Not Met N/A

24ePB. If not met, what was primary barrier? (Choose primary barrier)

24fPN. Parenting Education: Met Not Met N/A

24fPB. If not met, what was primary barrier? (Choose primary barrier)

**Drop down Barriers**

- a. N/A - Need was met or not a need
- b. Parent/Guardian refused service
- c. Whereabouts of parent/guardian/caretaker unknown
- d. Hours of operation (Alt. hours needed) a barrier
- e. Gender-specific service not available
- f. Specific service not available in the primary language of parent
- g. Transportation
- h. Service deferred pending completion of another
- i. Waiting list
- j. Delay in service by provider (not due to waiting list)
- k. Referred service unwilling to engage client
- l. Financing
- m. Delay in referral by DCF
- n. Delay due to medical insurance
- o. Reviewer determined that it was a need but it was not identified by the agency
- p. Unable to be determined
- q. Other \_\_\_\_\_

24VF. Was FREQUENCY of visits between Caseworker & Parent 1 sufficient?

Yes No N/A

**Guidance**

Visits were to have been conducted by Social Workers or Social Work Supervisors. Although case aides have frequent contact with children and families, these visits would not be considered in the determination of the answer to this question.

Base your determination on the frequency necessary to ensure the child's safety, permanency, and well-being and **not based on state policy** requirements regarding caseworker contacts or visits with the child. For example, if state policy is that the caseworker should visit the parent at least once a month, and you determine that given the circumstances of the case (for example, there are safety concerns), the caseworker should visit more frequently, then the answer to question A should be No. If the typical pattern of visits is less than once a month, the answer to question A should be No unless you determine that there is a substantial justification for a Yes answer.

Although visits can occur in the community (outside of the home) the reviewer should use their professional judgment whether the social worker visits of the parent IN THE HOME were sufficient.

N/A - This would be used in cases in which there was no time allotted to conduct visits such as in cases where the agency became involved due to a child's death.

Frequency Guidance:

In-home: Twice a month

In-home: Investigation to On-going services: Child is to be seen 1/week for the first four weeks after the case is transferred from investigation to on-going services.

FAR: Parent is to be seen within 5 days of the date in which the family was initially contacted.

Initial family contact can be via phone or face to face.

CIP: Once a month:

Contact is expected with parents (*i.e.*, biological, legal guardian or adoptive) of children having permanency goals of reunification, APPLA, transfer of guardianship and adoption.

The Social Worker shall have contact with the parents as follows:

\*when the child's permanency plan or concurrent plan is reunification, face-to-face contact shall occur at least once per month with the parent(s) with whom the child will reunify

\*when the permanency plan is other than reunification, face-to-face contact or telephone contact shall occur at least once per month

\*In cases in which there is less than monthly contact with a parent, the record shall reflect substantial justification for the deviation from the minimum standard. This shall be reassessed at least once every six months.

24VQ. Was QUALITY of visits between Caseworker & Parent 1 sufficient? (See further clarification on quality of visits on pg. 5)

Yes No N/A

24aR. Is there info in LINK regarding Parent 1 and the Child's Relationship?

Yes No

24bR. Were there identified concerns regarding Parent 1 and the Child's Relationship?

Yes No UTD-no info regarding relationship N/A

24cR. Did agency address concerns with Parent 1?

Yes No N/A

PARENT 2 - Please make sure you refer to timeframe and accurate individual according to the guidance in the beginning of this document.

If there is no parent 2, please choose N/A for questions 25-25cR

25. During the period under review, did the agency make concerted efforts to conduct a formal or informal initial and/or ongoing comprehensive assessment that accurately assessed the parent 2 needs?

Yes No N/A-No Parent 2

25a. Did agency make concerted efforts to provide appropriate services to Parent 2 to address ALL identified needs?

Yes No N/A-No Needs Identified or no Parent 2

The following questions speak to whether or not the agency made concerted efforts to address the identified need. If the reviewer determines that the agency made concerted efforts to meet the need, choose "Met." Please refer to the beginning of the document for guidance regarding "Concerted Efforts."

