INTRODUCTION & METHODOLOGY

On October 24, 2001 at 11:34 a.m. Ezramicah H. was brought to a hospital in critical condition. The six and a half-month-old infant was unconscious, had a lung contusion, acute myocardial infarction, acute renal failure, spinal cord injury, anoxic brain damage, respiratory arrest and retinal hemorrhage. Hospital staff reported to the Department of Children and Families (DCF) that the baby was likely a victim of Shaken Baby Syndrome[1].

For five months of the baby's six and one half-month life, he had been under protective supervision[2] with DCF. He had been removed twice from his family and returned twice with multiple service providers involved in supporting the family to keep him safe.

Ezramicah's father initially told hospital personnel and DCF investigative staff that Ezramicah choked while he was feeding him a bottle. He later reported that Ezramicah had fallen out of bed. Finally, he allegedly told DCF investigative staff and hospital personnel he had shaken the baby. Ezramicah remained on life support until October 27, 2001 at 6:45 p.m. The Medical Examiner ruled Ezramicah's death a homicide. Ezramicah's father is currently awaiting trial for the death of his son.

LEGAL CHARGE TO THE OFFICE OF THE CHILD ADVOCATE AND THE CHILD FATALITY REVIEW PANEL

Pursuant to Connecticut General Statute 46a-13k et seq., the Office of the Child Advocate and the Child Fatality Review Panel are mandated to "review the circumstances of the death of a child placed in out- of-home care or whose death was due to unexpected or unexplained causes, to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state." "Upon the request of two-thirds of the members of the panel, the Governor, the General Assembly or at the Child Advocate's discretion, the Child Advocate shall conduct an in-depth investigation and review and issue a report with recommendations on the death of a child."

The Office of the Child Advocate commenced an investigation into the death of Ezramicah on October 29, 2001. On November 7, 2001 The Child Fatality Review Panel (CFRP) held a special session to discuss Ezramicah's case. The CFRP unanimously voted to join the Child Advocate in the investigation into the baby's death.

METHODOLOGY

This joint investigation included extensive interviews with professional and paraprofessional persons who had been involved with Ezramicah and his family, including DCF personnel, private service providers, the courts, police, and legal and medical professionals. Additionally, a

[1] Shaken Baby Syndrome, see Appendix A

[2] Protective supervision provides supervision and assures the ongoing health, safety and well-being of a child. Child protective workers work with the child and parents with the goal of ameliorating the causes of the substantiated abusive or neglectful behavior. (DCF Policy 30-4-3)

comprehensive record review was conducted, including the DCF records, service provider files, health records, legal transcripts, and police records. The purpose of the investigation was to identify whether there were inadequacies in the systems Ezramicah was known to that were meant to protect him, and to develop recommendations to improve child protection and child welfare practices.

EZRAMICAH' FIRST FIVE WEEKS OF LIFE

Ezramicah was born on March 31, 2001 at a Connecticut hospital. There were no complications noted during labor and delivery. The newborn weighed seven pounds three ounces. He was discharged to his mother's care on April 2, 2001 following a routine hospital course. Ezramicah's mother was nineteen years old; his father, who lived separately, was twenty at the time of his birth.

In the first five weeks of his life, Ezramicah was seen by a pediatrician seven times, for two well-child visits, four urgent visits, and an emergency department visit once. He was admitted to a hospital with a broken leg after his seventh visit to a doctor.

- On April 4, 2001, Ezramicah's parents took him to his pediatrician for concerns regarding his skin. He received a complete exam at that medical appointment.

- Ezramicah returned to the doctor on April 9th, with cold symptoms, but no fever. He was diagnosed with a minor infection in his mouth.

- Ezramicah was seen again on April 20th for a well child appointment at which time he received a routine immunization.

- On April 28, 2001 Ezramicah's parents brought him back to his pediatrician for concerns related to fever and diarrhea. The doctor sent him to a local hospital for some tests, which were negative.

- On May 4, 2001 Ezramicah saw his pediatrician again for a scheduled well child appointment in which he received an immunization.

- On May 7, 2001 his parents took Ezramicah to the local emergency department because of a rash on his face. The parents reported to the hospital staff that the rash had been there since the beginning of April.

- Ezramicah was taken once again to his pediatrician on May 9, 2001. The concern expressed to the doctor at this visit was that the Ezramicah had been irritable, and had not been sleeping well for the previous two days. His left thigh appeared swollen and the pediatrician was concerned it might be related to his vaccination five days earlier. Ezramicah was sent to the local hospital for a full evaluation for infection, an ultra-sound of the left thigh, and to begin intravenous antibiotics.

- Ezramicah was admitted to the hospital after it was discovered that he had a mid-shaft fracture of the left leg femur (long bone) during the evaluation. A full skeletal x-ray was performed once the femoral fracture was identified.

EZRAMICAH'S FIRST REMOVAL FROM HIS PARENTS

On Friday May 11, 2001 a report of suspected abuse/neglect was made to the Department of Children and Families (DCF) Hotline by the hospital due to the type of the injury Ezramicah had sustained. DCF initiated an investigation that day.

Ezramicah's parents were interviewed in the early stages of the investigation and they were unable to provide an explanation of what happened to Ezramicah or how he had sustained such a serious fracture of his leg. According to the DCF case narrative, the parents reported that they had taken Ezramicah to the emergency department three times –allegedly May 6th, May 7th, and May 8th- prior to bringing him to the pediatrician on May 9th when he was ultimately admitted to the hospital. The parents reported that on each visit to the emergency department they were sent home with reassurances that they had "new parent jitters". However, the hospital records indicated only one emergency room visit, and that was on May 7, 2001 for the complaint of a facial rash.

Both hospital personnel and the DCF investigative worker indicated in their respective case notes that the parents "appeared very bonded" with their infant son, and that they were "appropriately distraught" and concerned about the baby's injury. Medical professionals strongly believed it was unlikely that this injury happened accidentally. Ezramicah's parents' questioned whether it was possible that the injury could be related to the mother's delivery of the baby only five-weeks earlier. Medical professionals indicated that a fracture to the femur could not have happened during delivery.

DCF requested that the hospital keep Ezramicah over the weekend until they could investigate further. The DCF investigative social worker and a DCF nurse made a visit to Ezramicah's home where they met his father. The case narrative described the apartment as scantily furnished, and disheveled. A puppy was fenced in the hallway. Safety concerns noted were that a pillow was in a bassinet and a crib was described as unsafe for having a railing disconnected from the headboard.

On May 14th DCF administration made the decision to take Ezramicah into their custody for 96 hours while they sought a court order for temporary custody due to suspected child abuse. DCF faxed a consultation request to their contracted medical child abuse expert. The consultation form provided the medical expert with basic demographic information, and the stated reason for the consultation request, "unexplained mid shaft fx[3] of femur".

Later that day, 5–week-old Ezramicah was discharged from the hospital in a "spica cast," a body cast that extended from his mid-chest to his toes on each leg. He was transported by ambulance to a foster home. Prior to discharge from the hospital, the foster mother received special instructions on how to care for Ezramicah in the spica cast.

The hospital made a referral for a visiting nurse to provide the foster mother with in-home services to care for Ezramicah in the spica cast. The visiting nurse care plan indicated that Ezramicah was to receive skilled nursing one to three times per week and a home health aide five to seven times per week as needed.

[3] Fracture

On May 15th the investigative worker documented a conversation with Ezramicah's foster mother to follow up on his first night in foster care. The worker also confirmed that the foster mother would allow Ezramicah's parents to visit the baby in her home. There was one notation in the DCF case file, also dated May 15, that documented that the foster mother was allowing Ezramicah's parents to visit him at the foster home. However, that would be the only entry in the case file documenting parent visits and there was no indication in the record about the foster mother's perception regarding the parent's interactions with Ezramicah, how often they were visiting, or the nature and duration of those visits.

On May 24th a court hearing was held on the Order of Temporary Custody (OTC)[4]. The parents opposed their child remaining with DCF. The Court continued the OTC and set a trial date for Thursday May 31st.

On May 26th the only other documentation of the baby's stay in foster care appeared. Ezramicah's foster mother took him to the hospital with symptoms of coughing and a stuffy nose. The foster mother expressed concern that Ezramicah might be allergic to her pets. The hospital called DCF to get permission to treat Ezramicah. There is no documentation on the outcome of that hospital visit.

On May 30, 2001 the DCF consulting medical child abuse expert met with Ezramicah's parents and great aunt. The medical expert's notes indicated that the parents said they were at a family party on Saturday May 5th and that many family members handled Ezramicah. The parents further described that Ezramicah went to sleep next to an aunt and she may have rolled on him, causing the break. The parents once again went on to explain their alleged visits to the local hospital emergency department on May 6th, May 7th and May 8th and then finally taking Ezramicah to his pediatrician on May 9th. The alleged visits of May 6th and 8th do not show in the hospital records. As previously stated a May 7th emergency department visit was documented with a concern of a rash, the other visit to the emergency department was on May 9th after the pediatrician's referral.

The expert documented in a faxed letter to DCF on May 30th that based upon the interview with the parents, review of DCF LINK[5] files, a review of part of the available hospital medical record, a preliminary review of copies of the x-rays taken at the hospital, and conversation with DCF personnel, he believed that the fracture most likely occurred on Saturday May 5th. The medical expert further indicated that it was not clear exactly how the fracture occurred, but he wrote that "abuse is unlikely and that it is more likely that the injury occurred from an accident." The letter indicated that in order to complete the evaluation the following would be necessary:

- Review of a complete record from the hospital;
- Review the original x-rays and consult with a pediatric radiologist;
- Examine Ezramicah;
- Speak to Ezramicah's physician.

