

**STATE OF CONNECTICUT  
OFFICE OF THE CHILD ADVOCATE  
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**PUBLIC INFORMATION BULLETIN REGARDING CHILD FATALITY REVIEW  
June 3, 2014**

The Office of the Child Advocate (OCA) has received many contacts from community members and the media regarding recent deaths of children receiving services or supervision from the Department of Children and Families. Callers often ask us how we will respond to the child's death. The purpose of this information bulletin is to provide a public response to the requests for information made to the OCA and a description of our current work and responsibilities related to child fatality review.

**Up to Date Information Regarding Child Fatalities in 2014**

- Between January 1, and May 31, 2014 at least 11 children whose deaths OCA received notification of lived in families that were involved with the Department of Children and Families at or near the time of the fatality.
- These families were also involved with multiple community and state systems, including health care, schools, mental health and the criminal justice system.
- Of the 11 DCF-involved children who died, OCA has identified 9 cases for further review.
- These children, mostly infants and toddlers, died from what appear to be a variety of causes, including a car accident, asphyxiation, possible unsafe sleeping conditions, and child abuse.
- At least two of the infants were allegedly killed by a caregiver.

These 9 children were among 60 child fatality notices that OCA received from the Office of the Chief Medical Examiner between January and May. Natural deaths (children who had life threatening illnesses due to medical complexities, special health care needs, and health complications associated with prematurity) account for 32 of the 60 death notices. None of the 9 cases referenced above have yet been determined as natural deaths.

**The Office of the Child Advocate's Responsibilities Regarding Child Fatality Review**

The Office of the Child Advocate is a statutory member and current co-chair of the state Child Fatality Review Panel (CFRP), which is responsible for reviewing all unexpected and unexplained deaths of children as well as the deaths of children placed in out-of-home care.

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- CFRP and OCA jointly issued an April, 2014 Public Health Alert regarding state child fatalities associated with unsafe sleep conditions for infants—the leading cause of preventable infant death in Connecticut.<sup>1</sup>
- OCA and CFRP will be issuing regular public health alerts regarding prevalent causes of child fatalities in our state and recommendations for prevention.
- OCA issues an annual report including a summary of child fatality data.
- OCA is also legally responsible for the evaluation of services provided to children by publicly funded agencies and conducts additional reviews where a child dies under state supervision.

### **Response to Concerns Raised With OCA Regarding Child Fatalities and DCF**

The 9 child deaths between January and May 2014 are under review by OCA as well as DCF.

The death of a child involved with DCF does not compel the conclusion that the death is the result of a systems failure or that more children should be removed from their homes when there are concerns of abuse or neglect. DCF, like many child welfare agencies across the country, is transforming its work with families to keep more children home by strengthening the family unit. Because a child dies in a home with an open DCF case does not mean that keeping families together, as a goal, is ill fated or undesirable.

Family preservation work necessitates tolerating more risk in the family unit. But the death of any child involved with state systems must be closely examined to determine how effective our safety net is for children. The transformation of DCF's practice has already included many positive changes, but also necessitate a rigorous and ongoing assessment of our state's *collective* ability to pursue the goals of family preservation in ways that do not undermine child safety. This vital work is often led by DCF, but is shared by many partners including other state and local agencies, pediatric providers, schools and community agencies.

### **OCA's Comprehensive Findings Regarding Child Fatalities to Be Published Soon**

OCA is currently finalizing an in-depth review of all 2013 deaths of children age birth to five that came to the attention of OCA and the State Medical Examiner. This upcoming report will include a comprehensive discussion, case examples, detailed findings, and additional recommendations for fatality prevention and systems reform.

As a lead-in to OCA's upcoming child fatality report, based on our direct advocacy on behalf of children and our participation in over 20 working-groups and taskforces related to supporting children and families, we recommend careful evaluation of our current capacity to preserve families and support child safety. This work belongs both to DCF and other state and local providers.