25aPN. Substance Abuse: Met Not Met N/A

25aPB. If not met, what was primary barrier?

25bPN. Domestic Violence: Met Not Met N/A

25bPB. If not met, what was primary barrier?

25cPN. Mental Health: Met Not Met N/A

25cPB. If not met, what was primary barrier?

25dPN. Medication Management: Met Not Met N/A

25dPB. If not met, what was primary barrier?

25ePN. Parenting Education: Met Not Met N/A

25ePB. If not met, what was primary barrier?

<b>Drop down Barriers</b>
---------------------------

- |  |
|--|
| <ul style="list-style-type: none"> <li>a. N/A - Need was met or not a need</li> <li>b. Parent/Guardian refused service</li> <li>c. Whereabouts of parent/guardian/caretaker unknown</li> <li>d. Hours of operation (Alt. hours needed) a barrier</li> <li>e. Gender-specific service not available</li> <li>f. Specific service not available in the primary language of parent</li> <li>g. Transportation</li> <li>h. Service deferred pending completion of another</li> <li>i. Waiting list</li> <li>j. Delay in service by provider (not due to waiting list)</li> <li>k. Referred service unwilling to engage client</li> <li>l. Financing</li> <li>m. Delay in referral by DCF</li> <li>n. Delay due to medical insurance</li> <li>o. Reviewer determined that it was a need but it was not identified by the agency</li> <li>p. Unable to be determined</li> <li>q. Other ____</li> </ul> |
|--|

25VF. Was FREQUENCY of visits between Caseworker & Parent 2 sufficient?

Yes No N/A

<p><b>Guidance</b></p> <p>Visits were to have been conducted by <u>Social Workers or Social Work Supervisors</u>. Although case aides have frequent contact with children and families, these visits would not be considered in the determination of the answer to this question.</p> <p>Base your determination on the frequency necessary to ensure the child's safety, permanency, and well-being and <b><u>not based on state policy</u></b> requirements regarding caseworker contacts or visits with the child. For example, if state policy is that the caseworker should visit the parent at least once a month, and you determine that given the circumstances of the case (for example, there are safety concerns), the caseworker should visit more frequently, then the answer to question A should be No. If the typical pattern of visits is less than once a month, the answer to question A should be No unless you determine that there is a substantial justification for a Yes answer.</p> <p>Although visits can occur in the community (outside of the home) the reviewer should use their professional judgment whether the social worker visits of the parent IN THE HOME were sufficient.</p> <p>N/A - This would be used in cases in which there was no time allotted to conduct visits such as in cases where the agency became involved due to a child's death.</p> <p>Frequency Guidance:</p>
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In-home: Twice a month

In-home: Investigation to On-going services: Child is to be seen 1/week for the first four weeks after the case is transferred from investigation to on-going services.

FAR: Parent is to be seen within 5 days of the date in which the family was initially contacted.

Initial family contact can be via phone or face to face.

CIP: Once a month:

Contact is expected with parents (*i.e.*, biological, legal guardian or adoptive) of children having permanency goals of reunification, APPLA, transfer of guardianship and adoption.

The Social Worker shall have contact with the parents as follows:

\*when the child's permanency plan or concurrent plan is reunification, face-to-face contact shall occur at least once per month with the parent(s) with whom the child will reunify

\*when the permanency plan is other than reunification, face-to-face contact or telephone contact shall occur at least once per month

\*In cases in which there is less than monthly contact with a parent, the record shall reflect substantial justification for the deviation from the minimum standard. This shall be reassessed at least once every six months.

25VQ. Was QUALITY of visits between Caseworker & Parent 2 sufficient? (See further clarification on quality of visits on pg. 5) Yes No N/A

25aR. Is there info in LINK re: Parent 2/Child relationship?

