



INFANT AND TODDLER FATALITY REPORT

Co-authored by Connecticut Office of the Child Advocate and Dr. Kirsten Bechtel

July 25, 2023

Brief findings

1. There were 97 children younger than 3 years old who died from non-Natural causes between January 1, 2019, and August 8, 2022, in Connecticut.¹ Eighty-five of these children were younger than 12 months old, and the median age of a child at the time of death was 3 months old with a mean age of 5.5 months.
2. Unsafe sleep-related deaths remain the leading factor in preventable deaths of infants in Connecticut. Despite multi-agency efforts to reduce infant fatalities associated with unsafe sleep environments, Connecticut has seen no decline in such deaths over the last 10 years.²
3. Children who died were disproportionately male (63%), and more than 50 % of children were identified as Black, Hispanic, or both consistent with national findings regarding Sudden Unexpected Infant Death (SUID) rates.
4. A review of state agency data shows:
 - 81% of children who died were Medicaid enrolled but only approximately 50% received Women, Infants, and Children (WIC) Nutrition program benefits.
 - 12.5% children/families received benefits or services from the Office of Early Childhood (OEC) within six months of the child's death.
 - 7% of birth mothers were involved with a Department of Mental Health and Addiction Services (DMHAS) referred or licensed service within 6 months prior to the child's death.
 - 13% of birth mothers had involvement with Judicial Branch- Court Support Services Division (JB-CSSD).
 - 26% of children lived in families that had a case open with the Department of Children and Families (DCF) at the time of death or a case open within the previous 12 months.
5. Eighty-three of the child fatalities were investigated by DCF. Of those, 30 (36.2%) led to a substantiation of a caregiver for Physical Neglect, Physical Abuse, and/or Medical Neglect.³

¹ OCA sought to review deaths over a recent period. The group size was chosen in August 2022 to enable consistent data collections from relevant state agencies.

² This statement is based on annual fatality data compiled and reported by the OCA. See annual reports <https://portal.ct.gov/OCA/OCA-Annual-Report/Recent-Annual-Reports>.

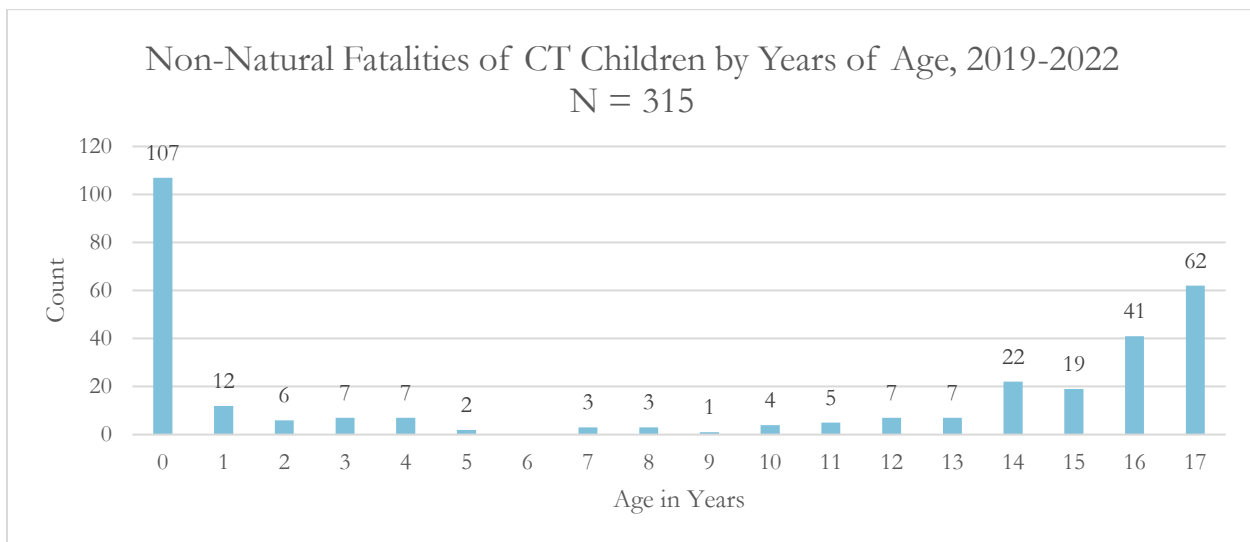
³ Physical Neglect is defined in DCF policy 22-3 and Connecticut state law as a child being found abandoned; denied proper care and attention physically, educationally, emotionally, or morally; permitted to live under conditions, circumstances or associations injurious to their well-being; and/or has been abused by a caregiver

6. Fentanyl intoxication in young children is a new development in child fatalities. 8 of the 97 (8.2%) children, ranging from 4 weeks old to 27 months old, died due to Fentanyl intoxication, a cause not previously documented within this age group in Connecticut.

Role of the Office of the Child Advocate (OCA) and Child Fatality Review Panel (CFRP)

By statute, OCA is empowered to investigate non-Natural (i.e., unexplained and unexpected) child fatalities. The State Child Fatality Review Panel (CFRP), staffed and currently co-chaired by OCA, reviews non-Natural deaths of children for the purpose of facilitating “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.”⁴

The chart below reflects data regarding non-Natural deaths of **all CT children**, birth through 17 years old between 2019 and 2022, demonstrating that children under 12 months of age are at highest risk of preventable death.



given access to or responsible for their health and welfare. A finding of Physical Abuse is defined as a child that “has been inflicted with physical injury or injuries other than by accidental means; is in a condition which is the result of maltreatment; and/or, has injuries at variance with the history given of them.” Medical Neglect is defined in DCF policy as the “unreasonable delay, refusal or failure on the part of the person responsible for the child's care to seek, obtain, and/or maintain those services for necessary medical, dental or mental health care when such person knows, or should reasonably be expected to know, that such actions may have an adverse impact on the child.” Id.

⁴ Conn. Gen. Stat Sec. 46a-13l *et seq.*

Methodology

This report focuses on the deaths of children younger than 3 years old accepted by the Office of the Chief Medical Examiner (OCME) for autopsy between January 1, 2019, and August 8, 2022,⁵ which includes the time period of the COVID-19 pandemic.

There was a total of 103 deaths in the initial group. Of these, OCME later found that 2 deaths were the result of Fetal Demise, defined in Connecticut as a death that occurs prior to a breath taken outside of the womb (for these deaths no “manner” of death would be identified by the OCME). Four deaths were deemed to be Natural, bringing the final group of children who died from non-Natural causes (i.e., Undetermined, Accident, or Homicide) during the Period Under Review (PUR) to 97 children.

OCA reviewed data from several state agencies regarding children or families’ receipt of benefits, services, or supervision prior to or at the time of the child’s death. OCA’s request for information referenced the 103 children in the initial group of child fatalities. Due to various federal confidentiality laws, OCA received certain information from state agencies in a child and family-specific manner (e.g., OEC provided child/family-specific data x family received home visiting, y family did not) and other sets of information from state agencies were received via a percentage (e.g., DMHAS provided information that x percentage of families in the group had a birth mother who was engaged in DMHAS services). Accordingly, given the subsequent change in the group size from 103 to 97 children/families, certain data points in this public health Report are referenced precisely and others are approximated—noted throughout the Report as applicable.

OCA was not able to obtain birth father information for every child, and therefore birth father information was not gathered. Fatherhood information is not always captured or available to the OCME, and approximately half of the children who died did not have a birth father identified on their birth certificate per information obtained by OCA from the Department of Public Health (DPH).

OCA reviewed information from the following state agencies:⁶

1. Office of the Chief Medical Examiner (OCME)
2. Department of Children and Families (DCF)
3. Department of Public Health (DPH)
4. Department of Mental Health and Addiction Services (DMHAS)
5. Department of Social Services (DSS)

⁵ Conn. Gen. Stat. Sec. 19a-406 provides, in relevant part, that the Chief Medical Examiner “shall investigate all human deaths in the following categories: (1) Violent deaths, whether apparently homicidal, suicidal or accidental, including but not limited to deaths due to thermal, chemical, electrical or radiational injury and deaths due to criminal abortion, whether apparently self-induced or not; (2) sudden or unexpected deaths not caused by readily recognizable disease; (3) deaths under suspicious circumstances; (4) deaths of persons whose bodies are to be cremated, buried at sea or otherwise disposed of so as to be thereafter unavailable for examination; (5) deaths related to disease resulting from employment or to accident while employed; (6) deaths related to disease which might constitute a threat to public health; and (7) any other death, not clearly the result of natural causes, that occurs while the deceased person is in the custody of a peace officer or a law enforcement agency or the Commissioner of Correction.”

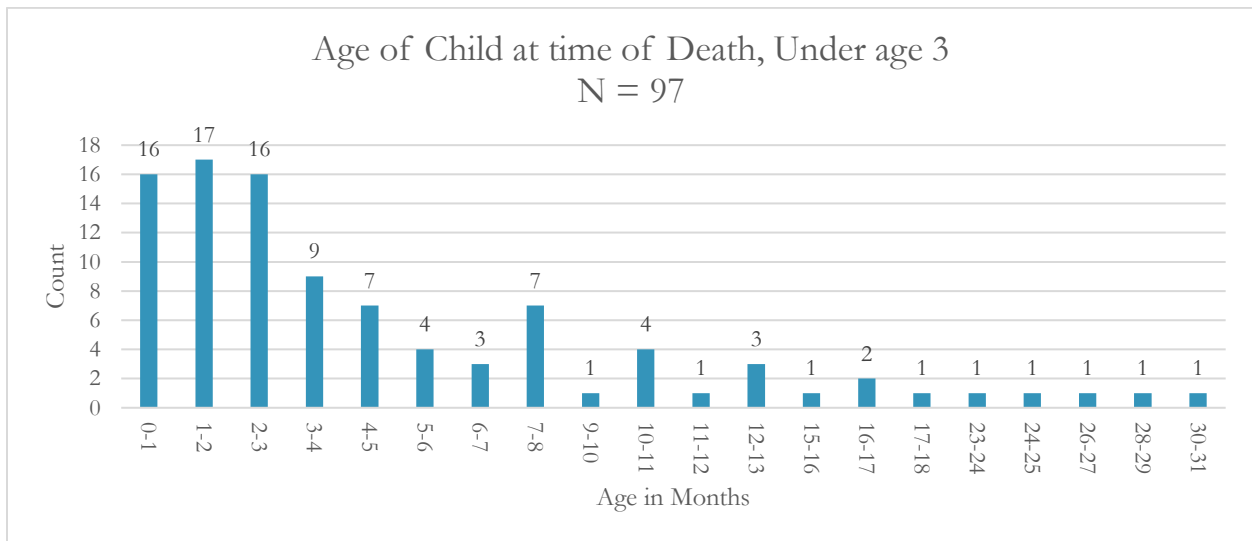
⁶ OCA has direct access to DCF’s case management information system (LINK). OCA makes information requests or issues subpoenas as needed to acquire information from other executive branch agencies.

6. Office of Early Childhood (OEC)
7. Judicial Branch Court Support Services Division (JB-CSSD)

OCA reviewed information contained in this Report with the Child Fatality Review Panel,⁷ multiple healthcare providers and state/national experts in child fatality review.⁸ Authors conducted literature review to ensure that this Report reflects up-to-date research to support the findings and recommendations. Authors acknowledge the data contributions of the state agencies and appreciate their cooperation and responsiveness throughout the review process.

