CHILD FATALITY REVIEW PROCESS

"Children are not supposed to die. The death of a child is a great loss to family, friends, and community and often represents unjust sufferings and unfulfilled promises. Understanding the circumstances causing a child's death is one way to make sense of the tragedy and may help to prevent other deaths of children. A child's death is a sentinel event and can be a marker in a community of the health and safety of children. Efforts to understand the entire spectrum of actors that lead to a death may help prevent other deaths, poor health outcomes, injury or disability in other children" (A Program Manual for Child Death Review, 2005).

Every state in the United States has a child fatality review process. Connecticut's child fatality review is outlined Conn. Gen. Stat. § 46a-13l and indicates that the Child Fatality Review Panel (CFRP) "shall 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". Between January 1, 2010 and December 31, 2010 the CFRP reviewed 126 child death cases; two of those cases involved children falling from windows. While child deaths from falling are a rare event, the loss of any child from a preventable incident is equally tragic. According to the Connecticut Department of Public Health, Injury Data Book, from 2000-2004 there were 841 children injured under the age of five who sought a hospital level of care for injuries associated with falls. According to Safe Kids USA, each year in the United States approximately 103 die from fall-related injuries and over two million sustain fall-related injuries. While this review focuses on one child primarily due to the family's involvement with multiple state systems; the review is also meant to serve as a reminder that primary prevention is a key ingredient to keeping children safe.

CASE OVERVIEW

In late May, Jayden was one of two children that died as a result of falling out of a window. Jayden was a three-years-old when he fell out of a 3rd floor window on the evening of May 21, 2011. When police arrived at the scene, Jayden had already been taken to the hospital by his eldest sister and a neighbor. Upon arrival at the hospital Jayden was in critical condition. and died five hours after he arrived at the hospital. Jayden's manner of death was ruled an accident by the Office of the Chief Medical Examiner. The cause of death was blunt traumatic head injury. The information that follows is excerpted from a report produced by the Department of Children and Families, Probate Court, and the Office of the Child Advocate/Child Fatality Review Panel.

CASE HISTORY

Record reviews and interviews indicate that Jayden was born into a complicated family system. The chaotic family structure and longstanding multigenerational issues across the maternal and paternal families (abuse and neglect, behavioral health disturbances, domestic violence, impaired parenting, incarceration, multiple foster care and residential placements, substance abuse and complexities of poverty) require a sophisticated understanding of family-centered and trauma-informed principles and practices, effective community services, and oversight from experienced supervisors. Participants in the Special Review indicated that the Department and Probate Court frequently encounter similarly complicated circumstances, stating further that multi-stressed families across generations are often embedded in a range of legal and social services systems.

Jayden's family was involved with three separate DCF Area Offices and three separate Probate Courts spanning three decades. There were four child protection reports on his immediate family beginning in 2008, with the last investigation opening at the time of Jayden's untimely death. There were three Probate referrals since 2002, all of which requested transfer of guardianship to someone other then Jayden's mother or father due to complex social issues for several years, resulting in their estrangement from each other and their children. Family therapy was provided for a brief period and was designed to assess the interpersonal context in which child-rearing and parental responsibility took place. The family intervention was conducted primarily with the mother and her eldest daughter and ended prematurely, without adequate follow-up or continued attempts to engage the family as a larger system. Without inclusion of the father, extended family or relevant social network, a problematic family pattern developed in which the eldest daughter took on the overburdened role as parent of her two younger siblings.

In 2004, prior to the birth of Jayden the eldest daughter was placed along with her younger sister in foster care in another state; after it was determined that the mother's complex social issues and father's absence had a negative impact on the children's safety and well-being. It was not evident in documentation or staff reports that the impact of the trauma related to the children's foster care placement and separation from their parents was addressed at any point during or following these transitions. Current literature and research of children and youth experiencing foster care indicate that they are four to six times more likely than those of the same age in the general population to encounter mental health disturbances such as anxiety disorders, depression, drug dependency and PTSD (Casey Family Services and Chapin Hall, 2005, *Psychotherapy Networker, July/August 2005*).