Yes No UTD-no info regarding relationship N/A

25bR. Were there identified concerns re: Parent 2/Child relationship?

Yes No UTD-no info regarding relationship N/A

25cR. Did agency address concerns with Parent 2?

Yes No N/A

26. Did family (either parent 1 and/or parent 2) have informal/natural supports?

Yes No N/A

DCF/CHILD - "\*" may require you to review information prior to the PUR

27. Was an MDE completed?\* (for cases for children who were in placement) Yes No N/A-not a CIP UTD

This information can be found in the running narrative or on the bottom left of the general tab of the medical icon:

28. Was child in Early Headstart Program? \*

Yes No N/A UTD

29. Was child in Child First?\* Yes No N/A UTD

30. Was child in a Positive Parenting Program?\*

Yes No UTD-child born prior to DCF

31. Was child in Help Me Grow?\* Yes No N/A UTD

32. Was child in Nurturing Families Network?\*

Yes No N/A UTD

33. Was child hospitalized during the PUR? Yes No UTD

34. Did child have any ER visits during the PUR? Yes No UTD

34a. If "Yes" to Q33 and/or Q34 was the ARG nurse consulted? Yes No N/A

35. Date of last social worker visit with child prior to the incident that resulted in a fatality or during the PUR if a "Comparison Case":

You can choose the date from the calendar or manually insert.

36. Date of last social worker visit with child. (Will be the same date as Q35 if a "Comparison Case.")

You can choose the date from the calendar or manually insert

37. Was there evidence that agency assessed child's sleeping arrangement during the PUR? During all visits During some visits No N/A

38. Was there evidence that agency had collateral contacts w/medical providers during the PUR? Yes No N/A

39. Was there evidence that agency had collateral contacts w/daycare providers during the PUR?  
Yes No N/A

40. Was there evidence that agency had contacts w/individuals who had regular contact w/target child during the PUR? With All With Some No N/A

41. Was there evidence that safe sleeping was discussed w/parents/caretakers during the PUR?  
Yes No N/A

42. Was there a Considered Removal Meeting during the PUR? Yes No N/A

Find this information in the running narrative or case plan. This would not be applicable for cases in which a child was in placement during the entire PUR and only began occurring in February of 2013.

43. Were the appropriate ARG consulted? Yes, All Yes, Some, No N/A

44. Was a legal consult conducted during the PUR? Yes No N/A

45. Was there a meeting (may appear as a Child and Family Team Meeting or a Family Meeting) held in which the family's identified natural supports participated in a joint meeting with the family and DCF? These meetings would have only begin in 2013.

Yes No N/A

46. Were Neglect Petitions filed in regards to target child? Yes No N/A

#### CENTRAL REGISTRY

47. Was at least 1 of the parents/guardians EVER on the Central Registry?\*

Yes, Before fatality Yes, After fatality Yes, Comparison Case No

48. Was at least 1 of the perpetrators EVER on the Central Registry\*?\*

Yes, Before fatality Yes, After fatality Yes, Comparison Case No

There are a number of resources to find this information.

1. Search individual under the "Perpetrator" tab in Link. You may have to try different ways to search the person such as searching the entire name, Person ID or last name with date of birth.
2. Once you find the person, open the icons. If the person is on the central registry, you will see the following information following their name:

Worker	Perpetrator
<input type="checkbox"/> Sounds Like: <input type="checkbox"/>	
DOB: <input type="text" value="04/04/1986"/>	
Gender: <input type="text" value=""/>	
) 3/4/2014 Disclosable	

### STRESSORS - During the PUR

For the Comparison Cases, the family is referring to whomever you identified as Parent 1 and Parent 2.