Findings

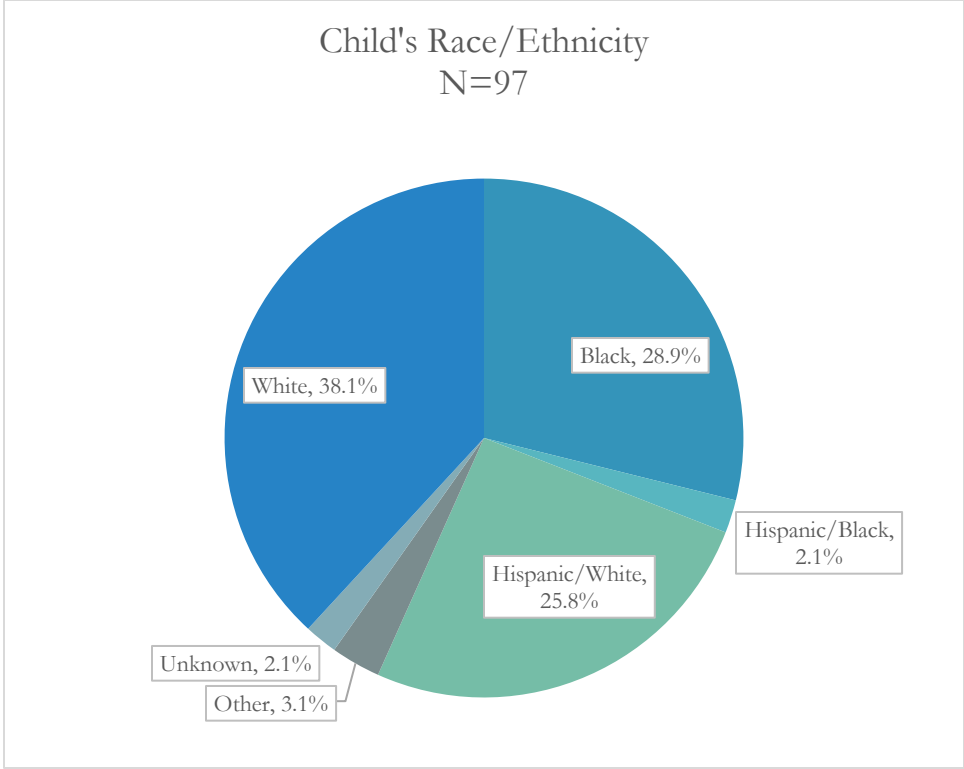
Findings regarding age of children birth to 3 who died from non-Natural causes during the period under review (January 2019 through August 8, 2022):



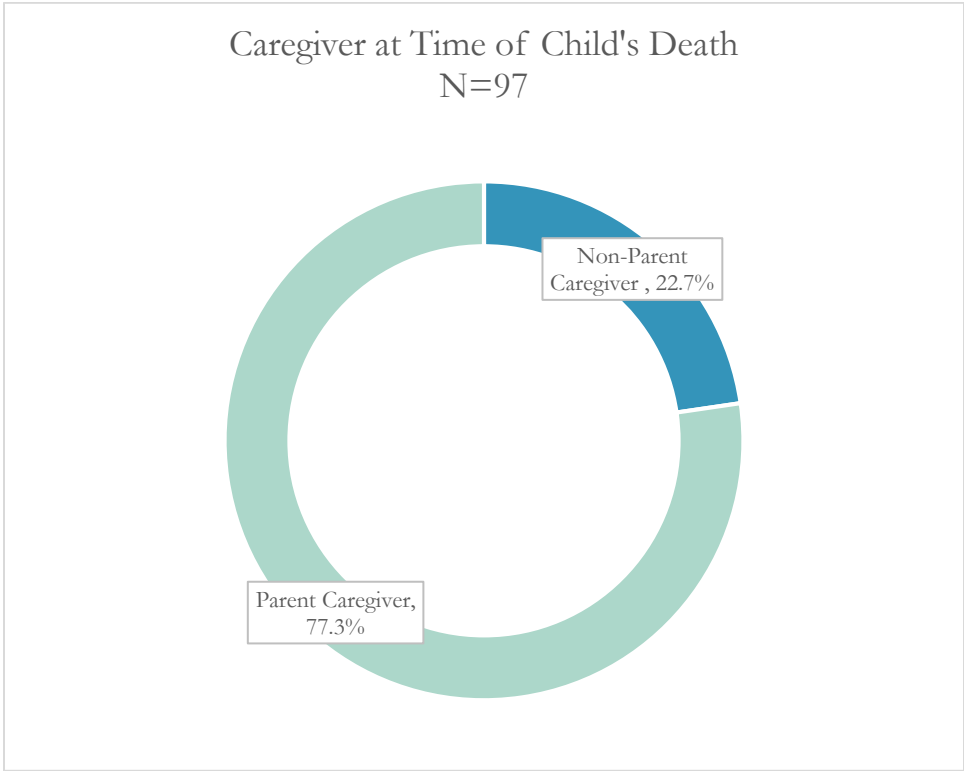
- Children within this group who were less than 3 months of age accounted for a majority (50.5%) of all child fatalities.
- The average age of the birth mothers who suffered the loss of child was 28.6 years old.

⁷ Membership for the Child Fatality Review panel can be found here: <https://portal.ct.gov/OCA/Fatality-Review/Fatality-Review/CFRP-Description>.

⁸ Consultants and experts included Board Certified Child Abuse Pediatricians, Emergency Department medical personnel, and staff from the National Center for Child Fatality Review & Prevention.



- Children of color are disproportionately represented in this group, representing more than 3 out of every 5 fatalities.



- Nearly 1 out of every 4 children died while in the care of someone other than their birth parent. This highlights the importance of safety messaging to not just parents, but anyone who may be in a caregiving role.
- Birthing hospital information was able to be identified for about 3 out of every 4 children in the group and associated to children that were determined to have unsafe sleep environments. Hospital information is critical for quality assurance efforts in assessing the communication and messaging of safe sleep procedures to new parents/caregivers.

Manner and Cause of Death

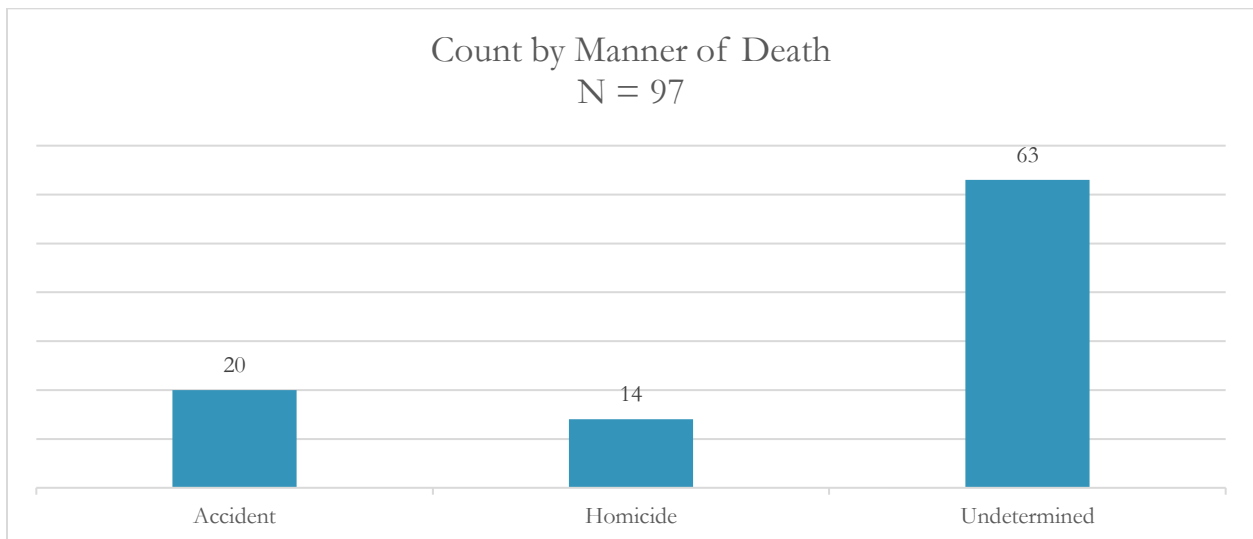
The manner of death is the determination of how the disease or injury leads to death made by the OCME following a complete investigation, often inclusive of an autopsy. There are five manners of death (Natural, Accident, Suicide, Homicide, and Undetermined). The cause of death is the disease or injury that produces the physiological disruption resulting in death. Note that “Homicide,” in this Report’s context, is a classification provided by the OCME, and not indicative of intent to harm or any potential criminal charges that may result from a law enforcement investigation. Listed below are the OCME definitions for the manners of death applicable to this Report.

Manners of Death, specific to this group, as determined by the Office of the Chief Medical Examiner

Accident: A death ruled an Accident when there is little evidence or no evidence that the injury occurred from intent to harm.

Homicide: A death ruled a Homicide is a death that was caused by the act of another.

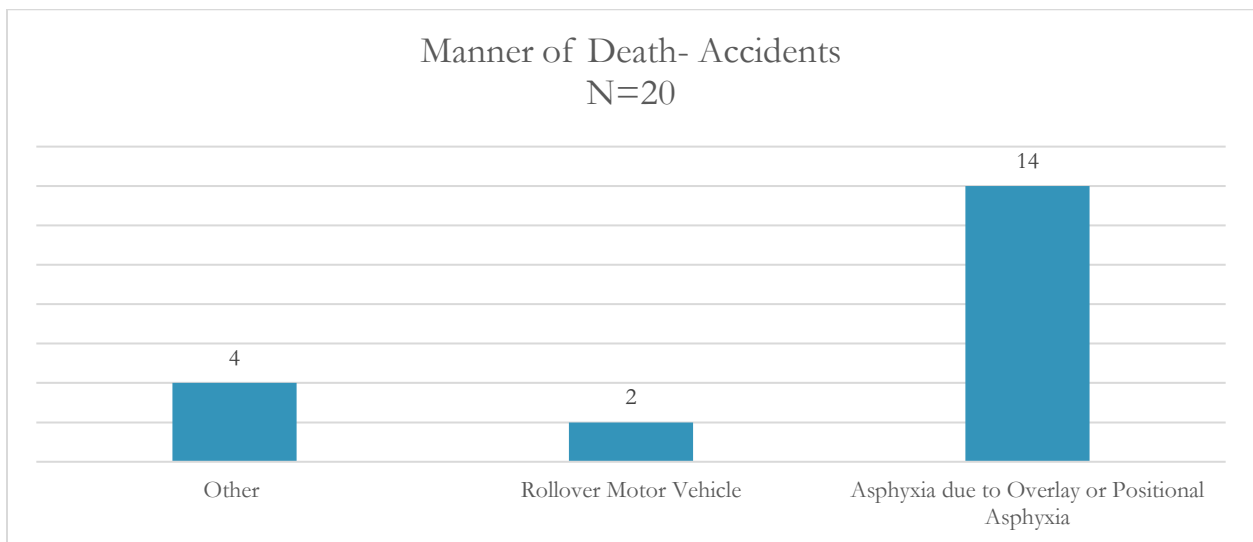
Undetermined: A death is ruled Undetermined when there is no sufficient degree of medical certainty to determine the cause of death. With these deaths, there is no sign of natural disease and there is no obvious injury such as you find in a homicide or suicide or accident, therefore the death is ruled as Undetermined. These cases, typically involving infants, have gone through a very rigorous examination by the OCME. Most often case review identifies modifiable risk factors in the infant’s sleep environment, such as the baby being in an adult sized bed, in an adult sized bed with other children, in their own sleep environment but with blankets, pillows, etc. These risk factors are typically referred to collectively as an “unsafe sleep environment.” “Unsafe sleep environment” also includes the position of the infant: i.e., infant is placed prone (on their stomach) or on their side. Unlike Accidental deaths where unsafe sleep conditions are definitively established, autopsy and scene investigation may identify unsafe sleep risk factors such as those listed above, but positional asphyxia or lay-over is not conclusively determined.



ACCIDENTS

Mother breast fed 3-week-old baby between the hours of midnight and 1:00am. Child had been fussy and was not able to sleep comfortably. The father took the child so mother could rest. When mother woke up, she saw that the baby was on the bed with father and was partially covered. The baby was found unconscious and did not survive. The baby's father shared with the Medical Examiner's office that he had placed the baby on his chest and that he was sleeping semi-prone with his back on a pillow and his head propped up. Father fell asleep and the baby's face became partially obstructed.

- There were 20 Accidental injury deaths; 7 (35%) were children of color, and 12 (60%) were male.
- Fourteen (70%) were determined by OCME to be caused by positional asphyxia or asphyxia due to overlay, which is the insufficient intake of oxygen when breathing, most frequently the result of a compromised airway due to the infant co-sleeping with an adult in an adult sleep space.
- These 14 children averaged 6.6 months old at time of death.
- DCF substantiated allegations of Physical Neglect in 3 of the 14 asphyxia/positional asphyxia cases (21.4%)
- Two deaths were due to injuries sustained due to motor vehicle back-over incidents. These children were close to age 2 and each incident occurred at the child's residence. The deaths were investigated by DCF, and no substantiation of abuse or neglect was issued.
- Four deaths were due to other accidental circumstances (2 choking injuries, 1 due to medical care complications and 1 animal related injury). These children ranged in age from 1 month to 30 months old. DCF investigated all four deaths and did not substantiate allegations of abuse or neglect for these incidents.



HOMICIDES

Parents put their 10-month-old down for a nap at around 8am on a mattress that was on the floor. Father, who worked overnights, laid down at the same time on a separate bed, in the same room, while mother worked from home. Mother came to check on the baby, concerned that he did not awake for his feeding. She found him unresponsive. Lifesaving efforts by first responders were unsuccessful. Naloxone was not administered. During the scene investigation, police found drug paraphernalia in the home. Child tested positive for Fentanyl upon autopsy.

- The mean age of death for children who died from Homicides was 10.6 months of age; 10 of the 14 fatalities were children of color (71.4%) and 9 (64.3%) were male.
- All 14 homicide deaths were investigated by DCF and led to a substantiation for abuse or neglect.
- 6 of the 14 Homicide deaths involved children who were drowned, intentionally smothered, or suffered inflicted head injuries. These children averaged 7.7 months of age at time of death, 50% were children of color, and 4 of 6 (67%) were male.
- The 8 remaining Homicides (57%) were due to Fentanyl intoxication, a new development in child fatalities. Work continues to understand the mechanism of ingestion in fatal pediatric Fentanyl cases. OCME officials indicate that breast-feeding is *not* a mechanism of ingestion injury. Even trace amounts, however, of Fentanyl, e.g., residue left on a utensil that is later used to prepare a bottle of formula, can be lethal to young children.

Authors sought to clarify with OCME its determination of Fentanyl intoxication deaths as Homicides. The OCME explained:

Pediatric neglect includes the failure of a caretaker to provide adequate supervision, protection, or a safe living environment necessary to meet the needs and maintain the health or safety of a child. The presence and accessibility of an illicit drug creates a clearly unsafe environment for a child. The OCME considers pediatric intoxication deaths that occur under these circumstances as a form of neglect.



DEA illustration of
2 milligrams of
Fentanyl, a lethal
dose in **most**
adults.