This case and others like this case also illustrate how difficult family-centered practice is to implement. The day-to-day reality for DCF and Probate staff is that their critical function as case managers and clinicians requires continuous support, dependable community resources, relevant training, and active supervision to handle the complexities and obstacles. Following Jayden's death, a four-generational genogram was developed in collaboration with DCF staff, Probate staff and the family. Genograms generally show patterns of difficulties and strengths in families and social systems, and assist in anticipating future behavior based on historical factors. Completion of Jayden's family genogram showed a multigenerational family wrought with repetitive mental health issues, chronic complex social issues, legal involvement (criminal, protective service), and estrangement. Most of the staff participating in this Review indicated that a genogram would have added depth to the assessment, engagement, and intervention processes with the family, and could have offered a consistent framework across the helping system for case management and supervision.

When working with families such as Jayden's that are embedded in multiple helping systems (courts, healthcare providers, schools, state agencies, and so forth), these agencies should be included as part of the family organization, like an arm of the extended family. These multiple systems often have competing demands and concentrate on different aspects of a family's life and relationships, which can lead to unfocused case planning, inconsistent implementation of services and territorial decision-making. In order to better define the relationship between the Probate Courts and DCF, an interagency agreement was developed in 2006 and refined more recently. The purpose of the agreement is to develop and implement policies and procedures that clarify roles, expectations and responsibilities within and across Agencies. . This Special Review has revealed that although much progress has been made to enhance these meaningful professional relationships, more work is necessary to promote consistency and continuity of service. In this case, the sharing of information and awareness of the actions of colleagues across state agencies was inconsistent and largely dependent on the individual staff from each Agency involved at any given time.

Jayden's death has had a powerful impact on his family and all of those involved with the Special Review. This case demonstrates that despite all of our best efforts, critical incidents and fatalities can happen anywhere, at any time, and to the most experienced and sensitive of professional teams. DCF Area Office and Probate staff have offered important suggestions about lessons learned that they believe will strengthen their collaboration and effectiveness with similarly complex, multigenerational cases. The following section offers *Key Findings and Recommendations* related to case activities, with a focus on assessment and engagement of families, and collaboration with internal and external helping systems.

KEY FINDINGS AND RECOMMENDATIONS

The joint review between the Department of Children and Families, the Probate Courts, and the Office of the Child Advocate/Child Fatality Review Panel offers an opportunity to examine larger systems coordination and communication, relevant policies and practices within and across state agencies and with community providers. The findings and recommendations are broken down into four categories; those that cross both agencies-DCF and Probate, those that are specific to each agency, and finally the Child Fatality Review Panel, while supporting all of the findings and recommendations, made a specific recommendation to the Probate Court system.

I. Cross-Agency Findings

Assessments and interventions over the life of the case did not adequately consider the relevant family history side-by-side with new requests involving the Probate Court, or new CPS reports, allegations or life cycle developments.

As one result, important information and understanding about the changing family context and problematic patterns of interaction were not fully incorporated. Documentation reflected an emphasis on current reports or episodes of involvement, and lacked sufficient coordination with other members of the helping system (courts, extended family, healthcare providers, relevant social network, state agencies, schools, out-of-state CPS, and so forth). Although very cumbersome, previous records and information from the CPS in the other state were not accessed or incorporated into the more recent case decisions (2004 to present).

Recommendation

It is recommended that DCF and Probate staff receive joint training in family-centered assessment and intervention, to include the use of genograms as a tool for connecting relevant parts of the client's history with current functioning. Family-centered practice incorporates a pattern-based approach that contextualizes present behavior and more clearly identifies signs of safety and signs of risk. Comprehensive family-centered assessments and interventions encompass an array of issues that impacted J.R. and his family, including: multigenerational behavioral health impairments; chronic substance abuse; domestic violence; educational delays; legal involvement; poverty; and, traumatic responses to these biological and social conditions. As part of the training, staff from both Agencies should be prepared to discuss a current case to illustrate ways in which expectations, responsibilities, and roles can be clarified to enhance collaboration and continuity.

Coordination and communication within and across agencies lacked continuity.

There was significant duplication of efforts between DCF and Probate staff with regard to visits and family contact, developmental assessments and interventions within and across systems. The discontinuity was manifested by ambiguity with regard to expectation, role and responsibility of staff representing the DCF and Probate Court. Although important changes have taken place since 2008, this Special Review has determined that practices and caseload standards for Probate Court Officers vary from jurisdiction to jurisdiction and require greater clarification.