49. Was obtaining and/or maintaining employment a stressor for family during the PUR?

Yes No UTD N/A

50. Was obtaining substantial food was a stressor for family during the PUR?

Yes No UTD N/A

51. Was obtaining or maintaining housing was a stressor for family during the PUR?

Yes No UTD N/A

52. Was paying for utilities a stressor for family during the PUR?

Yes No UTD N/A

53. Did the family identify safety concerns re: neighborhood during the PUR?

Yes No UTD N/A

54. Did family experience a move from one residence to another during the PUR?

Yes No UTD N/A

### RISK AND SAFETY/SIBLINGS - During the PUR

See the guidance regarding risk and safety in the beginning of this document.

55. Did agency conduct initial assessment to assess Risk & Safety concerns for other minor children residing in the home with target child? Yes No N/A

56. Did agency conduct ongoing assessments to assess Risk & Safety concerns for other minor



children residing in the home with target child? Yes No N/A

**Guidance**

“Risk” is defined as the likelihood that a child will be maltreated in the future.

An assessment of safety is made to determine whether a child is in a safe environment. A safe environment is one in which there are no threats that pose a danger or, if there are threats, there is a responsible adult in a care-giving role who demonstrates sufficient capacity to protect the child.

Risk and Safety assessment may be demonstrated in a variety of ways. They may be formal or informal. In many ways, they may seem similar to the formal/informal assessments of needs. The reviewer should look for case documentation that indicates that the safety and/or risk factors for the target child were assessed. This can occur formally through tools, evaluations, reports and informally through visits, conversations, observations, and etcetera.

These include, but are not limited to: Structured Decision Making Assessments (SDM)

SDMs if during the years since the agency policy incorporated

SDMs Refer to the formal and informal assessment lists below

SDM Assessments can be found in Link under the "Assessment" Icon

57. Did agency develop appropriate safety plan w/family AND continually monitor/update as needed for other minor children residing in the home with target child? Yes No N/A

**Guidance**

Safety plan” refers to a plan that describes strategies developed by the agency and family to ensure that the child is safe. Safety plans should address safety threats and how those will be managed/addressed by the caregiver, caregiver capacity to implement the plan and report safety issues to the agency, and family involvement in implementation of the plan. Safety plans may be a separate from or integrated into the case plan.

FATALITIES ONLY - If this is not a fatality case,

STOP HERE!

**Cause of Death**

58. Target Child's Date of Death (You can choose from calendar or manually insert)

59. What was the manner of death?

- Homicide** - in an intentional death committed maliciously by another person (gun shot, stabbing, etc)
- Accident** - is an unintentional death that is not willful or malicious (drowning, motor vehicle, falls, fires)
- Natural** - is a death where the natural disease process occurs (cancer, tumors, aging, natural disease, SIDS, and other medical complexities)
- Undetermined** - is a classification that after further review the death does not fit into one of the four other categories

60. If Homicide, select type:

- Burn
- Causing physical injury to child
- Child Drowning
- Child Falling
- Child left in car
- Child not provided proper nutrition/food
- Child not provided medical care/attention
- Drug ingestion
- Firearm
- Motor vehicle
- Poisoning (other than drug ingestion)
- Sexual Abuse
- Shaken baby
- Strangulation
- Suffocation
- Undetermined
- N/A not deemed a homicide
- Other \_\_\_\_\_

61. If Accident, select type:

- Accidental suffocation or strangulation in bed
- Child Burned
- Child Drowning
- Child Falling
- Drug ingestion
- Falling off bed while co-sleeping
- Firearm
- Motor vehicle
- Poisoning (other than drug ingestion)
- Unsafe Sleeping
- Undetermined
- N/A not deemed an accident
- Other \_\_\_\_\_