- In 7 of the Fentanyl cases, the parent was the caregiver at the time the child was found deceased. In one instance a grandparent was caring for the child.
- The mean age of children in this sub-group was 12.9 months of age, with a range of 4 weeks old to 27 months old.
- 7 of 8 (87.5%) were children of color and 5 (62.5%) children were male.
- DCF substantiated the caregiver/s for Physical Neglect in all these incidents.
- Within the group (N=97), there were no other ingestion related deaths recorded, with the 89 other deaths having negative toxicological screens at autopsy.
- Most fatal Fentanyl ingestion cases in infants and toddlers occurred in 2021 (n=6). Notably, from June 2021 through May 2023, there have been over 20 DCF-generated Critical Incident reports on children under age 3 reported to DCF due to suspected ingestion of opioids and concerns of abuse/neglect by a caregiver. First responders and/or health care professionals frequently administered Naloxone, and these children survived the ingestions. The threat of fatal/near-fatal opioid ingestion for children remains active, implicating a continued need for effective and easily accessible treatment options for caregivers with young children, expanded naloxone distribution/training efforts, along with safe storage messaging and intervention efforts.

UNDETERMINED

4-month-old infant placed to bed at 8:00pm in an adult sized bed with the baby's chest down and her head turned, as this was her preferred sleeping position. She was placed down with adult sized pillows on either side of her on a fitted sheet, with no blankets. Infant checked on at 10:15 pm by parent and was found to be in respiratory distress. Emergency help sought. Child was placed on a ventilator but succumbed to her condition the following day. Family did have a crib available in the home.

Undetermined deaths typically include findings that an infant was found in an unsafe sleep environment, e.g., sleeping prone, sleeping side-facing, co-sleeping, sleeping with items such as blankets/pillows/plush toys, overheating/overdressed, or with other sleep environment risk factors. Research confirms that sleep locations such as sleeping on a couch or armchair can be particularly

⁹ NIDA. 2018, May 1. The True, Deadly Scope of America's Fentanyl Problem. Retrieved from <https://archives.nida.nih.gov/news-events/noras-blog/2018/05/true-deadly-scope-americas-Fentanyl-problem> on 2023, May 30

dangerous for infants. Infant deaths associated with an unsafe sleep environment are by far the most common cause of preventable death in young children. In addition to sleep environment factors, research shows that additional factors increase the risk for SUID deaths, including from suffocation: e.g., pre-term birth, low birth-weight, lack of prenatal/medical care, smoking (which has been found to greatly increase a baby's risk for fatality), alcohol and drug use during pregnancy, and absence of breastfeeding.¹⁰ The U.S. National Institute of Health also warns that parental use of medication or other substances that affect the adult's ability to respond is a "very high risk" factor for SUID.¹¹

- The mean age of children at the time of death was 4 months, median age was 2.4 months, and 63.5% (40) of the children were male.
- 68.3% (43) of the children in this group were children of color, with 33.3% (21) of children identified in OCME records as Black.
- DCF investigated 54 (85.7%) of the Undetermined deaths, and substantiated allegations of Physical Neglect in 13 (20.6%). Not all non-Natural deaths are called in to DCF for investigation absent a clear indication of suspected abuse or neglect of the child.

Of the children younger than 12 months old who had a manner of death of Accident or Undetermined (n= 77), the majority (88.3%) were documented to have sleep environments that were inconsistent with the American Academy of Pediatrics (AAP) Safe Sleep Recommendations (Table 1).¹²

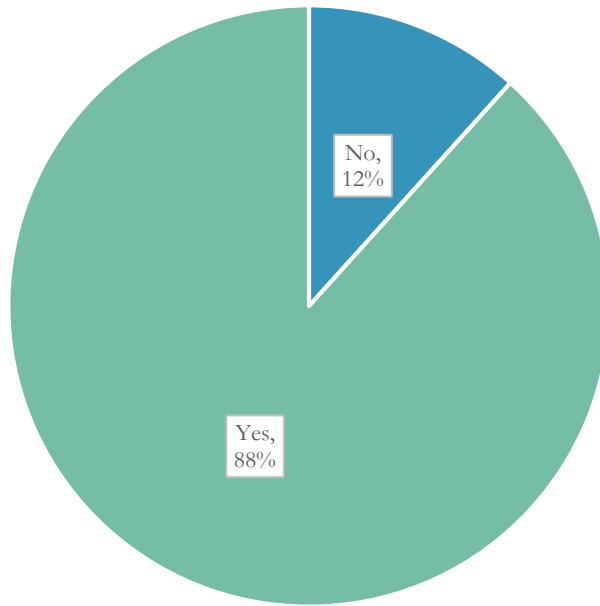
In 55.8% (43) of cases identified as an Accident or Undetermined, the child was placed on an adult sized mattress. Other environmental risk factors included: prone (on stomach) sleeping, objects or blankets/pillows in sleep environment, and couch sleeping.

¹⁰ National Institute of Health, *About Safe Sleep for Babies: What are Known Risk Factors*, found on the web at: <https://safetosleep.nichd.nih.gov/about/risk-factors> (last accessed July 3, 2023).

¹¹ Id.

¹² American Academy of Pediatrics: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment, Policy Statement, June 21, 2022. Found on the web at: https://publications.aap.org/pediatrics/article/150/1/e2022057990/188304/Sleep-Related-Infant-Deaths-Updated-2022?_ga=2.91032282.178238540.1686774499-1637622416.1684855483%3fautologincheck%3dredirected.

Indications of an Unsafe Sleep Environment:
Children <12M, Homicides Excluded, N = 77



The OCA enters child specific fatality review information into the national Child Death Review (CDR) database maintained by the National Center for Fatality Review and Prevention (NCFRP).¹³ Data entry includes information regarding children designated by the OCME to have unsafe sleep environment factors/elements at the time of death. Information listed below derives from the CDR and reflects the most common unsafe sleep environment elements seen in Connecticut infant death review during the PUR, with comparison group to 3 years prior. In most unsafe sleep deaths, the child was placed on an adult bed surface and shared a sleep surface despite there being an appropriate safe sleep option available in the home.

Death Related to sleeping or sleep environment, child under age 1	2016-18 N=52	2019-22 N=76
Child placed to sleep in/on Crib	12.3%	8.3%
...Bassinet	1.8%	3.6%
...Adult Bed	56.1%	56.0%
...Couch	0.0%	7.1%
...Floor	1.8%	0.0%
...Car seat	3.5%	0.0%
...Other	12.3%	10.7%
...Futon	1.8%	0.0%
...Rocking/Inclined Sleeper	1.8%	1.2%
...Swing	0.0%	1.2%

¹³ Funding for the NCFRP is provided in large part by the Maternal and Child Health Bureau (Title V Social Security Act), Health Resources Services Administration, U.S. Department of Health and Human Services.

...Unknown	0.0%	2.4%
Position placed to sleep- supine (on back)	59.6%	50.0%
Position placed to sleep- prone (on stomach)	19.3%	21.4%
Position placed to sleep- side	8.8%	11.9%
Child in new or different sleep environment	38.6%	35.7%
Child shared a sleep surface	57.9%	61.9%
Child placed to sleep with pacifier	7.0%	6.0%
Child swaddled prior to being placed down to sleep	12.3%	17.9%
Crib or bassinet in the home	56.1%	70.2%
Shared room with caregiver at the time of death	70.2%	64.3%

Findings regarding City/Town of Residence

37% of the children who died during the PUR resided or died in Hartford, New Haven, Bridgeport, or Waterbury. The chart below lists the city/towns where more than 1 child death occurred.

Town of Residence	Count	Town of Residence	Count
Hartford	12	Norwalk	2
New Haven	11	Bristol	2
Bridgeport	8	Danbury	2
Waterbury	5	Norwich	2
New Britain	4	Fairfield	2
Meriden	4	Enfield	2
West Haven	3	New London	2
Middletown	3	Ellington	2
East Hartford	3	Windsor	2
Stratford	2		

Findings from State Agency Data

(All of the findings below were based on the initial child fatality group of 103)

OCA sought data from state agencies listed below regarding the provision/referral/mandate for services to the child who died or the child's birth mother. As stated above, due to various federal confidentiality laws, certain agencies provided responsive information to the OCA via percentages of birth mother's/children's agency involvement or receipt of services. OCA did not have birth father information for many of the children, and therefore birth father information was not gathered from the state agencies. Fatherhood information is not always captured or available to the OCME, and approximately half of the children who died did not have a birth father identified on their birth certificate per information obtained by OCA from DPH.

Office of Early Childhood

The Connecticut Office of Early Childhood (OEC) oversees a network of early childhood care, education, and development programs.

The Birth to Three System is part of the Individuals with Disabilities Act (IDEA) Part C “Early Intervention.” In Connecticut, community-based programs support families to enhance their child’s development and connect to their communities. Children in CT are eligible if they are under age 3 and have a significant developmental delay based on a standardized test or have a diagnosis of a medical condition that’s likely to result in a developmental delay.

The Care 4 Kids program makes child-care affordable for low- to moderate-income families in Connecticut.

Home visiting programs improve the health of young children by providing support and services for them and their families — right in their own homes. These programs reach pregnant women, expectant fathers, and parents and caregivers of children under the age of 5. OEC provided child-specific data.

OEC Service Type	Count	%
Birth to Three, Part C IDEA	5	4.9%
Care 4 Kids Childcare Subsidy	4	3.9%
Home Visiting	3	2.9%

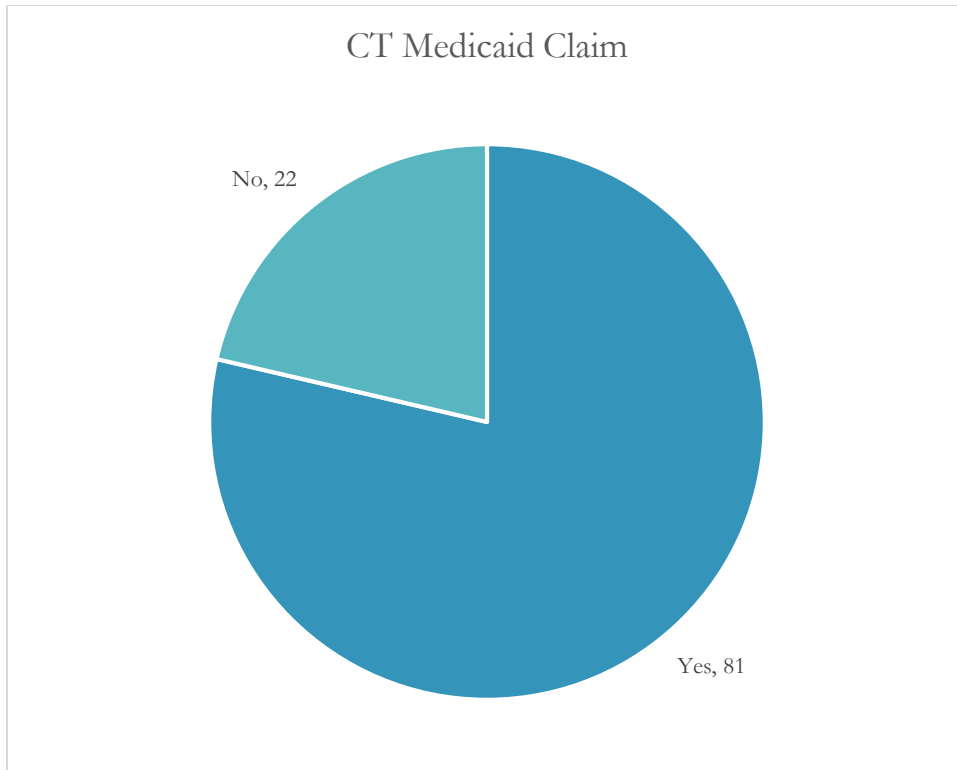
Twelve families that lost a child in this group were receiving services or benefits from the Office of Early Childhood.

Department of Social Services

The Department of Social Services delivers and funds a wide range of programs and services as Connecticut’s multi-faceted health and human services agency.

OCA sought data from the Department of Social Services (DSS), the state’s Medicaid operator, regarding benefits provided to families that experienced a child fatality during the PUR. DSS provided aggregate data based on the status of the child and birth mother. Most children were Medicaid enrolled at the time of their death. Overall, approximately 37% of Connecticut children under the age of 18 are on Medicaid.¹⁴

¹⁴ Children’s Health Care Report Card, published by the Center for Children & Families (CCF), part of the Health Policy Institute at the McCourt School of Public Policy at Georgetown University, found on the web at: <https://kidshealthcarereport.ccf.georgetown.edu/states/connecticut/> (last referenced July 18, 2023).



Department of Public Health

The Connecticut Department of Public Health is a state government agency that promotes, protects and ensures the health and wellness of all the citizens in the state of Connecticut.

OCA sought data from DPH to learn more about how many families that experienced a child fatality were receiving nutritional benefits at or near the time of the child's death. The Special Supplemental Nutrition Program for Women, Infants and Children, better known as the WIC Program, provides supplemental foods, health care referrals, nutrition education, and breastfeeding promotion and support to low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

People who apply for WIC must meet all of the following:

- Be in one of the following categories (type of participant): Pregnant women, Breastfeeding women, Non-breastfeeding (postpartum) women, Infants, Children
- Live in Connecticut. You do not have to be a citizen of the United States.
- Must meet the WIC income guidelines (at or below 185% of Federal Poverty Guidelines or on Medicaid or SNAP).
- Be at nutritional risk. Examples of nutritional risk include low-iron level, underweight, poor eating habits.