[4] Order of Temporary Custody (OTC) – This is an ex parte order that vests custody in whomever the judge selects (most frequently DCF) prior to any hearing. A hearing on the order must occur within ten days to confirm the validity of the original removal. This is ordinarily used only in emergencies. There must be imminent, serious hazard to the child.

[5] LINK is the DCF database that houses child and family case records and narrative reports.

The medical child abuse expert then noted that he would be away and would complete his evaluation in the "next few weeks."

EZRAMICAH'S FIRST RETURN TO HIS PARENTS

A court hearing was held on the next day, May 31, in Superior Court for Juvenile Matters. An agreement was reached between DCF, Ezramicah's parents, and all the attorneys. The parents would plead to neglect[6] and agree to protective supervision for six months. The court made a finding of neglect and the Order of Temporary Custody (OTC) was vacated. The court ordered the parents to adhere to the specific conditions agreed upon, including full cooperation with DCF, and not taking Ezramicah out of state without authorization from DCF. Additionally, the Court ordered specific referrals to be made for the family:

1) a parent-aid;
2) home health nursing service;
3) parenting classes.

That day after the court hearing, Ezramicah was returned to his parents by the DCF investigative social worker and the DCF nurse. He was exactly two months old. Ezramicah's parents, grandmother and aunt were present in the home upon his arrival. The case notes indicated that the apartment was viewed as clean. A new crib had been set up and the pillow had been removed from the bassinet but a pillow was in the new crib and the grandmother was asked to remove it for the baby's safety. The family was described as cooperative, pleasant, and responsive to the DCF nurse teaching them how to care for Ezramicah while in the spica cast. During the visit the DCF nurse witnessed Ezramicah's father roughly handle the family puppy by the neck. The worker did not witness the incident. The nurse mentioned what she saw to the worker, but they did not document it. Upon returning to the DCF office, the nurse spoke with colleagues about the incident with the dog but no concerns were ever documented in the case record.

Ezramicah's case was transferred from the DCF Investigations Unit to an Ongoing Services Unit[7] on the same day as the court hearing. Once the investigation concluded, there were no further efforts to identify the source of the injury and no protocol in place to follow-up with the medical child abuse expert for his final conclusion. The Ongoing Services Unit would provide protective supervision with a focus on keeping the child safe from that point on.

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[6] Neglect – A child may be found "neglected" who among other things, is being denied proper care and attention physically, educationally, emotionally or morally, or is being permitted to live under conditions, circumstances or associations injurious to his/her well being, or **has been abused** and has physical injury inflicted by other than accidental means, **injuries that are at variance with the history given them**, or a condition that is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.

[7] Ongoing Services Units have the responsibility for protective oversight, case management and coordination of court-ordered services.

There was no case transfer conference between the two units to communicate outstanding concerns or to inform the new worker that a social study[8] ordered by the court, had yet to be completed and that the medical child abuse evaluation was also not yet completed. The social work supervisor in the ongoing services unit reviewed Ezramicah's case record on June 1st. Based on the opinion of the medical child abuse expert that the injury was likely accidental, the supervisor assessed risk[9] to the child as being moderate. The investigations unit had assigned risk as high. The case was assigned to an ongoing services social worker without a review of these discrepancies.

The first visit by the newly assigned DCF worker to the family's apartment was made on Monday June 4th. That worker noted that both the mother and father were present and the home environment was "acceptable". The DCF worker inquired about the visiting nurse and the mother indicated that the nurse had come on the previous Friday and had not returned since. The worker informed the parents that she would be making a referral for parenting classes. There was no documentation referring to arrangements for a parent aide.

The DCF case narratives indicated that the worker visited the family on June 6th, 13th, 15th, 20th although field notes were available for those visits they were not part of the official case record[10]. While it was written in the case narrative that the parents were appropriate with the child and that the parents were cooperating with DCF, all four of those visit narrative entries were entered October 30, 2001, three days after Ezramicah's death.

There was confusing detail about the family's availability for visits in the case records. Ezramicah's cast was removed on June 13th. The visiting nurse reported an attempted home visit on June 20th, but there was no answer at the apartment. She later learned that the family had alerted the home care agency that they would not be available due to plans for going "south" on June 19th. If going south referred to going out of state, there is no corresponding DCF documentation of permission for Ezramicah to be taken out of state, a requirement ordered by the court. It is not known where the family went. In fact, The DCF case narrative indicated

[8] A social study is a statutorily mandated report to the Superior Court for Juvenile Matters that is a summary of the important information in the case record to support a disposition that will be in the best interests of the child. The social study varies in content depending on the petition it is attached to, but some of the common elements include: demographic information, background of the petition filing, reasons for the petition, family history, planning for independence, relatives, religion, services offered by other agencies, present situation, reasonable efforts and recommendation.

[9] Risk - Although no one can accurately or consistently predict human behavior, research has demonstrated that there are a variety of factors, which influence the probability that a child will be abused or neglected. Risk assessment is a continuous process in which the Social Worker and Social Work Supervisor weigh the factors in a particular case to determine the level of safety for a particular child within the family. The risk assessment process is ongoing, expands as new data emerges, so that family strengths as well as problem areas need to be continuously redefined and considered in case planning, takes into account the frequency, intensity and duration of risk factors and indicators which may decrease the risk of maltreatment or increase the positive effect of intervention, and supports and documents the need for and degree of DCF involvement. (DCF Policy Manual 34-13-1)

[10] All 4 home visit narrative entries were entered in the LINK system on October 30, 2001, 4 months after the visits allegedly occurred. Documentation – A case narrative is required to record all activities, observations, events and decisions during work with clients. Such narrative must be recorded in a clear, concise, factual and timely manner; be entered in LINK within three (3) working days of the "event"; and record the purpose of the activity and the person(s) involved in the activity. (DCF Policy Manual 31-8-8, Case Activity Notes.1994)

that the family was visited on June 20th, (although the field notes indicated a visit was made on June 22nd) the same day the family was unavailable for the nurse. Ezramicah's mother later phoned the nursing agency on June 25th indicating they were available. The last home care nursing visit was made on June 26th and that same day Ezramicah was discharged from home care service.

On June 27th, nearly one month after his preliminary review, one month after the child was returned to his parents and one month after the DCF investigation was concluded, the DCF medical child abuse expert called the social work supervisor. He reported that he had just reviewed copies of x-rays that had been taken at the time Ezramicah's injury was discovered. He noted that additional fractures were evident. Specifically the x-rays revealed "knee and ankle corner fractures." The medical expert consulted a pediatric radiologist who concurred with his impression. Due to the nature of these fractures there was significant concern that this child had been abused. The medical expert scheduled a repeat full skeletal survey of Ezramicah for July 2nd.

On Thursday June 28th, the DCF social work supervisor directed the worker to make a home visit and inform Ezramicah's parents of the new findings of additional fractures. The case narrative indicated that, when told, Ezramicah's mother expressed her willingness to do whatever DCF asked so that the baby would not be removed from her care again. Ezramicah's mother agreed that she would not leave him with anyone else. The worker informed her that she would get a parent aide to work with the family. Parent aid services, which were part of the May 31st court order, had yet to be initiated. Court-ordered parenting classes were also yet to be initiated. The family was not visited or contacted by DCF personnel again over the weekend.

On Monday morning, July 2nd, five days after the medical expert noted what he now believed to be evidence of physical abuse, the DCF worker transported 3 month-old Ezramicah and his parents to a hospital for a full skeletal survey. That same day the social work supervisor informed the Assistant Attorney General[11] (AAG) of the latest developments. The AAG advised that a service agreement be signed by the mother stipulating Ezramicah would not be left with other caregivers. The AAG said she would file a motion for a psychological evaluation of the parents. The DCF Program Supervisor was then informed. She requested a meeting between the AAG and the DCF nurse. The nurse was asked to obtain information from the child medical abuse expert regarding the nature of the injuries. An internal meeting was scheduled for 2:00 p.m. the following afternoon, July 3.

On July 3rd, before the internal meeting, the worker reported to her supervisor that Ezramicah's x-rays taken the previous day revealed scarring and evidence of breaks to both legs and arms. The parents were still insisting that they did not know how the injuries could have happened.

That morning the social work supervisor directed the worker to go to the home and do service agreements with each of Ezramicah's parents. The service agreements outlined six steps for Ezramicah's parents to follow:

1. Mother / father must be with the child at all times;
2. Mother / father must not leave child unattended;

[11] The Assistant Attorney General represents DCF in Superior Court for Juvenile Matters.

3. Mother / father must cooperate with Birth to 3 services[12];
4. Mother / father must comply with parent aide services[13];
5. Mother / father must cooperate with court ordered evaluations;
6. Mother / father must cooperate with DCF.

Later that day at the DCF internal meting, the AAG, the DCF program supervisor, the DCF social work supervisor, the DCF nurse, and the DCF worker met to discuss the case. The AAG asked for additional information. The nurse contacted the pediatric radiologist who reported that the skeletal survey done on July 2nd "showed a previously undetected new fracture on the other leg consistent with child abuse." The AAG then advised DCF to do an immediate removal of Ezramicah from his parent's care. It would later be determined that there were no additional breaks; Ezramicah did not have both legs broken and both arms broken. He did have a fracture of the left femur. It is unclear from the record how this misinformation was obtained.