62. If Natural Manner, select type:

- Chronic Illness

- Medical Complications
  - Natural death excluding SIDS
  - SIDS
  - Undetermined
  - N/A not a natural manner
  - Other \_\_\_\_\_
63. Was there an arrest as a result of the death?
- Yes
  - No
  - UTD
64. If "Yes" Q63, list charge(s).
- \_\_\_\_\_
65. If the cause of death was related to unsafe sleeping (Items that may have posed a safety hazard: blankets, toys, bumpers), indicate which situation:
- Sleeping in adult bed alone
  - Sleeping in adult bed with adult
  - Sleeping in adult bed with other minor children
  - Sleeping in adult bed with adult **and** other minor children
  - Sleeping on couch/chair with adult
  - Sleeping in a crib/bassinet with items that posed a safety hazard
  - Sleeping in crib/bassinet on stomach
  - Sleeping in crib/bassinet on stomach with items that posed a safety hazard
  - Sleeping in crib/bassinet on back with items that posed a safety hazard
  - Sleeping in car seat
  - Swaddling
  - UTD
  - Other \_\_\_\_\_
  - N/A
66. If child died as a result of the parent's abuse/neglect, what is the reason the parent provided for their behavior.
- Frustrated with child's tantrum-like behavior
  - Frustrated with child's medical needs
  - Felt child was provoking them with their behavior
  - Was trying to stop the child from crying
  - Child would not eat
  - Child would not use the bathroom properly
  - No reason provided
  - N/A
67. Review Status
- Completed
  - Pending
68. Do you have additional comments
- a. Yes, document attached
  - b. No

**APPENDIX B**

**State of Connecticut Department of Children and Families**

**Policies**

**34-2-6**

**Critical Questions to Answer**

<b>Critical Questions</b>	<p>The following are critical questions which an investigation must answer:</p> <ul style="list-style-type: none"> <li>• Is the child safe? If not, what type of Department or community response will ensure the child’s safety?</li> <li>• Can the Department assist the family to keep the child safe and avoid placement?</li> <li>• If the child’s safety cannot be assured within the family, what type or level of care does the child need? Are there relatives who can help the child and family?</li> <li>• Should ongoing Department services be offered to the family?</li> <li>• Is the family amenable to help?</li> <li>• Are there cultural issues that need to be explored?</li> <li>• Is there a criminal record?</li> <li>• Is domestic violence a factor?</li> <li>• Is substance abuse a factor?</li> <li>• Is child abuse or neglect substantiated?</li> <li>• In the absence of child abuse or neglect, is the family in need of other state or community services?</li> </ul>
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**34-12-2**

**High Risk Newborns**

Policy	<p>Reports from hospitals or other medical providers regarding newborn children considered to be at high risk due to their own special needs and their mother's condition or behavior shall be investigated by a DCF investigator.</p>
Indicators of Special Needs Newborns	<p>Indicators of special needs newborns include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• positive urine or meconium toxicology for drugs</li> <li>• positive test for HIV infection</li> <li>• serious medical problems.</li> </ul>
Indicators in Mother's Condition or Behavior	<p>Indicators in the mother's condition or behavior which may identify the newborn to be at risk include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• substance abuse</li> </ul>

	<ul style="list-style-type: none"> <li>• intellectual limitations which may impair the mother’s ability to nurture or physically care for the child</li> <li>• major psychiatric illness</li> <li>• young age.</li> </ul>
<p>Requirements of the Investigation</p>	<p>A high risk newborn investigation shall include an assessment of the following:</p> <ul style="list-style-type: none"> <li>• extent of the mother's pre-natal care</li> <li>• parent's willingness to participate in appropriate services</li> <li>• support services within the family or community that are available to the parent</li> <li>• safety and adequacy of the home</li> <li>• parent's ability to provide appropriate care in the home.</li> </ul>
<p>Report Substantiated:  Provision of Intensive In-Home Supervision</p>	<p>If a report is substantiated, the DCF worker shall provide or arrange for intensive in-home supervision to begin within three (3) days of discharge from the hospital.</p> <p>Such in-home visits shall occur at least twice a week for at least four weeks.</p> <p>For any substance exposed child, the worker will request parental participation in a substance abuse treatment program, including voluntary submission to urine testing.</p>
<p>Providers of In-Home Supervision</p>	<p>In-home supervision and services may be provided by any of the following, as appropriate:</p> <ul style="list-style-type: none"> <li>• DCF staff</li> <li>• parent-aides</li> <li>• public health nurses</li> <li>• Visiting Nurse Association</li> <li>• other regional contractual services.</li> </ul>