DPH provided aggregate data based on child/birth-mother information. Approximately half of children were or had received WIC benefits. For context, approximately 19% of all children aged 0 to 4 or pregnant/parenting individuals were enrolled in WIC in 2019.¹⁵

Given the concurrent eligibility between Medicaid and WIC for caregivers/infants, this data indicates that the infants and toddlers who died during the PUR were substantially under-enrolled in this essential program. National data (from 2019) on state’s WIC coverage rates (i.e. the share of people eligible for WIC who receive benefits) indicate that Connecticut had an overall WIC coverage rate of 55% (approximately the median percentile for the United States), and that while infants’ rate of coverage was 100%, children age 1 to 4 had a coverage rate of only 41%.¹⁶ Program leads at DSS and DPH acknowledged systemic under-enrollment in WIC for certain vulnerable populations, and indicated they are working to address this issue.

	Total	Not on WIC		Unknown		Ever Received WIC Services	
		Count	%	Count	%	Count	%
Children	103	52	50.5%	0	0.0%	51	49.5%
Birth Parents	99	47	47.5%	4	4.0%	51	51.5%

Department of Mental Health and Addiction Services

The Connecticut Department of Mental Health and Addiction Services (DMHAS) is, according to its website, a recovery-oriented state and federally funded healthcare agency which promotes the overall health and wellness of persons with behavioral health needs through a network of statewide services which foster dignity, respect, and self-sufficiency.

OCA sought data from DMHAS to learn more about whether a parent of a child who died during the PUR was involved with a DMHAS-referred service at or near the time of the child’s death.

7.1% of birth mothers had received DMHAS services prior to or at the time of their child’s death.

Connecticut Judicial Branch Court Support Services Division

The Judicial Branch Court Support Services Division (JB-CSSD) oversees pretrial services, family services, divorce and domestic violence services for people that are court-involved, and probation supervision of adults and juveniles. JB-CSSD also administers a network of statewide contracted community providers that deliver treatment and other support services to individuals who are court-involved.

OCA sought data from JB-CSSD to learn more about whether a parent of a child who died during the PUR was involved with a CSSD-referred or mandated service at or near the time of the child’s death.

¹⁵ WIC 2019 Eligibility and Coverage Rates, published by the U.S. Department of Agriculture Food and Nutrition Service, found on the web at <https://www.fns.usda.gov/wic/2019-eligibility-coverage-rates> (last accessed July 18, 2023).

¹⁶ Id.

JB-CSSD Service	Count	%
Birth mothers with the Judicial Branch involvement (Total)	13	12.6%
Birth mothers involved in a substance use treatment program	5	4.8%
Birth mothers involved with Adult Probation	6	5.8%
Birth mothers involved with Family Court	4	3.9%
Birth mothers involved with Adult Bail	4	3.9%

OCA subsequently sought information from JB-CSSD regarding whether any of the DCF-substantiated caregivers in the infant-toddler homicide cases were involved with mandated CSSD supervision (pretrial or probation) and/or a JB-CSSD referred or mandated service at the time of the child's death. Of the 14 child homicides during the PUR, 3 of the substantiated caregivers were involved with JB-CSSD supervision at the time of the child's death: one individual was on probation, one individual was on pretrial supervision (bail), and one individual was involved with family services. Two of the three homicides were related to the child's ingestion of Fentanyl, the third a result of physical abuse (caregiver was involved with family services).

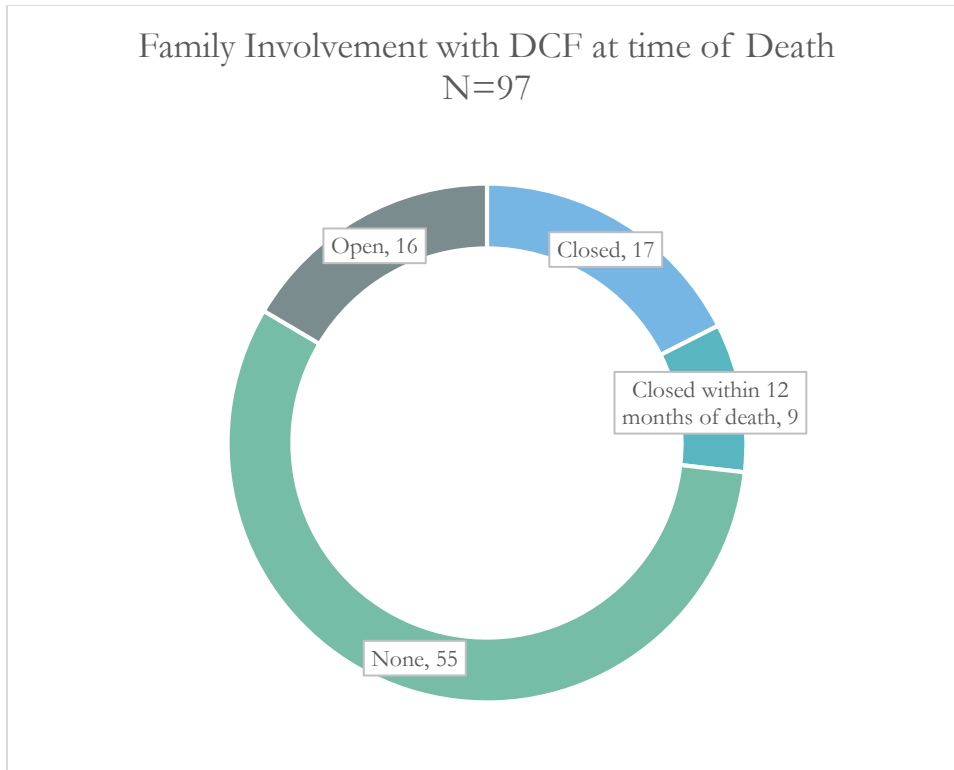
Department of Children and Families

DCF is CT's child welfare agency, responsible for child protective services and for ensuring a continuum of mental health services are available to Connecticut's children.

Research has found that a prior report to CPS was the strongest independent risk factor for injury mortality for children in the first five years of life out of all the risk factors studied.¹⁷ Research also demonstrates that a prior report is another significant predictor of SUID.¹⁸

¹⁷ Putnam-Hornstein, E. (2011). Report of Maltreatment as a Risk Factor for Injury death. *Child Maltreatment*, 16(3), 163-174.

¹⁸ Putnam-Hornstein, et al. (2014) A Prospective Study of Sudden Unexpected Infant Death after Reported Maltreatment. *The Journal of Pediatrics*, Vol. 64, No. 1, 142- 148.

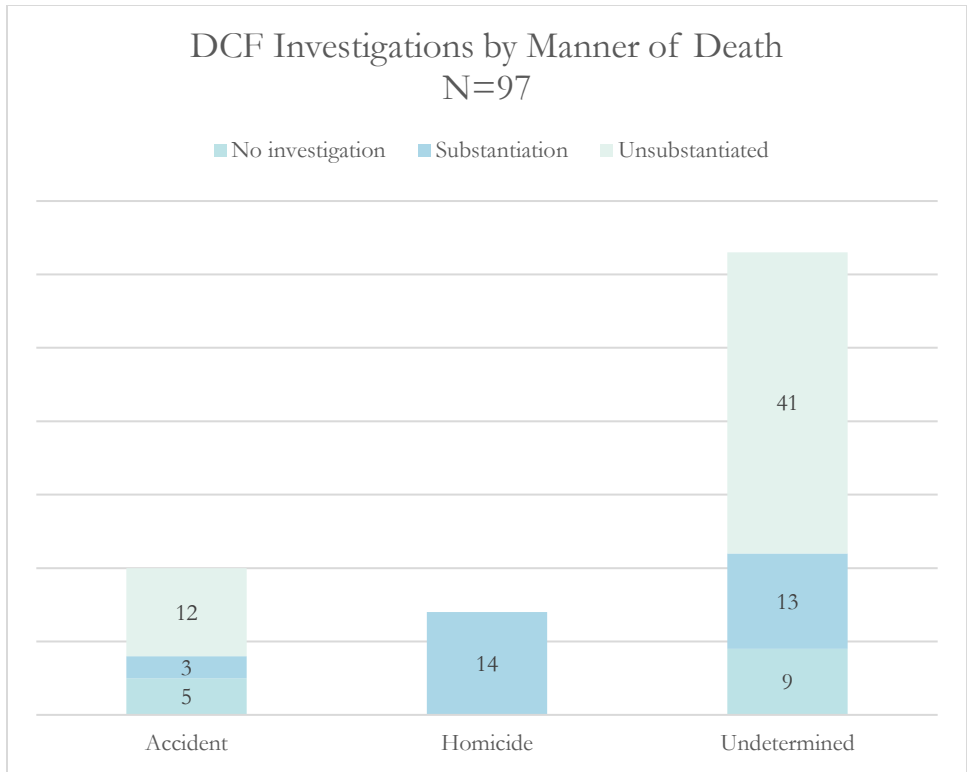


Twenty-five (25.8%) children who died lived in families that had an open case with DCF at the time of the child’s death or had an open case in the previous 12 months. DCF involvement addressed concerns about the infant/toddler and/or concerns about other children in the household.¹⁹ This is a slight decrease from a previous 3.5-year period, during which closer to 28% of infants and toddlers who died lived in families with an open case or a case closed within 12 months of the child’s death.

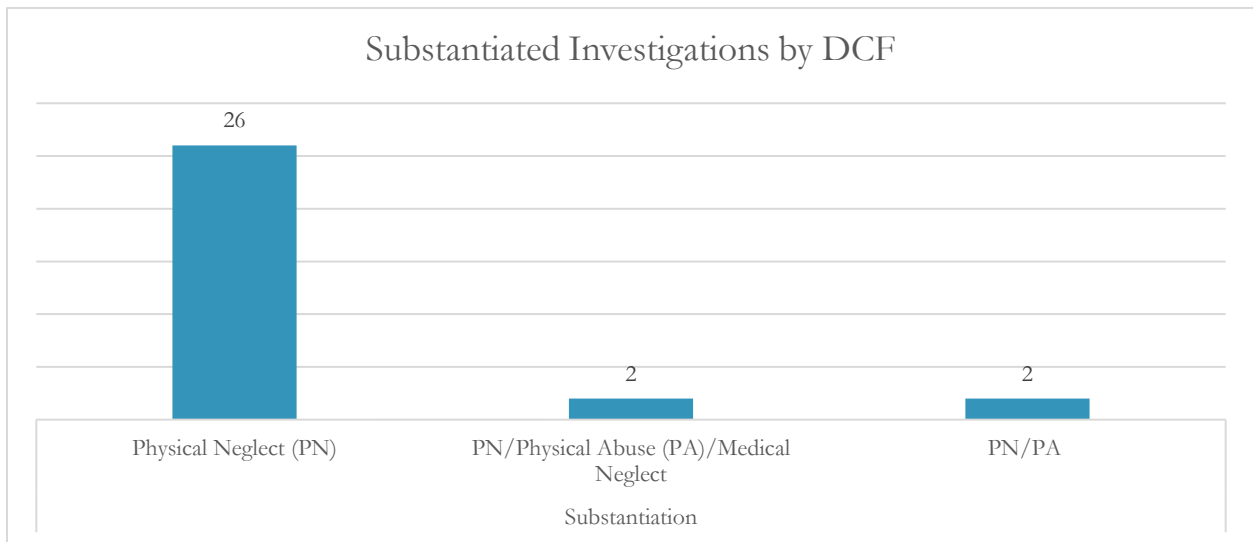
DCF investigated 83 of the 97 (86.6%) infant/toddler fatalities. OCA is not able to definitively establish how many of the fatalities were called into DCF by mandated reporters but were not accepted for investigation, due to the expungement of certain non-accepted reports within 2 years.²⁰ Not all non-Natural deaths are called in to DCF for investigation absent a clear suspicion of abuse or neglect of the child.

¹⁹ Of the families that had previous DCF involvement, but whose cases were closed at the time of a child’s subsequent death (N=26), 6 were involved after the birth of the decedent (DCF involvement included the deceased, the remaining intakes were closed prior to the birth). 16 of the 30 substantiated caregivers had previous DCF involvement (53.3%), with 6 cases open at the time of child’s death (20%), 4 closed within 12 months of the child’s death, and the remaining closed more than 12 months prior to the child’s death.

²⁰ Per DCF practice, a non-accepted report will be expunged within 24 months if there is no prior or ensuing accepted report.



- Of the 83 child fatalities investigated, 30 (36.1%) led to a DCF substantiation for child maltreatment. DCF substantiations documented concerns regarding inadequate supervision, conditions injurious to the child’s wellbeing, and most frequently, action/inaction leading to death. Multiple substantiations were based solely on the unsafe sleep environment provided by the caregiver, such as co-sleeping, with an absence of any other noted abuse or neglect concerns (seen more frequently in cases already open with DCF or recently open with DCF). Notably there were other investigations conducted where unsafe sleep risk factors were documented but where DCF did not substantiate allegations against the caregiver.