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<sup>1</sup> OCA's website: [http://www.ct.gov/oca/lib/oca/PublicHealthAlert\\_Safe\\_SleepApr\\_7\\_FINAL\\_\\_docx\\_%282%29.pdf](http://www.ct.gov/oca/lib/oca/PublicHealthAlert_Safe_SleepApr_7_FINAL__docx_%282%29.pdf)

As our child welfare system transforms its work with families, DCF is adding new staff and highly professionalizing its front line staff with higher credentialing standards and academic qualifications, while continuing to develop its quality assurance protocols and community service resources. DCF has recently implemented a new frontline supervision model and also partnered with the National Child Welfare Workforce Initiative to implement a professional development and performance management model for its middle and administrative management teams throughout the department.

The importance of workforce development and quality assurance for DCF and community providers cannot be overstated given the formidable challenges and profound risks some of our families present with. Effectively implemented, supported and strengthened, these efforts will be essential to ensuring the safety of children.

The following are areas for further consideration and development:

### **Workforce Development and Utilization is the Foundation for System Improvement**

- Many families coming to the attention of DCF struggle with substance abuse, mental health challenges and family violence.
- DCF should continuously inventory and report regarding its strategic plan for workforce development and utilization: high level of expertise must inform front line casework and supervision. Legislative and educational institutions will continue to be essential allies in this work.
- Case planning for families, particularly for our most at-risk children—babies and toddlers—should be accomplished through multi-disciplinary teaming, with frequent and rigorous review, particularly for children who remain in the home. The value of expanding DCF's Zero to Three Safe Babies Court Team model piloted in New Haven and Milford should be considered.
- We must bring to scale intensive parent-child supports that provide developmentally informed treatment.
- Expand efforts to ensure our child welfare staff and community service providers are adequately trained about the special needs of infants and toddlers and their heightened risk for mortality.

### **Quality Assurance Effectiveness and Capacity to Inform Operational Priorities**

- Quality Assurance (QA) should include routine case review and case sampling, using multidisciplinary teams and stakeholders from both the agency and the community to identify trends, problem areas and inform operational changes.
- Heightened QA protocols should be developed for infants and toddlers, including increased visitation and supervision requirements. Consideration should be given to mandating field observation/case work for supervisors and managers.
- QA reports should be public, including DCF's child death reviews.
- The legislature should hold an annual public hearing on child fatalities to review causes and prevention strategies and to determine resource allocation that will support children and families.

## **Data-driven Investment in Community Supports**

- Families struggling with multi-generational poverty, significant mental health needs, chronic substance abuse or domestic violence require sustained—not periodic or episodic—support. This reality has implications well beyond DCF's work with a family and speaks to the need for a "family strengthening" infrastructure in the community, supported and made possible through health care innovation.
- We must continue to inventory our community service needs to ensure we have the infrastructure to fully support family preservation work. We must support and further efforts to ensure that system building is coordinated through interagency, public-private efforts, is driven by data, and informed by program review and evaluation. Agencies are moving towards a “Results Based Accountability” framework. They must have the information technology and operational staff to fully implement this effort.

## **Systems Must Talk to Each Other**

- Too many times when a death is examined, we lament that nobody "connected the dots." In hindsight, we may see or find out from another source that many red flags existed for a child or family-- trouble in school, police involvement, or concerns of a pediatrician or other community provider that were not heard, sought or even reported in some cases.
- We must continue to improve quality information sharing between state and local agencies and public health providers, ensure mandatory reporting compliance and compensate professionals for consultation and care coordination efforts.

Nationwide family preservation is the direction of child welfare practice, and it is a shift based on experience, education and evidence. It is nearly impossible for a state to create a complete infrastructure to replace children's families. The preventable deaths of infants and toddlers, even where deaths are accidental, compel us to sound an alarm and review the effectiveness of our work and the strength of our community support system for children. Tragedies are an opportunity to hold ourselves accountable for the goals we set and to ensure our willingness to invest in children in the way they deserve.