**34-12-3  
Disabled Infants with Life Threatening Conditions**

<p>Policy</p>	<p>The Department of Children and Families shall</p> <ul style="list-style-type: none"> <li>• receive all reports alleging medical neglect of disabled infants with life threatening conditions</li> <li>• investigate the reports</li> <li>• ensure that the infant is receiving appropriate medical care</li> <li>• work jointly with the Department of Public Health (DPH) to effect this policy.</li> </ul> <p>Legal References: 42 USC §5101 et. seq.; CFR Ch. XIII, 1340.15;</p> <p>CONN. GEN. STAT. 46b-120</p>
<p>Definitions</p>	<p>Medical neglect is failure to provide adequate medical care, including but not limited to, the withholding of medically indicated treatment from a disabled infant with a life threatening condition.</p> <p>Withholding of medically indicated treatment is failure to respond to an infant's life threatening condition by providing treatment which, in the treating physician's reasonable medical judgment, would be most likely to be effective in ameliorating or correcting all such conditions.</p> <p>Exception: The term does not include failure to provide treatment when</p> <ul style="list-style-type: none"> <li>• the infant is chronically and irreversibly comatose</li> <li>• the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the infant's survival</li> <li>• the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment would be inhumane.</li> </ul> <p>Note: Appropriate nutrition, hydration and medication must always be provided.</p> <p>Reasonable medical judgment means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.</p> <p>An infant is a child less than one year of age.</p> <p>A child older than one year of age who has been continuously hospitalized</p>

	<p>since birth, who was born extremely prematurely, or who has a long-term disability may also be evaluated by this policy.</p> <p>An Infant Care Review Committee (ICRC) is a hospital committee whose function is to educate hospital personnel and families of disabled infants, recommend institutional policies and guidelines concerning the withholding of treatment, and review cases involving such infants.</p> <p>The Interdepartmental Investigative Team (IIT) is a joint DCF and DPH committee whose function is to investigate allegations of medical neglect involving disabled infants with life threatening conditions.</p>
<p>DCF Responsibilities</p>	<p>The Department of Children and Families shall</p> <ul style="list-style-type: none"> <li>• promote the establishment and foster the existence of Infant Care Review Committees in health care facilities providing in-patient infant care</li> <li>• identify and maintain a list of staff in each health care institution to act as a liaisons with DCF and DPH</li> <li>• establish a mechanism to update the list of liaisons annually</li> <li>• inform all health care institutions providing in-patient infant care that all cases of suspected medical neglect are required by law to be reported to the DCF Hotline (toll-free, twenty-four (24) hours a day.)</li> <li>• together with DPH establish an Interdepartmental Investigative Team.</li> </ul>
<p>Response Time</p>	<p>All referrals to the Interdepartmental Investigative Team shall be coded as emergency cases and shall require a same day response.</p> <p>The investigation shall be completed within thirty (30)calendar days.</p>
<p>Hotline Responsibilities</p>	<p>The Child Protective Hotline workers who receive a report regarding a disabled infant with life threatening conditions shall immediately</p> <ul style="list-style-type: none"> <li>• record basic identifying information in LINK</li> <li>• conduct a name search of active and inactive Children's Protective Service records in LINK</li> <li>• advise administrative staff of the report.</li> </ul>
<p>Administrative Response</p>	<p>Upon notification of the receipt of a report, the administrative staff shall immediately call the Director of Child Welfare Services and transmit the report information.</p> <p>For investigation procedures, see policy 34-12-3.1.</p>