- 16 of the 30 substantiated caregivers had previous DCF involvement (53.3%), with 6 cases open at the time of child's death (20%), 4 closed within 12 months prior to the child's death, and the remaining 6 closed more than 12 months prior to the child's death.
- Of the infant/toddler Homicide cases, 3 of the family's cases were open at the time of the child's death. Two of those 3 were a result of Fentanyl intoxication.
- 67 of the 77 cases where unsafe sleep environments were identified were investigated by DCF.

Related state agency data from DPH: PRAMS (general population)

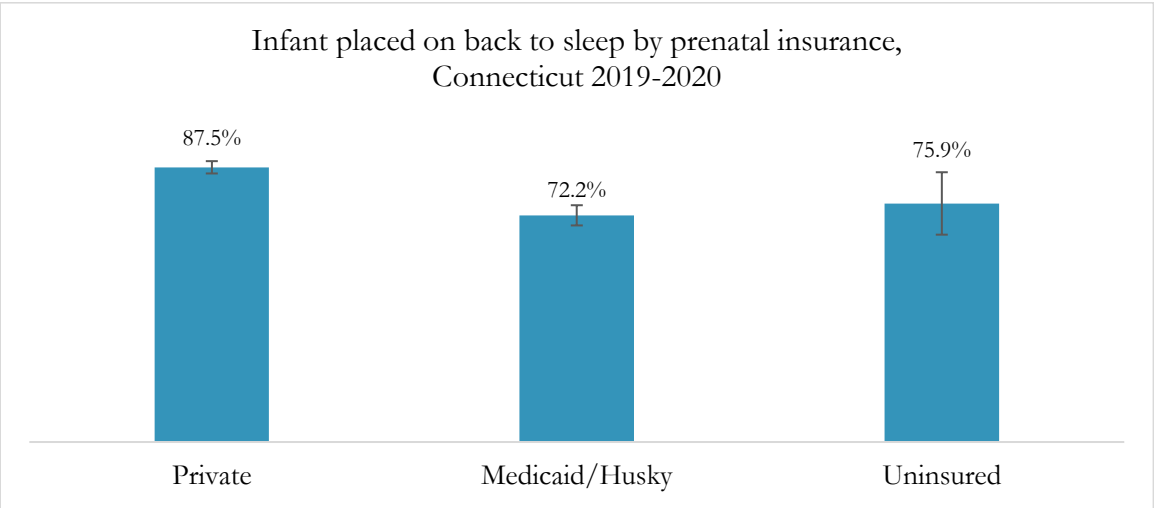
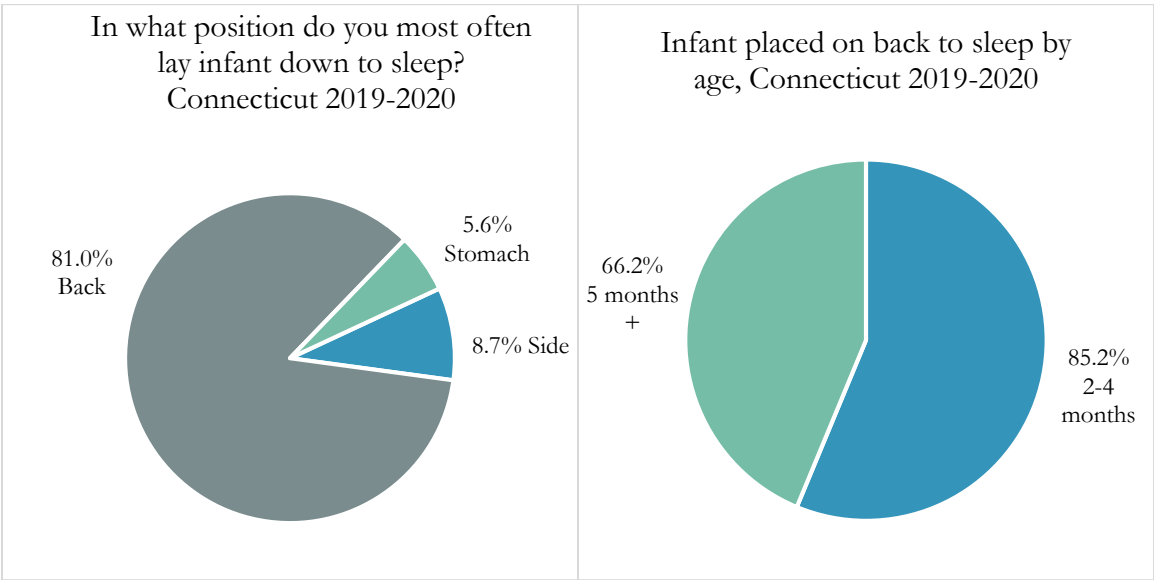
In the development of this Report, and due to the relatively large number of preventable deaths each year where the Medical Examiner makes a finding that the infant was found in an unsafe sleep environment (e.g., co-sleeping, sleeping on an adult bed, sleeping prone), OCA reviewed data from the Connecticut Department of Public Health's PRAMS Survey. According to the Department of Public Health website:

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a project of the Connecticut Department of Public Health and the federal U.S. Centers for Disease Control and Prevention (CDC). PRAMS collects information, voluntarily provided, on maternal attitudes and experiences before, during, and shortly after pregnancy from a sample of postpartum women in the state. Information from PRAMS is used to help plan better health programs for Connecticut mothers and infants. The goal of the PRAMS project is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant death.²¹

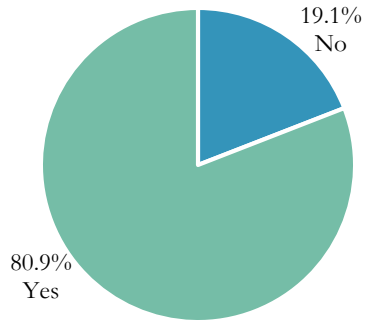
Below (pages 21-23) are some of the relevant survey questions and answers from the Connecticut PRAMS data. The figures and information below are consistent with data from around the country that maternal/caregiver practices regarding infant sleep vary to some degree by age, race/ethnicity, and public/private insured status.

The PRAMS data overall indicates that most caregivers place younger infants on their backs to sleep (more than 80% of infants who are between 2 and 4 months of age), and most infants sleep in the same room as their mother/caregiver. Responses show that caregivers do not consistently use an approved sleep surface for their children, and that many children are still placed to sleep with soft objects (toys e.g.), loose bedding, or bumpers in their sleep space. Infants who receive Medicaid were less likely to be placed to sleep on their backs than infants who have private insurance coverage. While the majority of caregivers report placing their infants to sleep on their backs, less than two-thirds (60.7%) of non-Hispanic Black caregivers did. Overall, the data shows that oftentimes infants are not using approved sleep spaces, may be co-sleeping with a caregiver, and have other risk factors associated with their sleep environment.

²¹ Connecticut Department of Public Health: Connecticut Pregnant Risk Assessment Monitoring System. Description found on the web: <https://portal.ct.gov/dph/Family-Health/Pregnancy-Risk-Assessment-Monitor-System/Connecticut-Pregnancy-Risk-Assessment-Monitoring-System-PRAMS>



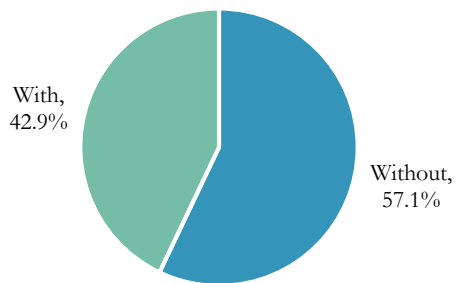
Infant slept in same room as mother, Connecticut 2019-2020



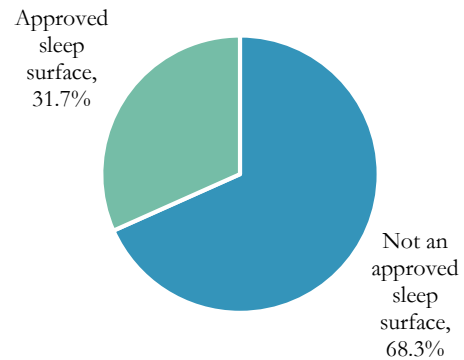
Infant slept in same room as mother, without bed sharing, Connecticut 2019-2020



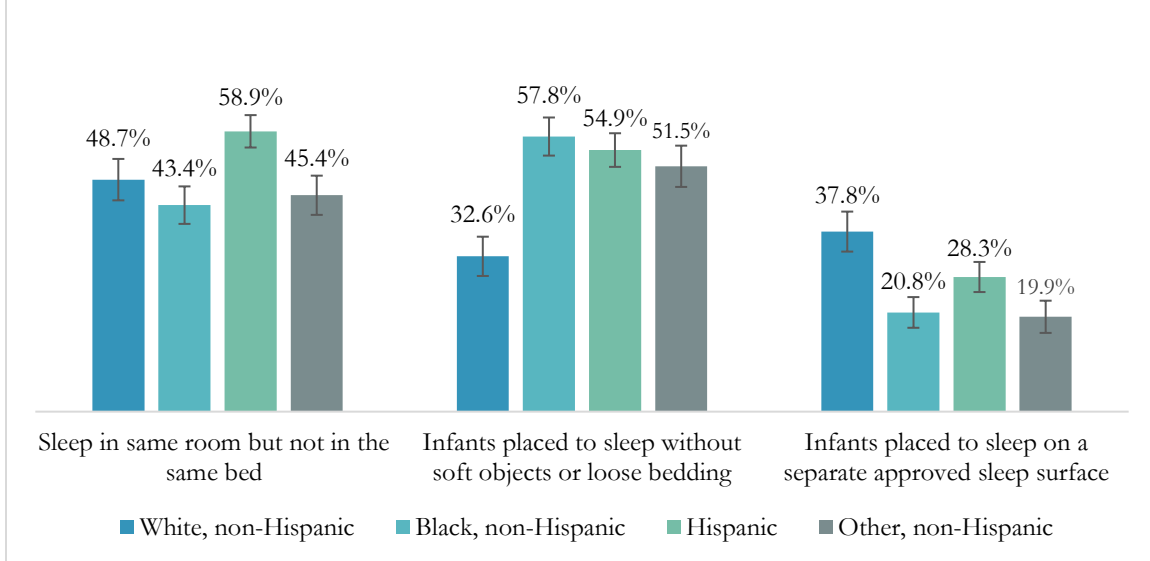
Infants Placed to Sleep without Soft Objects or Loose Bedding, Connecticut 2019-2020



Infants Placed to Sleep on a Separate Approved Sleep Surface, Connecticut 2019-2020



American Academy of Pediatrics Sleep Guidelines, Connecticut 2019-2020



Hispanic mothers were significantly more likely than all other Race/Ethnicities to have their infants sleep in the room with them, but not in their same bed.

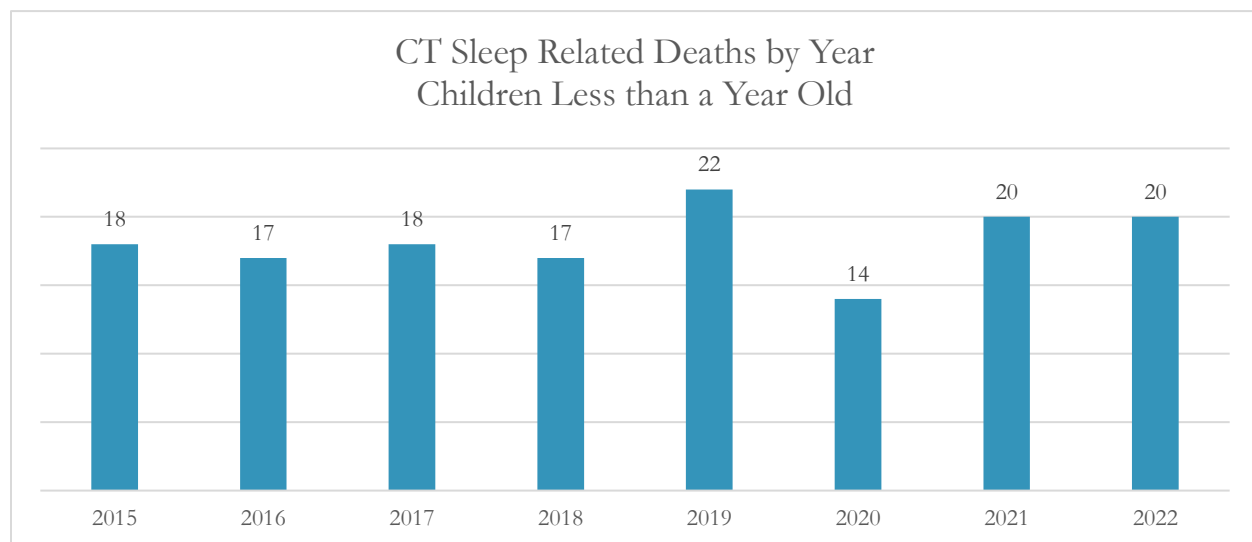
Non-Hispanic White mothers were significantly more likely than all other Race/Ethnicities to place their infants to sleep with soft objects or loose bedding.

Non-Hispanic White mothers were significantly more likely than all other Race/Ethnicities to place their infants to sleep on a separate approved sleep surface, however only 37.8% of non-Hispanic White mothers are doing this.

Discussion

Infants are most vulnerable to preventable death.