EZRAMICAH'S SECOND REMOVAL FROM HOME

On July 3rd, with new evidence of abuse, DCF invoked a second 96-hour hold on Ezramicah. The DCF worker, accompanied by a co-worker, proceeded to Ezramicah's home to remove him. Despite having signed an agreement earlier in the day not to allow Ezramicah to be left with any other caregiver, Ezramicah was not home when the workers arrived. Ezramicah's parents would not tell DCF where the baby was until they were informed that the police were en route. Ezramicah had been left with his grandmother. He was returned to his parents' apartment, and subsequently placed in a DCF-licensed foster home.

On July 5th the DCF worker went to pick up Ezramicah for a visit with his parents and was told by the foster mother that DCF needed to find another home for Ezramicah because "he cries a lot and she has another baby and just can't hold him all the time because this is a heavy baby." Ezramicah's parents had the visit and the case narrative indicated that the visit went well, lasting for an hour and a half.

On July 6th DCF obtained an Order of Temporary Custody (OTC) from the Superior Court for Juvenile Matters for the second time. Ezramicah was now 3 months old. He was removed that same day from the foster home and this time was placed in a DCF-licensed shelter for infants and children. His grandmother had been granted intervenor status[14] by the Juvenile Court and was approved by DCF as a child care resource, but Ezramicah was sent to and remained at the shelter.

During the month of July, Ezramicah's parents visited him weekly at the shelter. The DCF worker transported the parents and provided supervision. The visits were documented as "going well." The parents were described as appropriate with the baby, taking part in feeding him and changing his diapers. However, the shelter staff reported that the mother presented as

[12] Birth to Three is an early intervention program for children with identified developmental delays. Ezramicah had no developmental delays. A referral was therefore not appropriate as he was not eligible nor did he require Birth to Three Services.

[13] No referral for parent aid services had been made

[14] Intervenor Status– An intervenor is a person who voluntarily interposes in an action or other proceeding with the leave of the court. (Black's Law Dictionary, revised 4th Edition, 1968. St. Paul Minn: West Publishing Co.)

angry and was apparently concerned that Ezramicah was forgetting her and bonding with the shelter staff.

On July 25th the DCF worker, Ezramicah, and his parents had an appointment with the medical child abuse expert. There they were informed that x-rays revealed Ezramicah had a broken left leg and ankle that were now healed. Ezramicah did not have a fracture of his right leg as reported to DCF by the pediatric radiologist. Rather there was a slight malformation that was seen on the x-ray that was thought to be another fracture.

DCF faxed a referral to a community service provider on August 1st for parenting classes; a full two months after the court ordered the classes. An in-home visit was set up that same day. The parenting class provider met with Ezramicah's parents to give an overview of the parenting classes that would meet for three months twice a week from 10:00 – 11:15a.m. At that home visit the provider assessed a need for individual and couples counseling. Ezramicah's parents agreed to participate. A formal intake at the agency was set up for August 7th. A counseling appointment was scheduled for August 9th and parenting classes were to begin on August 13th.

On August 3, 2001, the DCF medical child abuse expert wrote an affidavit[15] outlining his findings in the case. The affidavit revealed that on June 28th the expert, along with a pediatric radiologist, reviewed *copies* of the skeletal survey taken on May 10th. On July 16th both the medical child abuse expert and the pediatric radiologist reviewed the *original* x-rays as well as the new skeletal survey x-rays taken on July 2nd. The child was physically examined on July 25th and the expert again met with both parents. The final findings were as follows:

- May 10: oblique fracture of mid-shaft of the left femur with extensive healing noted on July 2nd.
- May 10: distal metaphyseal fracture of the left femur; not seen on June x-ray.
- May 10: question of metaphyseal fractures of right tibia and left distal fibula (but difficult to be certain because the x-rays were taken while the child was in a cast); not seen on July 2 x-rays.
- July 2: there were no new findings on the skeletal survey related to child abuse.

The affidavit read,

> *"In summary, at five weeks of age this child had an oblique mid-shaft fracture of the left femur, and at least one, and possibly as many as 3 metaphyseal fractures on the lower extremities. There were no new findings related to child abuse on the skeletal survey of July 2. An unexplained mid-shaft fracture of the femur in a five-week old is likely due to child abuse. In addition, metaphyseal fractures are considered diagnostic of child abuse and are thought to occur from sharp jerking of a young child's extremities. Although the parents were helpful during the interview on May 30 and appeared very concerned about their child and their child's well being, these injuries are not consistent with the history provided by the parents and are more likely consistent with the diagnosis of child abuse. Although I had originally believed that abuse was unlikely, when I reviewed all the findings in the case, I believe that the most likely explanation for this child's injuries is physical abuse. Despite these findings, for all of June, Ezra was cared for in his home without suffering any new injures. I therefore, believe that reasonable efforts should be made to reunite Ezra with his parents".*

[15] Affidavits are routinely required for the procurement of warrants and are used in some jurisdictions to initiate juvenile court proceedings, such as requesting and securing an Order of Temporary Custody.

Ezramicah's parents continued to visit the baby at the shelter. Descriptions of interactions between them changed somewhat during the month of August. Ezramicah's mother visited the shelter alone with the worker on the 1st of the month. The mother was described as becoming upset and expressing her feelings about the baby, now four months old, not knowing her. The mother was not interacting with the child much and was compared to the father who tended to interact more with Ezramicah. There were general concerns noted regarding both Ezramicah's parents. According to shelter records:

> "Ezramicah's parents present as doting and caring, although they clearly need assistance w/ parenting. They responded to crying by feeding him, even if he just ate. They also held him all the time, rarely allowing him to lay on the ground and play." [The parents] "needed a lot of encouragement/direction during visits to play with Ezramicah, as their primary focus seemed to be feeding him and holding him."

The DCF worker described Ezramicah's mother as looking for more physical things to do such as changing the baby, feeding, and holding him, but being resistant to putting him on the floor. There was, however, no interaction reported between the staff who took care of the baby all week and the mother on her weekly visits. The mother was not brought up to date on any developmental milestones achieved, nor was she re-introduced to the baby as a transitional exercise each time she came to visit. Three more visits in August were documented by DCF. Again, however, as was the case in the June visits, all of these case narratives were documented in the case record on October 30, 2001, 3 days after Ezramicah's death.

On August 13th the parents were scheduled to begin parenting classes. However, the recent court-ordered psychological evaluations and parent child interactional studies were scheduled for the same date so parenting classes were delayed until August 16th.

The psychologist to whom the parents were referred found both of them well bonded to Ezramicah. They were both described as being distraught about the removal of their son for unexplained injuries. It was noted in the psychologist's report that the injuries had been determined to be accidental in nature. Ezramicah's parents were both described as caring and supportive. Neither parent was found to exhibit angry or hostile characteristics.
The psychologist recommended that the baby be reunited with his parents with protective supervision and completion of the parenting classes. However, the psychologist was not made aware of the latest medical concerns regarding possible new fractures.

On August 14th a DCF case supervisory meeting was held and it was noted that the mother had attended three individual counseling sessions and one session was missed due to the court ordered evaluation. The case narrative stated "DCF would like the child to stay in placement for another two weeks to give parents the opportunity to benefit from services and to give providers an opportunity to evaluate them." On that same day, the case narrative indicated that there was a conversation between the social work supervisor and the AAG during which the AAG wanted to know the DCF position regarding reunification. The SWS restated that DCF would like another two weeks.

On August 16, 2001 DCF held an administrative case review[16] (ACR) on Ezramicah's case. The only people in attendance[17] were the DCF case reviewer, the worker and one staff member from the shelter. Ezramicah's parents were apparently advised to attend what would have been their very first parenting class rather then attend the ACR. Ezramicah's case was reviewed and documentation from the meeting reflected an August 20, 2001 projected return home for the infant. The reviewer expressed concern regarding a plan for reunification and generated a request for an Urgent Managerial Case Practice Issue review[18]. The request documented information that had not previously been addressed in the record. The information included:

- A report from the worker that Ezramicah's mother had disclosed she suffered from post-partum depression and recovered without treatment;
- Parents had no explanation for child's injury;
- Neither parent was employed;
- Follow-up was needed regarding a police report and investigation;
- Mother had another young adult with a child living in her one bedroom apartment;
- Mother had history of abandonment as a child and violent victimization at age 17;
- The reviewer recognized that mother had attended an alternative education program but there was no information as to why.

Given these concerns, the request for a Managerial Review was generated on the same day as the ACR; however, the manager's response was delayed.

On August 17th a case consultation was held between the DCF social work supervisor and the DCF program supervisor. They agreed, "The decision about returning the child home will be made upon receiving positive recommendation from parents' individual therapist." That day DCF contacted the parenting class provider and was apprised that the family only attended one

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[16] Administrative Case Review – The purpose of the administrative case review (ACR) is to provide an orderly and structured meeting in which all participants are engaged in discussion focused on the permanency planning needs of the child. It is a process to ensure that proper services are being provided to DCF children and their families so that safety, permanency and well being are achieved. In essence, an ACR is an internal quality improvement mechanism. Applicable areas for the ACR in the Ezramicah H. case include, but are not limited to, a review of the treatment plan, the extent of compliance with the treatment plan, and a review of services to the child and parents. (DCF Policy 24-2).