**34-14-1**

**Referrals to Early Intervention Services**

<p>Policy</p>	<p>Every investigation of child abuse or neglect shall include a collateral contact with the child(ren)'s health care provider.</p>
<p>Referrals to Birth to Three</p>	<p>The investigator shall make contact with the child(ren)'s health care provider using the DCF-2147, and ascertain if a child under the age of three (3) is in need of a developmental evaluation by the State Birth-to-Three program.</p> <p>In cases where abuse or neglect has been substantiated and the child(ren)'s health care provider indicates "Yes", the child shall be referred to Birth-to-Three.</p> <p>In cases where there is no health care provider known, the child shall be referred to Birth-to-Three.</p> <p>In the event that the health care provider does not return the DCF-2147, it is the responsibility of the investigator to make additional attempts to obtain the information, including through phone calls, up to the point of the disposition of the investigation.</p> <p>In the event that the case is transferred to ongoing services, the ongoing services worker is responsible for making additional reasonable attempts to obtain medical information necessary for a comprehensive assessment of the child for the purposes of treatment planning.</p> <p>Legal Reference: Part C, Individuals with Disabilities Education Act, Section 106(b)(2)(A))(xxi)</p>

**33-7-15**

**Safe Havens for Newborns**

<p><b>Utilizing the Safe Haven Act</b></p>	<p>In accordance with Public Act 00-207, “An Act Concerning Safe Havens”, a parent or lawful agent of the parent may voluntarily surrender physical custody of an infant age thirty (30) days or younger to the nursing staff of a hospital emergency room.</p> <p>The parent or agent is not required to provide the hospital with his/her name or information regarding the medical history of the parent or infant.</p> <p>In such situations <b>when there is no abuse or neglect</b>, the parent or agent is not criminally liable for abandonment or risk of injury to the child.</p>
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<p><b>Role of DCF</b></p>	<p>Upon receipt of a Safe Haven report from a hospital, the Department of Children and Families shall</p> <ul style="list-style-type: none"> <li>• immediately obtain a 96-hour hold to assume the care and control of the infant</li> <li>• conduct an investigation of the situation, whether or not there is a suspicion of abuse or neglect</li> <li>• take action to achieve safety and permanency for the infant.</li> </ul> <p><i>(See below for specific Hotline and investigation procedures).</i></p> <p>The Department’s Division of Public and Community Relations shall prepare and distribute a public information brochure regarding the Safe Haven process to hospitals and other appropriate locations, such as doctors’ offices, clinics, and schools. The brochure shall include the following information and be updated when necessary:</p> <ul style="list-style-type: none"> <li>• an explanation of the Safe Haven process</li> <li>• the legal ramifications and protections for the parent or agent</li> <li>• what will happen to the infant</li> <li>• how to contact DCF with questions, including the procedures for reunification</li> <li>• the timelines involved in termination of parental rights and adoption</li> <li>• other relevant information.</li> </ul>
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<p><b>Role of the Hospital</b></p>	<p>In Safe Haven cases, the designated hospital nurse shall</p> <ul style="list-style-type: none"> <li>• take physical custody of the infant unless the parent or agent clearly expresses an intent to return for the infant</li> <li>• within twenty-four hours, notify the DCF Careline that a Safe Haven infant has been left at the hospital</li> </ul> <p><b>Note:</b> For <u>all</u> Safe Haven cases, within forty-eight hours of making the oral notification, the hospital must also submit DCF-136, “Report of Suspected Child Abuse/Neglect” to DCF. The hospital may indicate on the form that it is a Safe Haven case and is not required to disclose the name of the parent or agent, if known.</p> <ul style="list-style-type: none"> <li>• follow the usual hospital procedures to screen and stabilize the infant</li> </ul> <p><b>Note:</b> If abuse or neglect is suspected, the hospital will attempt to detain the parent or agent and call the police.</p> <ul style="list-style-type: none"> <li>• keep the infant at the hospital until the assigned DCF Social Worker arrives to take custody of the child</li> <li>• provide the parent or agent with information regarding the Safe Haven process</li> <li>• prepare an affidavit for DCF describing the circumstances of receiving the infant and subsequent actions taken. (See Attachment A, Affidavit)</li> </ul> <p>In addition, the hospital nurse may</p> <ul style="list-style-type: none"> <li>• request voluntary information from the parent or agent (See below)</li> <li>• provide the parent or agent with an identification bracelet to link the parent or agent to the infant.</li> </ul> <p><b>Note:</b> Possession of the bracelet does not authorize the parent or agent to take custody of the infant on demand. If parental rights have not been terminated, possession of a bracelet creates a presumption that the parent or person has standing to participate in a custody hearing for the infant and does not create a presumption of maternity, paternity or custody.</p>