Over the last decade, OCA, in consultation or in partnership with the Child Fatality Review Panel (CFRP), has published multiple public health Reports, analyses, and an in-depth report regarding the preventable deaths of infants and toddlers in Connecticut. A review of those prior reports confirms that infants younger than 12 months old are at the greatest risk for preventable death.



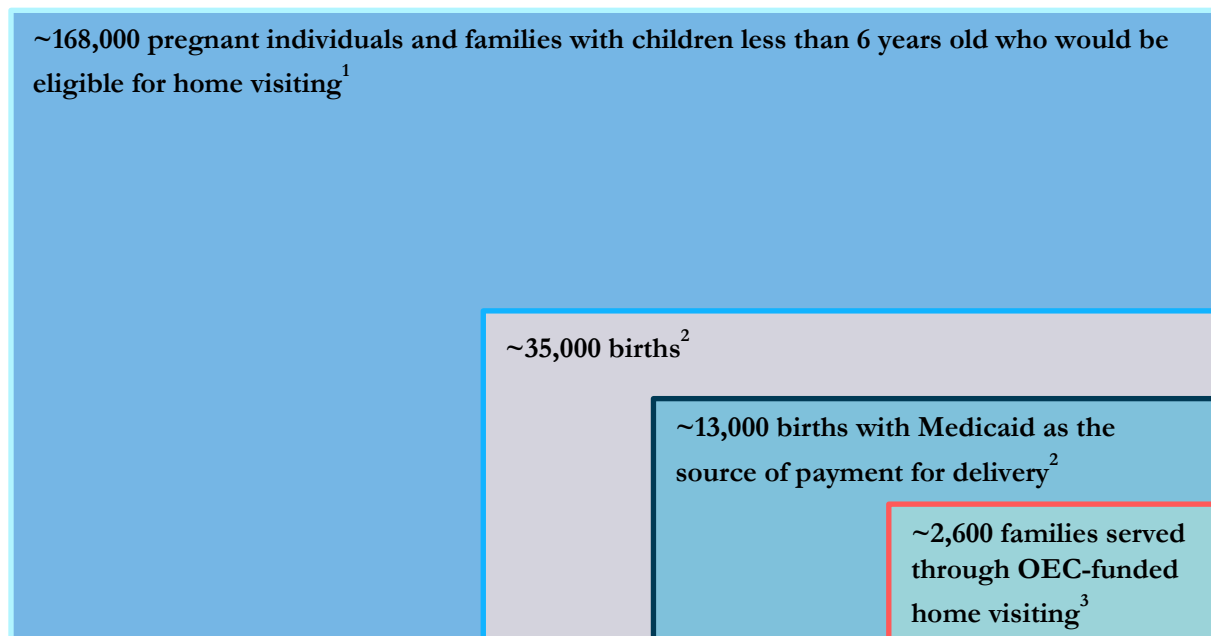
Majority of infants and toddlers who died during the PUR were low-income—more work needed to address unmet infant/toddler and caregiver needs.

More than 80 percent of infants and toddlers that died during the PUR were Medicaid eligible. Just under half of all the children were receiving WIC (nutrition) benefits. Multi-state research has shown that the WIC program plays an important role in improving birth outcomes and containing health care costs, including supporting longer pregnancies, preventing premature birth and low-birth weight infants, and decreasing infant fatalities.²² Given WIC's paramount importance to the health and wellbeing of infants, it is essential to close the benefits gap seen in this Report's data. State administrators meeting with OCA acknowledged the gap and indicated that they are working to address it in multiple ways, including participating in the development of Connecticut's health service portal, Health.CT.gov, and exploring the feasibility of automating outreach to families when a child is born that receives Medicaid. Currently there is no automated process for enrolling eligible pregnant women and/or infants in WIC benefits, either following a prenatal healthcare appointment or an infant medical care episode, including the baby's birth. Automating outreach requires sharing personally identifiable data between agencies, which is protected by State and Federal confidentiality rules and can be a challenge to navigate. Efforts to automate this system as much as possible and

²² U.S. Department of Agriculture Food and Nutrition Service *About WIC: How WIC Helps*, found on the web at: <https://www.fns.usda.gov/wic/about-wic-how-wic-helps>; see also Carlson, S., Neuberger, Z., *WIC Works: Addressing the Nutrition and Health Needs of Low-Income Families for More Than Four Decades*, Center on Budget and Policy Priorities (Jan. 2021).

ensure that all eligible pregnant women and children are enrolled in nutrition support are an important aspect of the state’s child fatality prevention efforts.

Data also indicated that few children and/or caregivers were receiving home visiting services or subsidized childcare benefits funded or administered by the Office of Early Childhood at the time of the child’s death. Research has shown positive impacts of home-visiting programs²³ and recent analysis in North Carolina showed that universal home visiting interventions reduced racial/ethnic disparities in maternal and infant health and wellbeing.²⁴ The Office of Early Childhood has been advocating and taking steps in recent years to develop a state-wide universal home visiting program. The agency has assessed the need for home visiting as greatly exceeding the capacity of current programs.²⁵



Less than 2% of eligible families receive home visiting through CT OEC

Note: Visuals not to scale and numbers rounded to the nearest thousand

1. [2022 National Home Visiting Resource Center Connecticut Profile](#)
2. [2021 records from the CT Department of Public Health](#)
3. 2022 information from CT OEC’s Early Childhood Information System (ECIS) received in January 2023

It will be essential to increase investments in a continuum of home visiting supports, including clinical interventions like Child First,²⁶ that work with the parent/caregiver and child from birth or even during

²³ Dodge, K., Goodman, W., (Nov. 2013), Randomized Controlled Trial of Universal Postnatal Nurse Home Visiting, *Pediatrics* Vol. 132(2), 140-146, finding nurse home visiting showed improved population-level infant health outcomes for the first twelve months of life.

²⁴ Dodge, K., Goodman, W., (Aug. 2022) Impact of a Universal Perinatal Home-Visiting Program on Reduction in Race Disparities in Maternal and Child Health: Two Randomized Controlled Trials and a Field Quasi-Experiment, *The Lancet* Vol. 15/100356.

²⁵ CT OEC & Social Finance, Rate Card Overview, May 2023.

²⁶ Child First is a national, evidence-based, two-generation model that works with very challenged young children and families, providing intensive, mental-health, home-visiting services. It works to connect families

pregnancy when a parent or child has a clinical treatment need. There remain concerns about capacity at all levels of community-based care for parents with very young children. In March of 2022, Child First reported more than 200 families on its waiting list and is facing additional budget cuts.²⁷

Notably while most of the children who died were Medicaid eligible, few of the families were receiving subsidized childcare benefits. While not necessarily connected to the low number of benefit recipients in this group, it is well documented that the state has a serious shortage of infant-toddler childcare settings,²⁸ and much work remains to strengthen this essential service system as well. Lack of childcare is frequently reported as a stressor by families, and addressing this need will be an important aspect of the state's efforts to improve supports for children and families.

New program focuses on helping young families succeed and thrive.

Young families in Greater Bridgeport have a new option for holistic and culturally informed support services, thanks to an expanded program offered by The Child & Family Guidance Center (CFGC) and funded through Connecticut's Office of Early Childhood (OEC). The Greater Bridgeport Home Visiting Partnership (GBHVP) — funded through a grant from OEC — builds upon existing home visiting services for the Greater Bridgeport area, specifically focused on at-risk parents of children 5 and under, parents under age 20, parents in the prenatal stage, and women at risk for poor birth outcomes. CFGC is leading the program, in collaboration with a partner team at Bridgeport Hospital. GBHVP's teams utilize two evidence-based models in working with families: Healthy Families America and Parents as Teachers. In addition to offering weekly home visits to families, case management and monthly parent groups, GBHVP includes the addition of a fatherhood home visitor and offers prenatal and postpartum mothers the option of working with a doula through Connecticut Community Doulas. Doulas are trained in providing emotional, informational, and physical support during pregnancy, birth and the immediate postpartum period — giving new or inexperienced mothers with limited resources both guidance and an extra set of hands.²⁹

New strategies needed to prevent infant deaths associated with unsafe sleep conditions— racial/ethnic disproportionality must be meaningfully addressed.

This fatality review confirms that unsafe sleep environment factors are typically present in almost all cases of infant SUID deaths or fatalities from accidental positional asphyxia. While there is variability

to needed community-based services to decrease stress, and build strong, loving, parent-child relationships that protect and heal the brain from trauma and stress. <https://www.childfirst.org/>

²⁷ Child First Connecticut email the OCA, March 2023, on file with OCA.

²⁸ “In March 2022, the Office of Early Childhood reported a shortage of 50,000 infant and toddler slots across the state. And according to data from the agency, about 660 childcare providers shut their doors between early 2020 and today and 560 opened — a net difference of 100 fewer childcare businesses across the state.” Emilia Otte, Connecticut Examiner, *As Demand for Childcare Grows, Connecticut Struggles to Balance Affordability, Competitive Pay for Workers* (Nov. 7, 2022), found on the web at: [As Demand for Childcare Grows, Connecticut Struggles to Balance Affordability, Competitive Pay for Workers - CT Examiner](#).

²⁹ The Child & Family Guidance Center *New Program Focuses on Helping Young Families Succeed and Thrive*, found on the web at:

<http://cfguidance.com/wp-content/uploads/GBHVP-Press-Release.pdf?eType=EmailBlastContent&eId=c6919ee2-99ae-45b0-b885-ce587676e11b> (last accessed June 14, 2023).

in data from year to year, the state has not seen a meaningful decline in the number of children who die in an unsafe sleep environment.³⁰ DPH survey data reveals that only 65.8% of mothers 8 weeks post-partum reported placing their infants alone in a crib for sleep. Like most national studies, Black infants have had a disproportionate rate of fatality from SUID. National recent research shows that rates of sudden unexpected infant death among Black infants rose in 2020, making the rate of SUID deaths for Black infants nearly three times as high as for White infants.³¹

The stubborn persistence of preventable deaths and the recent increase nationally in the rate of preventable SUID deaths for Black infants strongly suggest new approaches are needed to address infant fatalities. In a recent article in *Pediatrics* (Apr. 2023) authors posit:

These disparities are likely multifactorial, reflecting poverty levels, lack of access to prenatal and well-child care, and education regarding safe sleep and other practices, including the feeding of human milk, which can reduce the risk of SUID, and social norms related to these practices that vary between communities.³²

Researchers suggest new strategies may include revised messaging (some researchers recently recommended modifying messaging to address the risk of “suffocation,” as it is easier for caregivers to visualize the impact of soft bedding or prone sleeping); incorporation of community health workers/peer supporters, and other credible messengers into a fatality prevention campaigns; and state and local strategies that expand supports for pregnant and parenting caregivers.

In contrast to many middle- and high-income countries, the United States lacks large-scale support for families, including but not limited to lactation assistance to increase human milk feeding rates, home visiting programs to support families in their home and help identify and address unsafe sleep conditions, and support for maternal mental health, particularly in the postpartum period. [United States’] lack of guaranteed paid family leave means that parents may be forced to stop human milk feeding before they would like, parents are more desperate for nighttime sleep and thus, may turn to less safe sleep practices, and infants are often cared for by a variety of caregivers, not all of whom are adequately educated on safe sleep practices.³³

Importantly, research repeatedly confirms that beyond the sleep environment itself (i.e. bed sharing, sleeping prone, sleeping with pillows or blankets) that other intrinsic and extrinsic risk factors such as low birth weight, being small for gestational age, lack of regular medical care during pregnancy, and being unvaccinated, increase an infant’s risk for SUID.³⁴ Research also identifies protective factors

³⁰ See Annual Reports of the Office of the Child Advocate, containing annual child fatality data by manner of death, by year. <https://portal.ct.gov/OCA/OCA-Annual-Report/Recent-Annual-Reports>.

³¹ Carrie Shapiro-Mendoza, PhD, MPH; Kate Woodworth, MD, MPH, et al. Sudden Unexpected Infant Deaths: 2015-2020; *Pediatrics*. Vol. 151, Issue 4 (April 2023).

³² Carlin RF, Hauck FR, Moon RY. Increasing Disparities in Sudden Unexpected Infant Deaths Reflect Societal Failures. *Pediatrics*. 2023;151(4): e2022060798

³³ *Id.*

³⁴ National Institute of Health, *About Safe Sleep for Babies: What Are the Known Risk Factors*, found on the web at: <https://safetosleep.nichd.nih.gov/about/risk-factors> (last accessed July 3, 2023).

such as breastfeeding, room sharing (not synonymous with co-sleeping), and pacifier use can reduce the risk of SUID.³⁵

Research also shows that tobacco exposure during pregnancy is a substantial risk factor for SUID.³⁶ “[A]ny drug exposure during pregnancy, including alcohol, is associated with an increased risk for SUID.”³⁷ Connecticut has been working for several years to improve the health and well-being of substance exposed infants.