Recommendation

It is recommended that DCF and Probate Executive staff build upon their existing efforts to collaborate and clarify interagency practices and protocols. Three primary mechanisms should be enhanced: (1) Quarterly Executive Meetings; (2) Monthly Case Review Meetings; and (3) Case Conferences that take place in the Probate Court with families and DCF. Given the transition to new leadership at DCF and the arrival of several new Probate Court Judges, updated policies and criteria for these three collaborative endeavors should be developed and implemented. Refresher training in mandated reporting held jointly with DCF and Probate staff would serve to clarify when CPS reports should be made, under what circumstances, and with which facts, especially when Probate Court receives a new request or a new CPS report is received on an open Probate case. This case highlights the importance of joint visits in some situations, in order to enhance coordination and clarification of information, expectations and responsibilities for clients and professionals.

Decision-making and case dispositions were based on current circumstances and were made in isolation.

Although three DCF Area Offices and three Probate Courts had direct contact with the family during the past three decades, information from previous offices or courts was not routinely accessed or considered as part of the decision-making processes. Admirably, decision-making at various intervals by both DCF and the Probate Court was guided by attempts to keep the family, and particularly the sibling group, together. **Unfortunately, the children's parents and extended families were unable or unwilling to use this support to enhance their caretaking capacities.**

Recommendation

Case dispositions should bring together comprehensive information within and across agencies to ensure that decision-making encompasses the relevant history side-by-side with current functioning.

Examination of the physical environment and education about safety (safe sleep, supervision of young children, arrangement of furniture, and so forth) were not part of the overall assessment and intervention process.
This finding is relevant for organizational learning and professional development, and does not imply that J.R.'s accidental death was related to transactions between the family and professional staff, or neglect on the part of the family. DCF staff must assess safety during each home visit and client contact on a variety of dimensions, and communicate observations, questions or concerns within and across systems. When Probate Court Officers enter the home, they have the same obligation. During the Exit Meetings with both DCF and Probate Court, the participants indicated they would value cross training and education on child protection and safety.

Recommendation
A specific joint training should include comprehensive assessment of safety and risk, based on observations of the physical environment, along with the family's unique life cycle and developmental factors. This training could coincide with the mandated reporter training.

The Special Review team participated in two case review meetings with DCF and Probate Court, examining six cases.
This very effective and proactive process resulted in the appropriate transfer of four of the six cases to CPS Units. Case reviews occur monthly between DCF and the Probate management and staff at all Children's Courts, to case plan the most challenging and complex matters shared by the two agencies. The case review meeting affords colleagues from both agencies a routine opportunity to share information, case-related impressions, and timely decision-making. This best practice is complimented by the case conference process that takes place with families in Probate Court. Staff interviews indicate that the case conferences support informed decision-making and family engagement within and across Agencies. Some DCF Area Offices have out-posted staff in the Courts, which has enhanced relationships, understanding of roles and efficacy of assessments and interventions.

Recommendation
DCF and Probate Administration should develop clear protocols and criteria for bringing cases to the Case Review Meeting for DCF and Probate Court staff.

On an Executive level, the two Agencies continue to meet quarterly to examine policies, procedures and best practices designed to guide front-line staff and enhance decision-making.
The quarterly meetings have resulted in cross-training meetings in local areas to solidify professional relationships, clarify roles and expectations, and communicate changes to policies or procedures.

Recommendation
The Executive collaboration should continue through the transition to new leadership, and should be designed to reflect the philosophical changes at DCF and Probate Court.

DCF Findings

The Special Review indicates that DCF Probate cases are often very complex and do not receive the attention that CPS cases command.

Caseload sizes and expectations for DCF Probate staff do not necessarily align with family needs, and place unrealistic demands on Probate Units if such cases are not transferred to CPS Units. Interviews with DCF and Probate staff indicate that they encounter similarly complex cases routinely. In order to enhance the assessment process, Probate studies are now consistent with CPS studies for Juvenile Court.

Recommendation

As the Department transitions to new leadership, a thorough inventory of positions, functions and use of professional resources across the Agency should include an analysis of Probate cases.

DCF consultation with appropriate RRG (? Spell out the first time for those who do not know) was justified and under utilized.

The Special Review finds that there are two central issues related to RRG inclusion: (a) Standards of practice and protocols for use of RRG staff varies from Office to Office and Region to Region; and (b) There is a lack of appropriate resources within Area Offices and Regions, especially with regard to substance abuse specialists and nursing staff.

Recommendation

As part of an analysis of the DCF workforce during the transition, the function of RRG staff should be clarified. Existing resources for nursing and substance abuse specialists at Central Office and in DCF Facilities should be considered for deployment to Area Offices, in order to address this critical shortage.