[17] An ACR requires mandatory attendance of designated DCF staff. Other persons involved in the case are invited to attend. Those persons who must attend include the administrative case reviewer, the social worker on the reviewed case, the supervisor to the social worker, any member of the Regional Resource Group, a community consultant, support staff worker, and/or community provider who has participated in any aspect of the case in the seven (7) months prior to the review. Certain people must be invited to the ACR. In Ezramicah's case, they would have included the child's parents, the parents' counsel, and the child's counsel. (DCF Policy 24-5)

[18] Urgent Managerial Case Practice Issue - A "Managerial" is a situation that significantly impacts case management and compliance with child welfare or juvenile justice regulations. The Regional Office/Connecticut Juvenile Training School Manager must respond to the Case Practice Review Unit (CPRU) within fifteen (15) working days stating how the case practice issue was resolved." (Administrative Case Review Process. DCF presentation to OCA, July 17, 2001).

class. The therapist sent a letter indicating that he had only seen the family twice and could not answer all DCF's questions, but did acknowledge that within the two sessions, he had learned that Ezramicah's mother admitted to having a traumatic past. The DCF social work supervisor called the AAG indicating that "they could not agree to return the child home until appropriate therapeutic intervention is put in place." The program supervisor concurred with this assessment.

EZRAMICAH'S SECOND RETURN TO HIS PARENTS

On August 20, 2001 more than six weeks after Ezramicah was placed in DCF custody, a hearing was scheduled in Superior Court for Juvenile Matters to address continuing custody of the baby. Prior to commencing the hearing, the attorneys involved in the case agreed to review it in the judge's chambers. Present in the chambers were the attorney for Ezramicah, the attorney for the father, the attorney for the mother, the AAG for DCF and the judge. There is no transcript from the discussion that took place in chambers.

The chambers conference reportedly lasted approximately 10-15 minutes. There was discussion about the court-ordered psychological evaluations of the parents and the medical child abuse expert's report. The AAG expressed DCF's desire to extend custody for another two weeks. The facts that the parents had only attended one parenting class and two sessions of couple's therapy were not discussed. Reportedly, the AAG did not have this information. The AAG and the judge reportedly acknowledged that while they had concerns for the child, they agreed that there were not enough facts to warrant maintaining custody of the baby. They agreed that the case for continued DCF custody was weakened by the findings of the psychological evaluations indicating reunification was appropriate, and the medical child abuse expert's opinion that Ezramicah sustained no further injuries during the last month that he was in the care of his parents, therefore, reunification was appropriate. After the chambers discussion ended, the attorneys, the parents, and the DCF social work supervisor proceeded to the courtroom for a review of the case rather than a hearing. No one requested a formal hearing take place to voice concerns.

The official court transcript reflected the following information:

- The judge questioned Ezramicah's parents about their relationship;
- The parents indicated they were engaged and living together;
- Ezramicah's mother indicated that she planned to continue school in September for a certified nurses aide license;
- Ezramicah's father reported he was doing carpentry and painting work;
- The judge asked who would watch Ezramicah if the father was working and mother in school;
- The AAG indicated that DCF could make a referral to a therapeutic day care;
- The judge made a point about not having Ezramicah passed around;
- The attorney for Ezramicah's mother indicated that the paternal grandmother had been approved by DCF to watch Ezramicah, DCF concurred;
- Ezramicah's attorney offered the court the final report from the medical expert
- The AAG asked if the parties agreed to have the expert report, the psychologist report and the therapist letter marked as exhibits.
- All documents were marked as exhibits;

- The AAG indicated that she had specific steps… "drafted up based upon the discussion we've had today."
- The judge commented that the document she drafted looked "great".
- The AAG asked to "hear the courts feeling on whether or not the order of temporary custody should remain in effect at this time."
- The judge stated that "based on conferences that I've had with all the attorneys and the examination of the record, I have some concerns but I am going to order Ezramicah returned to the parents with significant conditions."
- The judge asked if there needed to be a canvass;
- The AAG indicated that she did not believe so as there was adjudication and protective supervision was already in place;
- The AAG asked that protective supervision go from today's court date to 6 months out;
- The judge walked the parents through the specific steps and reminded the parents that if at anytime they have a question, they should ask him and he would explain it again.

The Court ordered <u>specific steps</u> for both parents to follow:

- Keep all appointments with DCF.
- Cooperate with announced or unannounced home visits.
- Cooperate with the child's attorney. Ezramicah's whereabouts were to be known to DCF and his attorney. (The judge told Ezramicah's attorney that he wanted a "little extra" by monitoring this case very carefully.)
- Participate in counseling and make progress towards treatment goals, which included parenting, individual, family and couples counseling.
- Accept and cooperate with in-home support services referred by DCF.
- Notify DCF of any changes in their relationship.
- Not transport Ezramicah out of Connecticut unless authorized by DCF to travel temporarily out of state.

The judge indicated that his instructions were to be followed "to the letter." DCF was ordered to make one unannounced visit per week. When the judge asked the AAG if there was anything else, she restated that protective supervision would be from August 20, 2001 to February 20, 2002. The AAG asked the judge if he wanted a case conference or an in-court review in four months, which is the standard procedure. The judge indicated that he wanted an in court review sooner, in one month (scheduled for September 18th). Had DCF or the AAG strongly objected to the court ruling, a hearing could have been requested. Based on the information the AAG had, there were no grounds to request one and DCF staff did not pursue it. Immediately after the court hearing, Ezramicah was picked up at the shelter and returned to his parents' care.

On August 21, the day after Ezramicah was returned home, DCF made an unannounced home visit to Ezramicah's home. The case narrative described the home as clean. Ezramicah was described as "so happy." Ezramicah's mother reported that he had a good night's sleep and that the baby was "just happy to be home with his parents and his own surroundings." The next home visit would be on August 30th.

On August 23, 2001, two days after the baby was returned, Ezramicah's parents went to their joint counseling session. The counselor described them as very excited to have Ezramicah home. That would be the last counseling session for either parent. Later, on September 17th,

Ezramicah's parents would see the counselor and apologize for not getting in touch sooner. They reported they had been told by DCF that "they no longer need to come to the agency (sic) for individual or couple therapy as they are in treatment elsewhere and DCF feels they are doing well in caring for their child." The record does not indicate discharge planning and follow-up by DCF. The therapist did not follow-up with DCF or report to anyone whether the couple was in therapy with him or not. At that point their case was closed with the therapist.

It does not appear from the case file that Ezramicah's parents ever sought counseling elsewhere, and while there was acknowledgement that the parents were not satisfied with some aspects of the services they were receiving, there was no indication that they were instructed to leave the program before they had been accepted into another treatment program. This decision by the parents to unilaterally terminate counseling was a direct violation of a court order, yet it was not reported to the Court or documented in any record.

On August 28th, the DCF program supervisor's response to the Urgent Managerial Case Practice Issue request was released eight days after Ezramicah was returned home and 12 days after it was requested. The concerns generated by the Case Reviewer regarding the mother's past history with trauma and depression, the additional occupants in the house and the need for follow-up with a police investigation were not addressed in the response and there is no indication that the concerns were ever addressed with the family. Instead, the response addressed the worker's mention of the child's reunification and communication practices with the AAG only. The response stated:

> "There was no decision made to return the child. Worker made a statement to this effect in the ACR but this was a misunderstanding and this has been addressed with the worker. Consults with the AAG have been done on a regular basis throughout the life of this case and decisions were made very carefully. The judge finally made the decision to return the child in spite of our wish to proceed much more slowly."

Because the concerns that generated a review were not addressed in the managerial response, a second managerial could have been generated to procure a response to the neglected concerns, but that did not occur. DCF finally arranged for court-ordered services to be initiated in the family home on August 29th, ten days after the order. The DCF worker met with a private service provider of intensive in-home services to conduct a case presentation that provided a comprehensive overview of the circumstances of Ezramicah's family. The provider planned to utilize a team approach to work with the family. The plan included two one-hour, in-home visits per week with a focus on parenting skills, child development, physical safety of Ezramicah, and utilization of community and social resources.

On August 30th, the DCF worker made a home visit with the service provider to introduce the family to the services that would be offered. Both parents appeared to be accepting of the program. By this time the baby had been home for nine days. The worker documented Ezramicah as looking "very good he seem (sic) to be a little fatter and bonded to his parents."
In the eight weeks prior to Ezramicah's death, the in-home service team made approximately sixteen visits. Their observations were that the parents were nurturing of Ezramicah; initiating hugs and kisses on a consistent basis; and they provided stimulation to him and played well with him. The parents were described as attentive to Ezramicah, feeding, changing, and dressing him. The parents were described as a team that worked together to meet Ezramicah's needs.

The private agency reported that at no time did either parent demonstrate any behavior towards Ezramicah that was not loving or nurturing.

During that time the DCF worker continued to make announced and unannounced visits to the home. Service providers were in the home; the parents were participating in parenting classes, and the DCF worker and all other involved parties were apparently still under the impression that the parents were attending individual and couple's counseling. This misinformation was apparent at the September 18th in court review.

EZRAMICAH'S STAY AT HOME CONFIRMED

The September 18th follow-up court hearing was brief and this time a different judge presided. Attendees included the parents and their attorneys, the child's attorney, the DCF worker and the AAG. The Court was not informed that the parents had discontinued therapy. The Court record reflected the following discussion:

- The AAG reported that the DCF worker had filed a court update that morning. The court update reportedly indicated, "that the child was doing well in the parents' care under protective supervision, and the parents are responding to specific steps and services. And the parties agreed that there's no need for a further in-court hearing…"
- The Court noted that the source of the child's injuries was still unknown and the AAG confirmed that.
- Length of protective supervision was discussed and expected to remain in place until the scheduled expiration in February of 2002.
- The Court asked what services were being provided. The DCF worker reported that intensive family preservation services were in the home and another agency was providing, "parenting classes, educational classes. They do budgeting and other things with the parents. They also do couples and individual counseling."
- The parents were asked about how things were going and they both complained about the parenting classes and the distractions caused by other participants.
- The Court noted not being able to do anything about the quality of instruction but encouraged both parents to continue to participate.
- The mother reported parenting classes would end on October 13th and no one knew when intensive family services would end but the mother's attorney thought the program would last 6 months.
- The Court requested a report from the intensive family services provider for the next in court review, which was scheduled for December 18th.
- The Court offered good luck to the parents and told the father to "Keep up the good work."