The Substance Exposed Pregnancy Initiative of Connecticut, SEPI-CT (funded by DCF and DMHAS) has been working to strengthen capacity at the community, provider, and systems levels to improve the health and well-being of infants born substance-exposed through supporting the recovery of pregnant women, caretakers, and their families. One of the areas of focus of SEPI-CT is to support federally required Child Abuse Prevention and Treatment Act (CAPTA) implementation.³⁸ CAPTA requires that Connecticut hospitals submit a notification to the state’s CAPTA Notification Portal (managed by DCF) when an infant with prenatal substance exposure is born. Notifications to the portal are de-identified. A CAPTA notification must also include information that a Family Care Plan (FCP, formerly referred to as a Plan of Safe Care) was verified or developed post birth. The FCP is a document that outlines the supports that will help a pregnant or parenting individual to identify current or ongoing areas of need and to then connect with these services/supports. The FCP is ideally developed by the pregnant person and a trusted provider or support person as early as possible during the pregnancy. The FCP template has evolved subsequent to include additional categories such as “secure/safe storage” of medications/substances. Caregivers are encouraged to use lock boxes, lock bags and other harm reduction strategies to prevent access to and ingestion of Fentanyl and

³⁵ Id.

³⁶ Konstat-Korzenny E, Cohen-Welch A, Fonseca-Portilla R, Morgenstern-Kaplan D. Sudden Unexpected Infant Death: Review and Analysis of Adherence to Recommendations. *Cureus*. 2019 Nov 5;11(11):e6076. doi: 10.7759/cureus.6076. PMID: 31832293; PMCID: PMC6892570.

³⁷ Id.

³⁸ According to Childwelfare.gov, “[t]o receive Child Abuse Prevention and Treatment Act (CAPTA) funds, States are required to ensure that they operate programs relating to child abuse and neglect that include the following: Policies and procedures (including appropriate referrals to child protection services systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder (FASD), including a requirement that health-care providers involved in the delivery or care of such infants notify the child protective services (CPS) system of the occurrence of such condition of such infants; [and] The development of a plan of safe care (POSC) for infants born and identified as being affected by substance abuse or withdrawal symptoms or FASD to ensure the safety and well-being of such infant following his or her release from the care of health-care providers, including through addressing the health and substance use disorder treatment needs of the infants and affected family or caregivers.” *Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families*. Child Welfare Information Gateway, Administration for Children & Families, a division of the U.S. Department of Health and Human Services, found on the web at: <https://www.childwelfare.gov/pubPDFs/safecare.pdf>.

other prescription and illicit substances that may be in the home.³⁹ If there is a suspicion of abuse/neglect of the infant or other children in the home, a report must still be made to the DCF Careline pursuant to mandated reporter requirements.

Research regarding risk factors for SUID and the persistent findings in fatality data have significant implications for public policy regarding supports for caregivers and their children, including those that increase parent/child supports, access to medical and prenatal care, and services that reduce chronic stress for caregivers who are pregnant or who have young children. Such services can include provision of home visiting, health care supports to pregnant and parenting caregivers, access to childcare, provision of family/medical leave support and other income/stabilizing supports, and widespread access to family-centered, gender-responsive substance use treatment and tobacco cessation services. Notably, the US has one of the highest SUID rates of all high- and middle-income countries worldwide.⁴⁰ While Connecticut has a lower SUID rate than the US in general, we still have not made meaningful progress in this state to reducing preventable deaths among young children over the past decade. As one recent article in the journal *Pediatrics* put it:

These latest [national] data about the SUID rates during the first year of the COVID-19 pandemic reflect our societal failures. ... [T]he findings regarding increasing disparities sound the alarm about the need for interventions that look beyond individual counseling and toward community- and society-level solutions. All infants deserve a better start in life than we in the United States are providing to them now.⁴¹

Fentanyl deaths and critical injuries implicate heightened need for two-generational strategies to address the opioid epidemic.

Fentanyl ingestion is the latest risk/safety concern impacting infants and toddlers.⁴² In Connecticut, as in many other states, 2012-13 marked the beginning of a staggering rise in adult opioid related overdose deaths.⁴³ Connecticut saw a more than 300% increase in adult overdose deaths between 2012 and 2021.⁴⁴ Over the last several years, more than 80% of all overdose fatalities were due to Fentanyl. In Connecticut, as in other states, children became a victim of this public health crisis. State public health data indicates that over 110 newborns a year are exposed in utero to non-prescribed opioids.⁴⁵

During the PUR, there were 8 infant-toddler fatalities due to Fentanyl ingestion, and there were nearly 3 times as many near-fatalities due to suspected Fentanyl/opioid ingestion of young children. A recent article in the *Journal of American Medicine (JAMA)* cites a 30-fold increase across the country in

³⁹ Authors attribute language in this summary to DMHAS.

⁴⁰ Taylor BJ, Garstang J, Engelberts A., et al. International comparison of sudden unexpected death in infancy rates using a newly proposed set of cause-of-death codes. *Arch Dis Child.* 2015;100(11): 1018-1023.

⁴¹ *Supra* n. 31.

⁴² Gaither JR. National Trends in Pediatric Deaths From Fentanyl, 1999-2021. *JAMA Peds.* Published online May 08, 2023. doi:10.1001/jamapediatrics.2023.0793.

⁴³ Connecticut Department of Public Health, Opioid and Drug Overdose Statistics, found on the web at: <https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/The-Office-of-Injury-Prevention/Opioid-and-Drug-Overdose-Statistics> (last accessed July 18, 2023).

⁴⁴ *Id.*

⁴⁵ Per DCF CAPTA Notification Portal Data.

pediatric deaths from Fentanyl between 2013 and 2021, with a six-fold increase in deaths of children under 5 between 2018 and 2021.⁴⁶ Authors cite the need for “common sense” solutions, emphasizing harm reduction strategies, including increasing access to Naloxone in people’s homes.

According to the U.S. Centers for Disease Control:

Naloxone is a life-saving medication that can reverse an overdose from opioids—including heroin, Fentanyl, and prescription opioid medications—when given in time. Naloxone is easy to use and small to carry. There are two forms of naloxone that anyone can use without medical training or authorization: prefilled nasal spray and injectable... Both are safe, effective, and can help save a life.

Carrying Naloxone is no different than carrying an epinephrine auto-injector (commonly known by the brand name EpiPen) for someone with allergies. It simply provides an extra layer of protection for those at a higher risk for overdose.⁴⁷

While the precise mechanism of injury to the children who died in Connecticut or were critically injured in Connecticut remains unknown, it is reasonable to assume that young children may come into contact with substances/baggies/patches that contain Fentanyl and ingest the substance through hand-to-mouth or object-to-mouth behavior. One health care provider shared with OCA that they had handled a couple of infant ingestion cases where an adult had cleaned or mixed substances in a water bottle cap and then the water was subsequently used to prepare infant formula. Hospital providers consulting with OCA in the development of this Report recommend that first responders, including ambulance/fire/police personnel, should not hesitate to administer Naloxone to children, including infants, in distress or sub-optimally responsive. Additionally, doctors recommended that standard hospital toxicology screens on children include Fentanyl, and that where a child presents with a possible ingestion that multiple administrations of Naloxone may be needed to support them. Researchers who analyzed multiple cases of young children that ingested Fentanyl recommended “there should be a low threshold for Fentanyl testing” on an infant-toddler with altered mental status or respiratory distress, and that such testing should be done even if there is no history offered for possible Fentanyl exposure.⁴⁸ Connecticut Hospital Association reported that a substantial number of emergency departments are now including Fentanyl in urine toxicology screens and efforts are ongoing to standardize this practice across the state.

While the impact of the opioid crisis on children is grave and creates safety concerns for children in certain caregiving situations, engaging with caregivers and offering services in a non-stigmatized way is essential for treating adults and promoting the health and welfare of children. Simultaneously it is essential that the child has a reliable and sober caregiver. Connecticut state agencies currently fund several harm reduction and treatment supports for caregivers and other individuals, including in-

⁴⁶ Supra n. 42.

⁴⁷ U.S. Centers for Disease Control, Lifesaving Naloxone, found on the web at <https://www.cdc.gov/stopoverdose/naloxone/index.html> (last accessed June 14, 2023).

⁴⁸ Slingsby B, Moore JL, Barron CE. Infant and Toddler Ingestion of Illicit Fentanyl: A Case Series. *Clinical Pediatrics*. 2019;58(13):1449-1451. doi:[10.1177/0009922819877870](https://doi.org/10.1177/0009922819877870). Researchers described multiple ingestion cases where caregivers offered no information about possible prescribed or non-prescribed opiates in the home.

patient and residential treatment, medication assisted treatment, and recovery coaches/care navigators.⁴⁹ Given the number of fatalities and near-fatal injuries to young children in recent years from suspected/established opioid ingestion, we must ensure that all caregivers, whether parents or household members with children, have timely access to essential services and collateral supports such as childcare, housing, and peer supports. It will be important to continuously update the state's analysis of caregiver needs and service availability and gaps in different regions of the state, and swiftly address presenting needs. This may be done as part of the progress monitoring of the State's Triennial State Substance Use Plan, with measures specific to two-generational needs assessment and service delivery.⁵⁰ This may require scaling up successful models of intervention, likely increasing Medicaid funding for certain substance abuse treatment services and ensuring that all services consider the needs of the family and the child, where applicable. The state's newly formed Opioid Settlement Committee should consider whether additional investments/strategies are needed to support infants exposed or at risk of exposure to opioids. The Department of Children and Families must also ensure, through rigorous quality assurance, that it is ensuring the safety of young children and timely connecting families to appropriate treatment and parenting supports.

Additionally, the state must continue to expand its Naloxone distribution efforts. Last year over fifty thousand kits (100,000 doses) of Naloxone were distributed statewide, exceeding the current saturation recommendation contained in a 2022 research report funded by the National Institute of Health.⁵¹ While Connecticut has been in the top ten of states for adult overdose deaths per 100,000 (as of 2021)⁵² the state did see a 4 % reduction in adult overdose deaths in 2022.⁵³ In March 2023, the Food and Drug Administration announced that Naloxone could be sold over the counter in local pharmacies. DMHAS funds many community providers' access to Naloxone. Effective July 1, 2023, all JB-CSSD Probation Officers will carry Naloxone, provided by DMHAS when conducting home visits. DCF told OCA that their workers do not currently carry Naloxone, but that they ask providers to help parents download the NORA App (NORA is a free app from DPH that includes information to prevent, treat, and report opioid overdose)⁵⁴ to their phones and that all social workers have also

⁴⁹ State of Connecticut, Department of Mental Health and Addiction Services Triennial State Substance Use Plan (2022), found on the web at: https://portal.ct.gov/-/media/DMHAS/EQMI/2022-Triennial-Report-FINAL_11723.pdf. See also Department of Mental Health and Addiction Services, Opioid Crisis Response: What's Working in CT? Presentation to the Alcohol and Drug Policy Council (April 19, 2022), available on the web at: <https://portal.ct.gov/-/media/DMHAS/ADPC/Presentations/Whats-working-in-CT-ADPC-presentation-REV.pdf>.

⁵⁰ Id.

⁵¹ Irvine MA, Oller D, Boggis J, Bishop B, Coombs D, Wheeler E, Doe-Simkins M, Walley AY, Marshall BDL, Bratberg J, Green TC. Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. *Lancet Public Health*. 2022 Mar;7(3):e210-e218. doi: 10.1016/S2468-2667(21)00304-2. Epub 2022 Feb 10. PMID: 35151372.

⁵² KFF, Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted), found on the web at: [https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?activeTab=map¤tTimeframe=0&selectedDistributions=opioid-overdose-death-rate-age-adjusted&sortModel=%7B%22collId%22:%22Opioid%20Overdose%20Death%20Rate%20\(Age-Adjusted\)%22,%22sort%22:%22desc%22%7D](https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?activeTab=map¤tTimeframe=0&selectedDistributions=opioid-overdose-death-rate-age-adjusted&sortModel=%7B%22collId%22:%22Opioid%20Overdose%20Death%20Rate%20(Age-Adjusted)%22,%22sort%22:%22desc%22%7D) (last accessed June 14, 2023).

⁵³ *Supra*. n. 43.

⁵⁴ Connecticut Department of Public Health, Naloxone Overdose Response App, NORA Saves, found on the web at <https://egov.ct.gov/norasaves/#/HomePage> (last accessed June 14, 2023).

been asked to download the app and talk to parents about these resources. DCF stated that its Senior Advisory Board has been meeting for several months on Harm Reduction Strategies, Naloxone being one of the topics and that they will “continue to meet to determine strategies to address this area of need.”⁵⁵ In Connecticut, as around the country, most pediatric critical and fatal opioid ingestions happen at the child or caregiver’s home, therefore ensuring caregivers have access to Naloxone and know to administer it to a child and seek immediate medical attention, is critical to reduce child fatalities and near-fatality events.

Safe storage and harm reduction messaging remains critical for all providers, health care professionals, and state agency personnel working with adult caregivers of young children who have or live with someone who has a substance use disorder. DMHAS reported to OCA that it has worked with a vendor and developed a Secure Storage video that is being widely distributed for educational purposes for parents, caretakers, and others in our recovery communities.⁵⁶

Families with prior child welfare involvement have higher rate of subsequent child fatality from preventable causes—strong safety planning and robust services needed for higher need families with young children.