This complex case would have been better served as part of the Department's Child Protection Services structure, where caseloads and practice standards are more intensive.

Based on record reviews and staff interviews, on at least two occasions (December 2008 and April of 2010), there were grounds to file neglect petitions and transfer the case to on-going services. A DCF Probate worker and supervisor properly made a referral to the DCF Hotline in 2008. This was excellent case practice. The subsequent investigation resulted in an appropriate substantiation of neglect. The case remained in the Probate Unit following this disposition. As outlined in *Finding Five,* this Special Review indicates that the case would have benefited from a Case Review meeting, where a decision to file neglect petitions could have been discussed across agency.

Recommendation

DCF supervisors and local leadership should bring similarly situated cases to the Case Review process with Probate Court, and utilize Structured Decision Making tools and Regional Resource Group staff to support decision-making. Pattern-based, rather than event-based decision-making will ensure that accumulating risk factors and family history are considered more deliberately.

II. Probate Court Findings

A collaborative approach for examination of critical incidents or fatalities enhances the Special Review process.

This collaborative Review was initiated in conjunction with the Probate Court Administrator, Child Fatality Review Panel (CFRP), DCF Commissioner and Office of the Child Advocate (OCA). The participation of the various agencies provides a broader perspective and helps to ensure factual accuracy. In addition, it provides a valuable cross-training tool for DCF and the Probate Courts. In cases when DCF and the Probate Court are involved, collaborative reviews such as this Special Review are the best practice. Should a critical incident arise involving Probate Court, but not DCF, a similar process led by the Probate Court Administrator would be warranted.

Recommendation

Probate Court Administration should continue to collaborate with the DCF Special Review team, Office of the Child Advocate and Child Fatality Review Panel in conducting reviews of critical incidents and fatalities..

At the time of the fatality, the Probate Court computer system did not have the capacity to share information between Probate Courts.

This Special Review indicates that relevant and timely sharing of information is dependent on informal mechanisms and each court's access to historical information, usually via family relationships and present-day interviews. Because family members are not always forthcoming about previous encounters with other courts, valuable information may not be considered as the decision-making process evolves. During the course of this Special Review, the Probate Court Administration implemented a system-wide computer network that will enable courts to access information about prior case activity in other courts. Probate Administration has also pursued necessary legislative changes to promote timely communication and sharing of information within and outside of the Probate system.

Recommendation

Probate Court Administration should continue to develop their computer system and to seek legislative support to update the confidentiality statutes to facilitate communication among courts and with external agencies.

III. ***Child Fatality Review Panel***

After a thorough review of the report, the Child Fatality Review Panel (CFRP) found that the Probate Court system does not have the same access to expert clinical consultation that is available to case workers in DCF. DCF has a variety of clinical consultants available to support case practice decisions including nursing, psychology, and psychiatry. The Probate Court system does not have a similar process whereby Court Service Officers (CSO) have access to a multi-disciplinary level of clinical consultative services. While Probate Court Support Service Officers (CSO) are all masters level prepared and credentialed, access to other clinical consultation seems warranted on complex cases such as Jayden's.

Recommendation

On February 16, 2011 The CFRP voted to support all of the recommendations outlined in this Report. Additionally, the CFRP recommends that Probate Court Support Services Officers have on-going access to expert clinical consultation.

IV. ***Conclusion/Prevention***

We share Jayden's story with you first and foremost to encourage communities to ensure screen and window safety in homes and apartments where children reside or play. Also, Jayden's story has helped state entities to communicate more effectively and efficiently According to USA Safe Kids, "young children are still developing mobility and coordination and can be prone to injures caused by falls. Head injuries are associated with most deaths and severe injuries resulting from falls. While the death of any child is a tragedy, the preventable death of a child is even more compelling. Make sure the area around little children is safe to toddle, tippy toe and topple. Always actively supervise your little child as he explores around the home". Below are general tips to prevent injuries associated with falls.

Furniture:

- Do not place toys or items that attract children on top of furniture.
- Place furniture away from windows, and secure it to the wall with anchor straps.

Stairs:

- Install safety gates at the top and the bottom of staircases.
- Actively supervise toddlers on stairs. Hold their hands when climbing up and down stairs.
- Make sure stairs are clear of toys and other objects.

Windows:

- Install safety guards on windows. Screens are mean to keep bugs out, not children in.
- Keep windows locked when they're closed

For more tips about children's safety go to USA Safe Kids at www.safekids.org

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