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<p><b>Obtaining</b></p>	<p>Although the hospital staff may ask for the name of the parent(s) or agent and information on the medical history of the infant and</p>
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<p><b>Voluntary Information from the Parent or Agent</b></p>	<p>parents, the parent or agent is not required to provide such name(s) or information.</p> <p>If the parent or agent does provide such name(s) or information, it shall be kept confidential except that the hospital must provide DCF with all available medical history.</p> <p>The hospital nurse will</p> <ul style="list-style-type: none"> <li>• complete forms DCF-337B, “Genetic Parent(s) Information”, and DCF-338B, “Medical Information on Genetic Parent(s)” with non-identifying information</li> <li>• submit these forms to DCF for inclusion in the child’s Uniform Case Record.</li> </ul> <p><b>Note</b> While the information on DCF-337B and DCF-338B does not identify the parent, the hospital must disclose confidential information if ordered to do so by a Court.</p>
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<p><b>DCF Careline Procedures</b></p>	<p>Upon receipt of a Safe Haven report from a hospital, the DCF Careline shall take the following actions:</p> <ul style="list-style-type: none"> <li>• accept the report as physical neglect/abandonment and assign for a same day response time</li> <li>• immediately obtain a 96-hour hold and fax a copy to the hospital</li> <li>• call the State Police to notify them of the Safe Haven report and determine if there are any reports of missing infants</li> <li>• during regular hours, forward the Careline report to the appropriate DCF regional office for assignment to a regional investigator</li> <li>• during after-hours, assign the report to a Hotline investigator.</li> </ul>
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<p><b>DCF Investigation Procedures</b></p>	<p>The assigned DCF Social Worker (regional or Careline) shall</p> <ul style="list-style-type: none"> <li>• investigate a Safe Haven report in accordance with the usual investigation policies and procedures for an abandoned baby case.</li> </ul> <p><b>Exception:</b> DCF will not involve the local police in a Safe Haven investigation unless there are indications of abuse or neglect which require police notification, as specified in Policy 33-6-18.</p>
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	<p>The Careline is responsible for checking with the State Police <b>only</b> to notify them of the Safe Haven report and to determine if there are any reports of missing infants.</p> <ul style="list-style-type: none"> <li>• respond to the hospital within the same day</li> <li>• obtain an affidavit from the nurse who took physical custody of the infant and, if necessary, from other involved hospital personnel</li> <li>• obtain forms DCF-337B and DCF-338B completed by the nurse, when available</li> <li>• make arrangements to place the infant in out-of-home care until a permanent home is identified</li> <li>• consult with legal counsel regarding court procedures to obtain temporary custody and termination of parental rights if the parent and child will not be reunited. <i>(See below.)</i></li> </ul>
<p><b>Request for Reunification</b></p>	<p>Prior to termination of parental rights, a person claiming to be the parent or agent may submit a request to DCF for reunification with the child. The parent or agent should contact the Juvenile Court and apply for a court appointed lawyer if they cannot afford their own lawyer.</p> <p>The Department shall identify, investigate and contact the parent or agent to determine if such reunification is appropriate or if parental rights should be terminated.</p> <p>Any request to reunify with the infant should be made as soon as possible since the court may grant the request to terminate parental rights on the first day that the termination petition is considered. The court may grant the request for termination if the parents do not appear and they have been provided proper notice.</p>