CHANGES AT HOME

In early October, Ezramicah's family appeared to become somewhat distressed over finances and housing concerns. The father was not working, and the mother just began working at a fast food restaurant. Only three days after the court hearing, the DCF worker discovered the family had no milk and no money to buy milk for the baby. The worker provided milk on September 21st and again on the 26th. The in-home services worker assisted Ezramicah's father in preparing a resume, but he remained unemployed. While the mother worked, the father was at home all day with the baby. On October 2nd, the local police were called to Ezramicah's residence for a

domestic disturbance between a man and a woman. Police records indicate the dispute was settled at the scene and advice was given.

The DCF case narrative does not reflect any concerns regarding the change in family structure when the mother went to work and father started staying home alone with the baby. In fact, the case record indicated that service providers were saying "great" things about the parents. The DCF worker visited Ezramicah weekly and documented that the infant was "big", "a small football player", "gaining a lot of weight", and "very solid". All but one person interviewed for this report indicated that there were no problems noted between Ezramicah's parents. That person was an employee of one of the provider agencies. Reportedly Ezramicah's mother revealed in a phone conversation her frustration with the way Ezra's father was treating her. She reportedly described his use of name-calling and verbal abuse. The conversation was not reported and no one else reported being aware of any discord in the family.

When Ezramicah was six months old, other family members had moved into his parents' small, one-bedroom apartment. DCF reportedly did background checks on the people staying in the home and found that two adults had records. It is not clear what type of background checks were done and what actions, if any, DCF took in response to the findings. On October 16th, the police were called to the residence once again for a report of a dog being beaten and crying in pain. Again the police disposition of the call was "advice given." The very next day, Ezramicah's father reported to the intensive family service workers that it was tough being at home all day. He reported that, "all he did was scream" when the mother left. While expressing these thoughts, the father was described as not seeming stressed but matter of fact.

On October 21st, the police were called again to Ezramicah's home for a domestic dispute. This call prompted an Incident Report. The incident report narrative indicated accusations that a family member was harassing Ezramicah's father. The officer on the scene also documented that Ezramicah's mother "thought we were here because someone called DCF on her again. She states they were called last time because her child had a broken leg. The child was sleeping." There is no evidence that the police forwarded any concerns to DCF.

During this time, despite being asked by the judge to provide extra monitoring, Ezramicah's attorney made no inquiries with service providers to check on his progress or condition. There were no visits between the attorney and client. The attorney had no first-hand knowledge about how the infant was doing.

EZRAMICAH'S FATAL INJURY

On October 24, three days after the police left the scene of a domestic dispute, almost 7-month-old Ezramicah was brought to an area hospital in critical condition. Ezra's father initially told hospital personnel and DCF investigative staff that Ezramicah choked while he was feeding him a bottle. He later reported that Ezramicah had fallen out of bed. Finally he allegedly admitted to shaking Ezramicah. Ezramicah remained on life support until 6:45 p.m on October 27, 2001 when it was discontinued and he died. Ezramicah's diagnosis included: prolonged unconsciousness, contusion of lung, acute myocardial infarction, acute renal failure, anoxic brain damage, respiratory arrest and retinal hemorrhage. Ezramicah's death was ruled a homicide by the Medical Examiner. On October 29th, Ezramicah's father was arrested and charged with murder in the death of his son.

EPILOGUE

The DCF Special Review Unit (SRU) commenced a review following Ezramicah's death. Citing DCF Policy section 34-25 regarding child fatality reviews, the SRU described the purpose of any Special Review,

> "…is to assess the utilization of policies and procedures in case practice. Specific areas of consideration include the supervision process, risk assessments, court involvement, treatment services, investigation reports and overall case management. The special review process is designed to evaluate current practice and to identify ways to improve DCF's primary goals of safety, permanency and well being."

The SRU Report was released on December 27th. It chronicled the events while Ezramicah's case with DCF was under investigation and protective supervision. Included in the chronicle was the May 30th appointment with the medical child abuse expert who "reported that it was his assessment that Ezra's broken leg was most likely caused by accident. It was further described that the medical child abuse expert "completed a report and the report was filed in the DCF case record." There was no mention of the physician's notice that his findings were only preliminary and that he would have to review the original x-rays and the complete hospital record before completing an evaluation.

The SRU report also referred to what appears to be an interview with the medical child abuse expert wherein he stated that in his affidavit he had recommended DCF work toward reunification of the baby and his parents, "but that reunification should not occur until the parents had been involved in services for some time." The affidavit includes no such remark.

Throughout the SRU report and particularly in the recounting of the days leading up to the August 20th hearing (3 full pages of it) evidence was presented in each paragraph that DCF argued against returning the baby to his parents. One account stated that on August 17th, "the supervisor documented that due to the parents misrepresentation of the facts, DCF could not agree to return Ezra home until appropriate therapeutic intervention was in place." OCA reviewed the entire case record and was unable to locate this documentation, nor was their discussion noted that the parents were misrepresenting themselves or their actions. Referrals for services did not occur in a timely manner, and services did not begin in a timely manner.

After three pages of reviewing the August 20th hearing, the SRU contained one three-sentence paragraph that addressed the September 18th hearing in Juvenile Court where it was reported that the child was doing well and the parents were cooperating with court-ordered services. The SRU apparently did not discover the information that the parents were not attending court-ordered individual and couples therapy.

The Assessment of the SRU was that "DCF staff provided timely and appropriate services to the family." And that "all service providers involved with the family reported that the parents were cooperative, and that Ezra was being well cared for," even though the therapist (as a service provider) had not been questioned about the parents' involvement in counseling.

The problems that the SRU identified included: 1) an inadequate number of home visits in the first month of ongoing services; 2) an inaccurate statement made by the social worker at the ACR that there was a plan for reunification; 3) the decision to return Ezra being "left to the judge"; 4) the constantly changing opinions of medical professionals and 5) the psychologist's making recommendations for reunification without seeing the medical child abuse expert's affidavit. The only recommendations made by the SRU were to address compliance of medical staff to document activities in LINK files; to review protocol with the AAG regarding the sharing of information; to review protocol for the AAG to represent DCF in and out of formal court hearings; and to review the psychological assessment regarding the recommendations being within established guidelines.

Before the SRU investigation had been completed, the DCF Commissioner issued a memorandum to staff dated October 29, 2001, which referred to the August 20th court hearing…stating, in relevant part: "DCF workers did not believe the parents were ready to keep the baby safe. *Over our objections*, the Juvenile Court ordered the child's return home." (*Emphasis supplied*). Similar statements attributed to the Commissioner appeared in the press. A news story in a Connecticut newspaper reported the arrest of Ezramicah's father charged with murder in the death of his son occurred, "two months after a juvenile court ordered the boy returned to his family over the objections of the state Department of Children and Families." The Commissioner of DCF made several comments to news reporters regarding the case, including a description of the baby's injuries, DCF investigators' and a doctor's findings in an earlier abuse investigation, and events occurring in Juvenile Court. A public discourse between the Commissioner and the Court ensued in the press following the Commissioner's statement, "Over our objections, the court ordered the baby home."

On October 30th, the Judge who had presided over the August 20th hearing told a Connecticut newspaper "judicial ethics and state confidentiality laws prohibited him from discussing the matter." But on November 3rd, another article appeared citing a "highly unusual move by a judge" who issued a public statement rebutting the Commissioner's claims. The Judge shared a summary of the Juvenile Court hearing records that evidenced no objections from the DCF AAG to the child returning home. A review of the August 20th hearing transcript confirmed that DCF made no objection to the return of the child on the record during the hearing. Nor did DCF expressly consent to the return during the hearing. There is no transcript of what occurred during the pre-hearing conference in chambers. In a memorandum the DCF AAG has stated "I reiterated on several occasions that *the Department would not agree* to return the child today" (e*mphasis supplied*).

In January 2002 a Connecticut newspaper obtained a copy of the internal SRU report. An article appeared in the paper on January 15th that noted the SRU findings contradicted the Commissioner's previous claims that the DCF AAG opposed the judge's decision to return Ezramicah at the August 20th hearing. The SRU was reported as intimating that the AAG did not take a position on the child returning home in the chambers or the court. The Attorney General's office was quoted as calling the SRU report "inaccurate in key respects." The same article referred to the August 20th presiding judge as noting that in a follow-up hearing in September, "the agency again did not object to the child's being returned home. Instead, the social worker assigned to the case reported that the child was doing well and the parents were cooperating with the court-ordered services."

The Office of the Child Advocate was notified of Ezramicah's death on October 29, 2001. According to state statute and the request of the Child Fatality Review Panel, an investigation was launched into the circumstances of the child's life and death. In the course of the Child Advocate's investigation, the public claims of the commissioner and the SRU findings were noted to be inconsistent with the evidence reviewed by the Child Advocate.

SUMMARY OF FINDINGS AND ANALYSIS

The Child Advocate's findings may be organized in seven categories with related findings and analysis in each category.