This Report’s data showed that a quarter of families who experienced a preventable child fatality during the PUR had an open case with DCF at the time of the child’s death or within the previous 12 months, though previous involvement did not always involve concerns regarding the child who later died. National research indicates that a prior report of alleged maltreatment of a child was the “strongest independent risk factor for injury mortality in the first five years of life out of all the risk factors studied.”⁵⁷ Research also shows that infants previously reported to child welfare also had a higher rate of SUID deaths, those deaths typically associated with an unsafe sleep environment, with a rate that “was more than 3 times higher than infants not reported [to child welfare services].”⁵⁸

Researchers question whether children who later died have risk factors that make them more vulnerable to a sudden, unexpected death such as prenatal alcohol or drug exposure, one of the main drivers of reports to child protective service agencies.⁵⁹ Researchers also question whether high risk infants live in families where there “remains a partial or lagged penetration of public health campaigns,” and where families “may have a concentration of both chronic and acute stressors that reduce adherence to safe-sleeping guidelines.”⁶⁰

Implications of this Report’s data regarding families’ prior or active child welfare agency involvement at the time of a child fatality are numerous and include ensuring strong DCF protocols for safety practice and robust service delivery to families with infants, both by DCF and state-local prevention agencies. In 2022 DCF implemented several new training initiatives aimed at strengthening safety

⁵⁵ Email from DCF Clinical Behavioral Health Director to the OCA, May, 2023.

⁵⁶ Email from DMHAS, July 10, 2023, on file with OCA.

⁵⁷ Putnam-Hornstein, E. (2011). Report of maltreatment as a risk factor for injury death. *Child Maltreatment*, 16(3), 163-174.

⁵⁸ *Supra.* n. 18 at 145.

⁵⁹ *Id.*

⁶⁰ *Id.* at 146.

planning for families, including addressing specific needs of caregivers with substance use disorder (including Fentanyl misuse) and their children. DCF recently reported to OCA that it was implementing a comprehensive quality assurance tool to assess the efficacy of its practice with “in-home” cases—cases that are opened for ongoing DCF supervision and where the child remains in the home—a critical development. It will be equally important to track whether these families are timely connected by DCF or its contracted providers to effective services, including treatment, parenting supports, in-home services, and need-based supports (housing, child-care) that will strengthen families’ capacity to safely care for their children. Identified gaps must be swiftly addressed through multi-agency strategic planning and requests for funding.

Caregivers touching the Judicial System may need parenting supports and safety planning.

Data showed that more than 12% of birth mothers whose infant or toddler died for non-Natural reasons during the PUR were involved with the Connecticut Judicial Branch Court Support Services Division at or near the time of the child’s death. Information further showed that three of the caregivers in child deaths deemed a homicide by the Medical Examiner were being served or supervised by JB-CSSD at the time of the child’s death—one individual on pretrial supervision (bail), one individual on Adult Probation, and one individual involved with Family Services.

This data highlights the importance of ensuring that agency staff engage with adults under supervision about their caregiving role and responsibilities to help determine whether additional services or interventions may be offered or needed to support the adult and/or the child. While various areas of JB-CSSD supervision and case management have different parameters and responsibilities, agency staff can play an important role in counseling adult caregivers regarding harm reduction and safety planning relevant to infants and other young children, and connecting adults to community-based support services, be they parenting support or substance use treatment. Ensuring that agency staff talk to individuals who are struggling with opioid use disorder or other substance use disorders about the need for safe storage of substances, including substances associated with medication assisted treatment, and the risk of even microscopic Fentanyl exposure for young children is critical. Agency staff should also assist individuals with accessing Naloxone and advising them to use Naloxone if they suspect an opioid ingestion in an infant, young child, or adolescent and to immediately seek medical attention.

Statewide fatality prevention/critical injury prevention plan needed.

Overall, the child fatality information supports the need for a comprehensive and coordinated approach at the state level to investment and delivery of services and support for caregivers and children. Researchers and maternal/infant health care providers are increasingly recommending societal solutions to support families in the first year of life, such as expanded paid family leave, increased access to high quality medical care for pregnant mothers and their children and universal home visiting, to name a few.⁶¹ Connecticut has taken strides on many of these issues in recent years,

⁶¹ Within our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, The Commission to Eliminate Child Abuse and Neglect Fatalities, Final Report (2016), found on the web at https://www.acf.hhs.gov/sites/default/files/documents/cb/cecanf_final_report.pdf; DL, Kitzman H, Knudtson MD, Anson E., Smith JA, Cole R. Effect of home visiting by nurses on maternal and child mortality:

including increasing home visiting slots, creating a family leave benefit, and expanding Medicaid coverage for prenatal and postpartum services. OEC, DCF, DSS and community providers are collaborating to implement a universal home visiting pilot in Bridgeport—Family Bridge—designed to be available to all families with newborns residing within a defined service area. Recent legislation requires the state to “within available appropriations, develop a state-wide program to offer universal nurse home visiting services to all families with newborns residing in the state to support parental health, healthy child development and strengthen families,” examining state, federal, and insurance funding streams to support the service.⁶²

Connecticut DSS is working to implement a health care payment model called a “maternity bundle,” which shifts paying for maternity care in HUSKY from a fee-for-service model to a bundled payment, including breastfeeding supports and doulas. The goal of the bundle is to promote health equity by addressing disparities of access, utilization, and outcomes for pregnant women.⁶³ Connecticut also recently passed legislation that will require DSS to design and implement Medicaid reimbursement for community health workers, who could play a critical role in engaging pregnant and parenting individuals with support services for them and their children. Ongoing coordinated analysis examining general population needs, service landscape/access/utilization, will be critical to scaling up supports for children and caregivers.

As of 2018, federal law requires that states describe a statewide comprehensive plan to prevent child maltreatment deaths.⁶⁴ While a minority of preventable deaths in Connecticut are maltreatment-related, a state plan to prevent such deaths will necessarily incorporate state and local, multi-agency strategies for supporting high risk infants and their caregivers. We must hold ourselves accountable for achieving progress in improving infant-toddler mortality and meaningfully addressing racial/ethnic disparities in child deaths.

Recommendations

- Revise/Strengthen State’s Safe Sleep Public Health Campaign
 - Strategically incorporate community-based service providers and credible messengers to support delivery of safe sleep messaging. Providers and messengers may include community health workers, peer supports, adult and family treatment providers, home visitors, state agency staff, and other family support workers.
 - Research into the reasons for why parents decide to bedshare in the first place and develop recommendations and strategies to support parents to make safer decisions as to where their infant sleeps.

results of a 2-decade follow-up of a randomized clinical trial. *JAMA Pediatr.* 2014 Sep;168 (9): 800-6. doi: 10.1001/jamapediatrics.2014.472.PMID:25003802; PMCID: PMC4235164. Prenatal and infant/toddler home visitation by nurses is a promising means of reducing all-cause mortality among mothers and preventable-cause mortality in their first-born children living in highly disadvantaged settings.

⁶² Public Act 23-147 *An Act Protecting Maternal Health*

⁶³ <https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle> (last accessed June 20, 2023).

⁶⁴ The Family First and Prevention Services Act (FFPSA) (2018), enacted as part of Public Law No: 115-123.

- Back of the bus campaign regarding safe sleep recommendations and available support.
 - Continue to expand support for paid family leave upon the birth/adoption of an infant so that parents don't have to work when they are sleep deprived with a young infant.
 - Explore feasibility of a feedback loop with birthing hospitals after the sleep-related death of an infant, to help support hospital quality assurance efforts regarding care and discharge planning.
 - Support 24-hour help lines for pregnant and parenting caregivers.
 - Strengthen supports for tobacco cessation efforts for pregnant and parenting caregivers.
- Strengthen Investment in Early Childhood Supports and Services
 - Continue to expand the continuum of care for young children, inclusive of prenatal support. Such continuum includes home visiting, clinical and healthcare services for caregivers with young children, childcare and childcare subsidies, housing/income support, peer and parenting supports, and care navigation/care coordination. Such expansion should be data driven and informed by a dynamic analysis of service need, access, and utilization. Progress towards addressing gaps in care should be continuously reviewed.
 - Expand WIC enrollment to close the gap between children who are Medicaid eligible and children who are receiving nutrition benefits. The state should continue to explore methods of automating enrollment and providing information to families about the importance and availability of WIC benefits in culturally and linguistically diverse methods, including use of social media. Efforts should continue to maximize enrollment of eligible caregivers prior to the child's birth.
 - Continue to strengthen child protective service practices and connections to care for families with infants and toddlers and corresponding quality assurance protocols specific to the safety, wellbeing, and service needs of this population.
 - Adult-serving agencies and their contracted partners should ensure assessment and engagement of adult caregivers who have young children to determine the need for parenting support services, and safety planning as applicable.
- Fentanyl Injury Prevention
 - Continue Naloxone saturation efforts with strategic attention to caregivers.
 - Expand messaging regarding safe storage of medications, in particular opioids.⁶⁵
 - Develop back of the bus-public health messaging on recognizing a child's possible exposure/overdose, that it is safe and may be necessary to administer Naloxone to an

⁶⁵ Public messaging campaigns such as this message from the Substance Exposed Pregnancy Initiative of Connecticut (<https://www.youtube.com/watch?v=TzFAUs7twPQ>), when widespread and strategically disseminated, can be essential tools in raising awareness about key issues such as keeping substances stored and away from young children.

infant, young child, or adolescent, and the importance of seeking immediate medical attention in case of accidental exposure.

- Ensure all first responders, including police/fire/ambulance personnel, are trained to administer Naloxone to non-responsive infants and toddlers or children in respiratory distress.
 - Support all adult and child serving state agencies and contracted partners to maintain Naloxone, help caregivers access Naloxone, and counsel caregivers regarding risk of accidental exposure to a child and how to respond.
 - The Connecticut Hospital Association can assist with further education in Emergency Departments about the importance of adding Fentanyl to standard toxicology screening practices, and that children rescued after Fentanyl exposure need multiple doses of Naloxone some hours after presentation (recurrence of respiratory depression after first dose of Naloxone wears off), and so children should be admitted for close monitoring and repeat administration of Naloxone given if needed, in consultation with a toxicologist and/or Connecticut Poison Control.
 - Continuously update the state's analysis of caregiver needs and two-generational service availability, and swiftly address any gaps and emerging needs in different regions of the state. This may require scaling up models of intervention, increasing Medicaid funding for certain substance abuse treatment services and ensuring that all services consider the needs of the family and the child, where applicable.
 - The state's newly formed Opioid Settlement Committee should consider whether additional investments and/or strategies are needed to support children exposed to or at risk of exposure to opioids.
 - Create a working group under the auspices of the state's Alcohol Drug and Policy Council to examine integration of scientifically-based substance use harm reduction strategies and child protection priorities, with the goal of strengthening best practice approaches for managing risk and safety in caregiver substance dependency cases.
- Infant-Toddler Fatality Prevention Summit and Statewide Plan
 - State agencies along with community service partners, and health care providers should convene a Summit to discuss implications from child fatality data and, where applicable and available, near-fatality data, to develop a coordinated statewide plan to prevent such injuries and deaths.
 - A statewide plan should be data-driven and incorporate feedback from state and local agencies, and families. It should include specific actionable strategies for service delivery and funding to address unmet human service, health, and safety needs of young children and caregivers. The plan should include outcome measures that will be tracked over time and a process for providing policymakers with ongoing recommendations to improve child health and wellbeing outcomes.
 - The statewide plan should specifically address the state's public health strategies for reducing deaths attributed to unsafe sleep environments and substance exposure.

Table 1:

2022 AAP Recommendations to reduce the risk of sleep-related death
<ul style="list-style-type: none"> • Back to sleep for every sleep.
<ul style="list-style-type: none"> • Use a firm, flat, non-inclined sleep surface to reduce the risk of suffocation or wedging/entrapment.
<ul style="list-style-type: none"> • Feeding of human milk is recommended because it is associated with a reduced risk of SUID.
<ul style="list-style-type: none"> • It is recommended that infants sleep in the parents’ room, close to the parents’ bed, but on a separate surface designed for infants, ideally for at least the first 6 months.
<ul style="list-style-type: none"> • Keep soft objects, such as pillows, pillow-like toys, quilts, comforters, mattress toppers, fur-like materials, away from the infant’s sleep area.
<ul style="list-style-type: none"> • Offering a pacifier at naptime and bedtime is recommended to reduce the risk of SUID.
<ul style="list-style-type: none"> • Avoid smoke and nicotine exposure during pregnancy and after birth.
<ul style="list-style-type: none"> • Avoid alcohol, marijuana, opioids, and illicit drug use during pregnancy and after birth.
<ul style="list-style-type: none"> • Avoid overheating and head covering in infants.
<ul style="list-style-type: none"> • It is recommended that pregnant people obtain regular prenatal care.
<ul style="list-style-type: none"> • It is recommended that infants be immunized in accordance with guidelines from the AAP and CDC.
<ul style="list-style-type: none"> • Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SUID.
<ul style="list-style-type: none"> • Supervised, awake tummy time is recommended to facilitate development and to minimize the risk of positional plagiocephaly
<ul style="list-style-type: none"> • It is essential that physicians, nonphysician clinicians, hospital staff, and childcare providers endorse and model safe infant sleep guidelines from the beginning of pregnancy.
<ul style="list-style-type: none"> • It is advised that media and manufacturers follow safe sleep guidelines in their messaging and advertising to promote safe sleep practices as the social norm.
<ul style="list-style-type: none"> • Continue the NICHD “Safe to Sleep” campaign, focusing on ways to reduce the risk of all sleep-related deaths. Pediatricians and other maternal and child health providers can serve as key promoters of the campaign messages.
<ul style="list-style-type: none"> • Avoid the use of commercial devices that are inconsistent with safe sleep recommendations.
<ul style="list-style-type: none"> • There is no evidence to recommend swaddling as a strategy to reduce the risk of SUID.