- **ASSESSMENT:** The identification of risk indicators;
- **OVERSIGHT:** Case management of protective supervision and court-ordered services;
- **COMMUNICATION:** The coordination of support services;
- **THE CHILD'S VOICE:** Legal representation;
- **PROTOCOL:** Consultations with Medical Experts;
- **IMPACT:** The Juvenile Court proceedings.
- **INVESTIGATING CHILD ABUSE:** The investigation process

ASSESSMENT

RISK INDICATORS - "RED FLAGS"

FINDING

The absence of a comprehensive, ongoing risk-based assessment of a family's strengths and weaknesses precluded the assurance of child protection.

There are certain circumstances, situations or conditions that have been found to indicate the risk of poor family or parent functioning. These "red flags" may alone be insignificant, but when combined, increase the risk of impacting parents' capability to keep their children safe. According to DCF policy 44-13-1, "Although no one can accurately or consistently predict human behavior, research has demonstrated that there are a variety of factors which influence the probability that a child will be abused or neglected." "Children are more likely to be abused or neglected or placed in imminent risk of harm when a combination of risk factors are present."[19] These include but are not limited to:

[19] Connecticut Department of Children and Families, Mandatory Reporting of Suspected Child Abuse and Neglect , (undated).

Stress, chronic and acute, resulting from:

- Inability to meet daily living needs due to unemployment, underemployment, limited education;
- Isolation and lack of support from family or community;
- Domestic violence;
- Parent being emotionally needy, immature, or abused as a child;
- Lack of parenting skills or understanding of child development;
- Low level of frustration tolerance; poor impulse control;
- Young age; single parenting;[20]
- Child abuse is highly correlated with animal abuse;[21]

There were a number of these identified risk factors apparent throughout the life of Ezramicah's DCF case that should have been noted and addressed.

Early Investigative Phase

Ezramicah's parents were young, 19 and 20. Their knowledge level about child rearing was limited as evidenced by the findings of the crib in use while broken, the presence of a pillow in the crib and then in the bassinet after the parents were informed the pillow posed a risk, resistance to allowing the baby to crawl, and the tendency to attempt to feed the baby, even when he was not hungry. In the first visit to the home, it was found to be in poor condition. Ezramicah's mother was reported to have had a history of abandonment and violent victimization as a child. All of these findings suggested a risk to the baby's safety and in fact likely influenced the initial decision to remove the baby when he was found to have an unexplained injury.

Ongoing Services Phase

After Ezramicah's case was transferred from investigations to ongoing services, many of the same risks or red flags remained. Supports and services were not initiated in time for substantial change to occur before the baby was returned. The in-home services worker assisted Ezramicah's father to complete a resume but there is no evidence anyone addressed the economic stress of the family, other than the social worker providing milk when food and money were short on at least two occasions.

New risk indicators that should have been identified included the possible maltreatment of an animal, continued unemployment for the father; unexpected return to work by the mother and the resulting isolation it presented to Ezramicah's father; and financial stress that even affected the ability of Ezramicah's parents to stock the refrigerator with milk and food. The fact that

[20] Ibid.

[21] Animal abuse child abuse correlation In 88 percent of New Jersey families reported for child abuse in 1983 at least one person had abused animals. In two thirds of the cases the abusive parent had injured or killed a pet and in one third of the cases children were the animal abusers. (DeViney, Dickert & Lockwood, 1983 in First Strike Campaign, Human Society of the United States, 199). Eighty-three percent of families in Great Britain with a history of animal abuse had also been identified by social service agencies as at-risk for child abuse or neglect. (Hutton, 1981 in First Strike Campaign, Human Society of the United States, 1999).

neither parent was committed to comply with court-ordered individual and couples counseling should also have been red flagged. Crowding in the small one-bedroom apartment may have been causing stress. Finally, verbal abuse and domestic violence occurring as evidenced by Ezramicah's mother's disclosure to one person and the summoning of the police on several occasions were also red flags that were not recognized as such and not communicated.

There was documentation of a grandmother and an aunt being present during home visits and of other relatives living in the home, but no indication of whether any of those people were resources or added stress to the family. There was no assessment of a social support network for the family.

RECOMMENDATON

Investigations of families suspected of child abuse must include global family assessments that take into account all factors affecting parenting including social economic factors, history of abuse/neglect upon all members, connectedness to communities and family composition. Any delivery of services should be determined by the global assessment and adjusted overtime as the assessment process identifies changes in family situation.

OVERSIGHT

CASE MANAGEMENT OF PROTECTIVE SUPERVISION AND COURT-ORDERED SERVICES

FINDING

Quality assurance measures and treatment planning were ineffective and failed to provide appropriate case management and child protection.

Ezramicah was monitored by child protective services from May 11th until his death on October 24, 2001, approximately 5 of his 7 months alive. Protective supervision implies that a child will be kept safe through a process of scrutiny of his physical well-being, the state of his environment, his access to food and medical care, and the behavior of his caregivers. There are generally specific behaviors or steps expected of supervised caregivers. In addition to face-to-face visits, it would be reasonable to expect that compliance with all referred or ordered services would also be "supervised" as part of the child's protection plan. It would further be reasonable to expect that the treatment plan and administrative case review process would provide oversight and supervision of these interventions. In the case of Ezramicah, it did not.

The investigation of Ezramicah's leg injury was never completed before his case was transferred to ongoing services. After approximately two and a half weeks, the case was transferred from investigations to ongoing services based on an incomplete investigation. The medical child abuse expert made preliminary findings based on incomplete data and copies of x-rays. The order of temporary custody was vacated despite the fact that the circumstances of the child's injury were still undetermined, the medical child abuse evaluation was only preliminary and no action was underway to identify the perpetrator of the injury.

There was no case transfer conference when Ezramicah's case was transferred to Ongoing Services on May 31st. DCF policy requires a transfer summary and meeting to take place when a case is transferred from one unit to another.[22] Ongoing services were not updated as to any outstanding concerns, or the fact that a social study was not completed. There was no indication that the investigative staff shared concerns or expectations with the new social worker or supervisor. Although the investigations unit determined the child to be at high risk, ongoing services determined the child to be at only moderate risk upon return home. This determination was based upon the medical child abuse expert's preliminary findings that the child's injuries were not caused by abuse. Yet no one appeared to note that the findings were based upon a purely preliminary review of the evidence.

Visitation between the parents and the infant was not documented for frequency, length or quality of interactions. In the beginning of this case, from May 14th to the 31st Ezramicah was in the care of a foster family, not yet under protective supervision. During that time, the biological parents were not referred to any services. There was no record that any representative of DCF visited the infant while he was under DCF custody in foster care and no record describing visits between the parents and the infant.
Court-ordered services to the family under protective supervision were not initiated in a timely manner or monitored adequately. Ezramicah was first returned to the care of his parents on May 31st with protective supervision and specific court-ordered referrals including parent aid services, home health nursing, parenting classes and individual and couples' counseling. Home health nursing services had been initiated by the discharging hospital for Ezramicah's care in a spica cast while in foster care. There were no referrals made for the parent aide or the parenting classes before July 3rd when the infant was once again removed from the home.

The delay in initiating court-ordered services hindered the ability to determine effectiveness of the interventions. Ezramicah was in a DCF-licensed shelter for a full month before his parents were referred for parenting classes, a full two months after the original court order. They would not attend their first class for another two and a half weeks. The parenting class providers assessed the parents as needing couples counseling but in interview could not relate clearly what that assessment was based upon other than that they observed "communication problems" between the two. The court would eventually order this therapy on August 20th, along with several other specific services. Yet no one was ever made aware that the couple dropped out of the therapy sessions immediately after the infant was returned home. The therapist understood no obligation to report their lack of participation and the parenting class provider was reportedly only obligated to report on the couple's attendance in classes, not therapy. The DCF worker did not make any inquiries regarding attendance in therapy and but did report in court that the couple were attending counseling. DCF did not make a referral for a parent aide until the end of August. Again, the lack of oversight to ensure the parents were meeting their court-ordered obligations was apparent.

The treatment planning and administrative review process were an ineffective means for oversight of case management and parents' compliance with services. Attendance at the August 16th ACR (just 4 days before the court hearing) was out of compliance with DCF policy. The policy requires, in addition to the case worker and the administrative reviewer, the supervisor to the social worker, any member of the Regional Resource Group, a community consultant,

[22] (DCF Policy 34-17 Case Transfer Conference)

support staff worker, and/or community provider who has participated in any aspect of the case in the seven months prior to review. That would include staff from the parenting education class, the therapist providing court-ordered individual and couples therapy, and staff from the in-home support program. The parents should also have attended the ACR and yet they were told to attend a class instead. There seems to have been no effort to reschedule the conference to accommodate schedules for appropriate participation. Information shared at the conference was incomplete and inaccurate due to the absence of these participants. The reviewer did note specific concerns serious enough to warrant a Managerial Review, but there was no follow-up on the specific concerns; they were not even addressed in the managerial response.

Before the August 20th hearing that returned Ezramicah to his parents, the DCF supervisor and worker had learned that the parents had only attended one parenting class and two counseling sessions. Apparently based upon this information, the supervisor informed the AAG "they could not agree to return the child home until appropriate therapeutic intervention is put in place." At that point, they had had nearly 3 months to put those interventions in place; in fact, those interventions were court-ordered yet never put in place.

RECOMMENDATION

The Department of Children and Families must comply with its own policy on administrative case review and case management. ACR's must be attended by all involved persons as required by DCF policy and scheduling must be flexible to accommodate participation. Social workers must be prepared to report on all services in place, compliance with those services, and progress or lack there of towards treatment goals.

COMMUNICATION

COORDINATION OF SERVICES

FINDING

There were significant communication gaps at all levels of Ezramicah's case. There was inadequate communication between the contracted service providers and DCF staff, incomplete information shared between DCF staff and the AAG, inaccurate information provided to the Juvenile Court, at least one missed communication between a service provider employee and their management, and no communication between the local police and DCF.

Communication about Ezramicah and his family was consistently not updated from the time he was first taken into custody until his death. During the month of May while the child was first in DCF custody, there is only one day's entry evidencing communication between the foster family and DCF regarding the child or the parent visits. There were at least twenty-two (22) entries made in the DCF case narrative after Ezramicah was killed, some up to 4 months later than DCF policy demands. The purpose of the narrative entries is to communicate events, actions, and progress or lack there of, of the child and family towards treatment goals. Late entries interrupt the flow of updated information and accuracy may be impacted by delayed recording.

It took four days for a supervisory conference to be held with senior DCF personnel and the AAG after it was learned from the medical child abuse expert that the infant had additional fractures. Upon learning of the new findings, the DCF supervisor directed the worker to complete service agreement with the family. Five days later, there was a more specific service agreement signed and later that same day the child was removed. There was an increasing intensity of concern communicated to Ezramicah's parents each time DCF approached them during this course of events. When DCF finally went to remove Ezramicah he was gone, despite the service agreement his parents had signed.

There were no shared goals or service plans among programs and there was no coordinating effort to follow-up on court-ordered participation in services. By the end of August Ezramicah and his parents were presumed to have several services in place. They were under protective supervision and ongoing services from DCF so they had a DCF social worker. They were attending parenting classes through a program that provided a case manager, a teacher, a nonprofessional family worker, and a therapist. Through another provider they had a team of two family support workers who would provide in-home supports. Among all of these supports, there were no known common goals or objectives for the family. The parenting program was not aware of the in-home services program. The in-home services program was the only program that was documented as having been presented a "comprehensive overview" of the family's circumstances. Yet there was no evidence that treatment goals for Ezramicah's family were determined by a comprehensive, risk-based assessment of the family, nor did the goals change when the family changed.

There is no documentation of any providers working with the family at any time communicating with each other or coordinating services. DCF received monthly reports from providers but did not follow-up on all services. For example, DCF was not aware that all counseling services had stopped three days after Ezramicah was returned. Before the parents reported to the therapist that they were no longer required to participate in counseling, he assumed they were not appearing at sessions due to a lack of transportation or childcare. In fact, the family was taking full advantage of transportation and childcare being offered free by the parenting program housed in the same agency as the therapist. The court ordered services in place to ensure that the child was safe and the parents were supported in their parenting. The likelihood of interventions being fully effective or efficient in absence of communication and a coordinated approach is unlikely.

Shortly before Ezramicah died, the police responded to several reports of domestic disputes at the residence. During one incident, the baby's mother shared with the police that DCF had been called in the past and that the child had had a broken leg. If there had been a communication made between the police and DCF, DCF could have been alerted to the fact that there were disturbances in the home of an intensity that warranted police intervention. Disturbances of that nature may have predicted the violence to come.

Even after Ezramicah's death, DCF lines of communication remained hindered. The SRU review of Ezramicah's death did not meet the purpose of evaluating "current practice and to identify ways to improve DCF's primary goals of safety, permanency and well being." The information it contained lacked detail and even accuracy. It provided little opportunity to improve practice and OCA even learned that DCF staff involved in cases that are reviewed by SRU are unaware of the process or the reports generated.

RECOMMENDATION

Communication must be clear and open. Contractual agreements with providers must include expectations for reporting of compliance and outcomes as well as participation in meetings. At a minimum, case workers must communicate with all providers regarding family participation in court-ordered services before making any recommendations in treatment planning and court proceedings. Accurate, timely information will keep children safe.

PROTOCOL
FOR CONSULTATIONS WITH MEDICAL EXPERTS

FINDING

There was an over-reliance on the medical child abuse expert's preliminary opinion despite a significant lack of protocol regarding the completion of evaluations by DCF consultants and a disregard for the level of completion.

It took a full month for the medical expert consultant to complete his evaluation; a full month that the child was in the care of suspected perpetrators. The infant was removed from his family a second time on July 3rd. It appeared there was new evidence of physical abuse, but actually, the findings were based upon the medical child abuse expert's concluding findings from the original investigation initiated in May. Original x-rays were finally viewed; a radiologist was consulted; a new set of x-rays had been made; the child was examined; the parents were interviewed; and findings were definitive for abuse. No one had attempted to contact the expert for his evaluation results in the meantime. The medical expert did note that reunification was recommended based on the fact that during that month, the child received no further injuries.

DCF has no established protocol for making evaluation referrals or following up on the completion of those evaluations with medical child abuse experts. The medical expert stated that his evaluation was not completed, and even outlined what he would need to complete the evaluation. There was nothing in place to ensure his timely access to clinical evidence for the evaluation and no one assigned to follow up with his work. Although he did inform DCF at the time of his preliminary findings that he would be away and would complete the evaluation in a "few weeks," there was no apparent expectation for the evaluation to be completed in a specific period of time.

RECOMMENDATION

DCF must establish and follow specific protocol for referrals to medical child abuse experts in the case of evaluating alleged victims of child abuse. That protocol should include at a minimum, identification and communication of necessary data, response time, assignment of follow-up responsibilities, and alternative sources of expertise when an expert is not available to complete the investigation in a timely manner.

THE CHILDS VOICE

LEGAL REPRESENTATION

FINDING

Ezramicah's court-appointed attorney failed to monitor his client's care or his client's parent's compliance with services as ordered by the court.

All children in juvenile court have legal representation. The presumption is that the child's interests are represented to the court and advocated for among state agencies. Ezramicah's attorney never saw the infant while he was at home with his parents. There were no visits at the shelter. There were no inquiries made with service providers to check on his progress or condition. Even when the court ordered extra monitoring by the child's attorney, the attorney had no first-hand knowledge about how the infant was doing.

RECOMMENDATION

Mechanisms must be in place to ensure attorneys representing children meet all obligations of their appointment and follow court orders as well.

IMPACT

THE JUVENILE COURT PROCEEDINGS

FINDING

The publicized attempts to blame a judge's decision in the death of a child distracted from the process of fatality review. Furthermore, inaccurate allegations combined with disclosure of confidential court documents threaten the integrity and effectiveness of court proceedings.

Ezramicah's death is an example of system failure characterized by poor communication, poor case management, and poor coordination of services and lack of oversight. The significance of the lack of follow-up on the parents' compliance with court ordered services and the lack of communication to the Court and the AAG is particularly troubling. DCF had every opportunity to provide information about Ezramicah's family and avoid his return. The AAG and the Judge were never informed that the parents were not fully complying with court ordered services. DCF staff, at all levels, consistently neglected to ask the right questions about the family. When concerns were identified and a managerial review was generated, that was an opportunity to thoroughly review the case and the family's ability to keep Ezramicah safe. But the review did not address the specified concerns, no one addressed the inadequacy of the manager's response and no one even informed the AAG that a managerial review had been generated.

Before returning Ezramicah to his parents at the August 20th hearing, the Judge ordered very specific steps for the parents that went beyond the standard requirements. One of those steps was to inform the court of any changes. In addition, the Judge ordered an in-court review in one month, and not the standard four-month time period. Given that protective supervision would continue, the court must have assumed that the parents' compliance with court ordered services would be monitored and reported.

In fact, at the follow-up hearing on September 18th DCF staff reported to the court on record that the parents' were in compliance with court orders and the baby was doing well. Unfortunately, the report to both the court and the AAG were inaccurate. Concerns that had been identified in the August ACR were essentially ignored; there was obviously no in-depth communication with all providers and none at all with the therapist. The worker even stated on the record that the parents were attending classes and doing couples' and individual therapy. It is not clear where this information came from but it is grossly inaccurate and evident of poor monitoring of service compliance.

The controversy that ensued over what happened in the court proceedings generated considerable public attention in significant disproportion to the death of Ezramicah. A dispassionate look at what occurred reveals that there is less of a discrepancy between the Assistant Attorney General and the Court than public statements indicated. The Commissioner of the Department of Children and Families issued a memorandum that indicated that, "over our objection, the Juvenile Court ordered the child's return home." This investigation has shown that the Assistant Attorney General did not object on the record. Instead, the AAG reportedly indicated in a closed chamber meeting, that DCF "opposed the child's return home" that day. The plan, the AAG reportedly stated, was to return Ezramicah to his home in 2-4 weeks once services to the parents were put in place. However, all of those present in the chambers indicated that the evidenced facts did not support keeping Ezramicah in foster care. Consensus was reached in chambers and reflected in the court record.

Regardless of decisions made at the August 20th court review, the court ordered an early in-court review to follow to ensure Ezramicah's parents' cooperation and the child's safety. On September 18th, the DCF worker, the AAG, the parents, and all involved attorneys appeared before the court to review the situation. All parties agreed, "That there's no need for a further in court hearing." The second court review was an opportunity to review the decision of August 20th. The decision to return the child in August was not disputed and no new concerns were brought forth. DCF had four weeks of opportunity to evaluate Ezramicah's safety and communicate any concerns to the AAG and the court. They did not. The outcome of the second hearing negated any relevance of the August 20th hearing in terms of placing blame for Ezramicah's death on any particular court action.

A publicized argument of blame distracts from the issues related to the death of a child. Furthermore, the impact of such public discourse on court proceedings could have a chilling effect. In Connecticut, a Judge is responsible to issue an Order of Temporary Custody (OTC) for a child to be held by the Department of Children and Families for more than four days. The judge relies on DCF and relevant attorneys to present reasonable and fair arguments on behalf of the child and family. However, more than that, the judge relies on the state agency to present factual and complete evidence. Once a decision has been made, the judge relies on the state agency to oversee the protection of the child if that is so indicated.

If a judge cannot rely on the state agency for complete and factual information about a child, and further must expect to defend his position in confidential proceedings in the public media, his ability to make reasonable decisions may be jeopardized. Also, publicized argument that involves the disclosure of confidential documents from closed court proceedings may impact the degree to which all court officers, families and providers are forthcoming.

RECOMMENDATION

Complete and accurate information communicated to the AAG and the Court is critical. Public discourse should be avoided until such a time as all the relevant information is gathered and investigations are complete and the facts are fully known.

INVESTIGATING CHILD ABUSE

THE INVESTIGATION PROCESS

FINDING

This case was closed after two-and-half weeks in the investigations unit. While there was an agreed upon plea to neglect in the court, the circumstances around the serious fracture of Ezramicah's leg and a perpetrator were never discovered, nor was there continued effort to find out what had happened to this child. Further, DCF did not notify the police when Ezramicah was removed for the second time.

There is no argument that investigating child abuse is a difficult and complex matter. It is more difficult when the child victim is non verbal and not visible in the community. DCF investigations must be completed in a short period of time to get cases ready for court and there is often a dilemma in determining responsibility for abuse when the child is too young to explain and the parents are trying to cover up a problem.

Investigators should have the ability to extend an investigation when a case is complex or unsolved. DCF should routinely conduct in-depth interviews with parents, family members, neighbors, doctors and anyone else in contact with the child. Some may believe this is too intrusive, but in difficult cases, the more information collected, the more informed a decision could be made about the child. In particular, family violence, a critical factor in assessing risk, may only be revealed through interviews with neighbors or family members.

These investigations are often more akin to criminal investigations and therefore engaging the assistance of the local police is also essential. The attorney general may work closely with DCF on an investigation to assist with determining what experts are needed and what records should be obtained. Given the potential roles for a variety of disciplines, a multidisciplinary approach to investigation of child abuse is an effective model to incorporate. Public Act 98-241 *An Act Concerning Multidisciplinary Teams* allows that the Commissioner of DCF as the lead agency and the appropriate state's attorney to establish multidisciplinary investigative teams (MIT) to review particular cases or types of cases of child abuse or neglect. The purpose of MITs is to advance and coordinate the prompt investigation of suspected cases of child abuse and neglect, to reduce the trauma of any child victim and to ensure the protection and treatment of the child. Furthermore, efficiency and effectiveness of investigators is improved through the sharing of expertise.

MITs have been established in Connecticut since 1989. Their existence has been codified in state statute. The focus of the fifteen Connecticut MITs is on investigation of alleged child sexual abuse. Given the success the teams have shown in this realm, expanding capacity to include investigations of suspected abuse upon children who are nonverbal and not visible in the community would allow for improved and reliable findings and better access to protection and care.

RECOMMENDATION

Expand the capacity of the existing multidisciplinary investigation teams in order to allow them to conduct collaborative investigations of suspected child abuse beyond sexual abuse, particularly in cases where alleged victims are nonverbal and not visible in the community.

APPENDIX A

SHAKEN BABY SYNDROME

Abusive head trauma is the most common cause of traumatic death in infancy. Since the 1940's, the features of abusive head trauma, also known as "shaken baby" or "shaking-impact" syndrome, have been well described. The first description of children who sustained head injury from shaking was by Dr. Robert Salinger, in 1946. He examined infants who had been killed or seriously injured by an infant nurse who had become angry and frustrated over an infant's crying and had proceeded to grab the children about the chest or between the shoulders and elbows and shake them violently until they ceased to cry. Autopsies on 2 of these infants revealed severe injury (subdural hemorrhage) over both sides of the brain.

Caregivers who cause these injuries are sometimes unaware that they had injured the child. However, a competent observer to such injuries would inherently realize that the caregiver's actions would be injurious to the child. Infants and children are often shaken due to a caregiver's unrealistic expectations of the infant or child or as a disproportionate response to increasing levels of frustration. In some instances, it may be difficult to determine if the caregiver's intent was to inflict harm or to simply stop the infant or child from crying. Recent studies have demonstrated that perpetrators who injure children in this manner are most likely to be, in descending order, fathers, male paramours, female babysitters and mothers.

The histories provided by caregivers may be vague, such as "I found him like this when he awoke from a nap." There may be suggestion to a remote, poorly defined event, such as "He may have fallen off the couch yesterday" or to a minor fall, such as "He fell and hit his head on the ground" or "He hit himself in the head with a toy". There is much literature to support the concept that household falls or falls down stairs rarely result in life threatening brain injury.

Children with abusive head trauma can have a wide spectrum of symptoms and signs. Children with milder injuries may have only irritability, vomiting, poor feeding or sleepiness. These are symptoms that overlap with a myriad of common pediatric illnesses, and thus these children might not be recognized to have sustained an inflicted head injury. Children with severe injuries often present with more ominous symptoms and signs, such as being in a coma, having seizures or, in severe cases, cardiopulmonary arrest (when the child stops breathing and his heart stops beating). The highest incidence of such injury is in children under 6 months of age, due to their proportionally larger head, weak neck muscles and poor head control, though varying degrees of injury can be seen in children up to 2 years of age. Older, but physically smaller, children with developmental delays can also suffer from these injuries.

On physical examination, there may not be obvious signs of trauma to the head, neck or chest. Bruises to the scalp may only be seen when the head is shaved or when the scalp is exposed during surgery. There also may be bleeding in the back of the eyes (retinal hemorrhages). Such bleeding behind the eyes can be seen in 60% to 95% of children with abusive head trauma. Other hallmarks of shaking injury include posterior rib fractures and fractures to the ends of the long bones, such as the thigh and shinbones. At the time of the acute injury, such fractures may not have overlying tenderness or swelling, and there may not be loss of function of the involved extremity. When these fractures are present with the previously described brain and eye findings, this constellation of injuries is diagnostic for abusive head trauma.

Long-term outcome of survivors of abusive head trauma tends to be poor, and is dependent on the severity of symptoms on initial presentation. Children who present with apnea, seizures and coma are more likely to have long-term neurologic resulting conditions as developmental delay, seizures and persistent vegetative states (static encephalopathy). The overall mortality from such injuries can be as high as 25%.

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Appendix B

FRACTURES IN CHILD ABUSE

Fractures are common injuries in children who have been physically abused. While there are some fractures that are highly correlated with child abuse, there can be much overlap among fracture patterns in both inflicted and accidental injuries. While the fracture pattern may provide some information about the mechanism of injury, the key elements in distinguishing between accidental fractures and fractures due to child abuse are the history of the mechanism of injury and the child's developmental level.

A child who sustains a fracture will most often have a change in their demeanor at the time they are injured. They may cry, become irritable and difficult to console, or have limited use of the affected extremity. Caregivers may note that handling the infant or child in a particular way caused the child to cry or become irritable. Such a change in behavior helps to localize the time at which the fracture most likely occurred. Children who do not roll, pull to stand, cruise or walk are least likely to sustain fractures in general because their motor activity would not typically place them in a situation at risk for fracture. Lack of witnesses, no provided mechanism of injury or a mechanism of injury that suggests a developmental level more advanced than that which is expected are all factors that should raise concern of child abuse.

The fracture pattern may provide clues as to the mechanism of injury. Spiral or "corkscrew" fractures, typically occur from twisting mechanisms. Such fractures of the long bones, such as the humerus, or upper arm, of the femur, or thigh bone, in children who don't walk should strongly suggest the possibility of child abuse. In some cases, these fractures may occur as the caregiver grasped the child's extremity during a fall, and a consistent history of such should make one less suspicious of child abuse. In toddlers and younger children who are walking, accidental spiral fractures of the femur may occur as a child is running, then trips and twists the lower extremity while falling. Spiral humeral fractures in young, non-ambulating children have historically been considered to be abusive. However, there have been recent published reports to suggest that such fractures may sometimes be accidental. For example, there has been a published case of a witnessed humeral fracture, which was incidentally videotaped, in an infant who rolled from the front to back position, entrapping his upper arm in doing so. In addition, simple skull fractures may be seen in short falls from beds, chairs and changing tables onto firm surfaces, and when children tumble down flights of stairs. Again, the key to distinguishing these injuries as due to an accident or child abuse depends on the information the caregiver provides as to how the child was injured.

However, there are some types of fractures that are highly suggestive for child abuse, and are rarely seen in childhood accidents. Posterior rib fractures are due to vigorous squeezing of the child's rib cage, often when as he or she is shaken back and forth by a caregiver. Sternal fractures, or fractures of the breastbone, may be due to direct blows, and without a history of such trauma, are highly specific for child abuse. Metaphyseal corner fractures, also known as "bucket handle" fractures, occur due to twisting of the end of a child's limb by a caregiver, and are most often seen at the ends of the long bones of the legs, such as the shin bone (the tibia), or thigh bone (the femur), as well as the bone of the upper arm (the humerus). Multiple fractures in different stages of healing are highly suggestive of repetitive trauma and, therefore, child abuse, but also should prompt one to consider other causes of bony fragility that have a propensity for fractures. However, when multiple, healing fractures are seen with other unexplained injuries, it becomes much more likely that the constellation of these injuries were due to child abuse[23].

[23] Bechtel, K. (2001). Identifying the subtle signs of pediatric physical abuse - Part I: Bruises, fractures, burns, and head trauma. Pediatric Emergency Medicine Reports, 6:57-68.