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STATE OF CONNECTICUT

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ANNUAL REPORT OF THE
CHILD FATALITY REVIEW PANEL
1998

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Presented By:

The Office of the Child Advocate

Child Fatality Review Panel

April 16, 1999

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STATUTORY MANDATE OF

THE CHILD FATALITY REVIEW PANEL

Connecticut General Statutes sec. 46a-13l (b) and (c):

(b) There is established a child fatality review panel composed of seven members as follows: A

pediatrician, appointed by the Governor; a representative of law enforcement, appointed by the president pro tempore of the Senate; the Child Advocate, or his designee; a public child welfare practitioner, appointed by the minority leader of the Senate; a representative of a community service group appointed by the speaker of the House of Representatives; a medical examiner, appointed by the minority leader of the House of Representatives; and the Chief State's Attorney, or his designee. The chairperson shall be elected from among the panel's members. The panel shall, to the greatest extent possible, reflect the ethnic, cultural and geographic diversity of the state.

(c) The panel shall review the circumstances of the death of a child who has received services from a state department or agency addressing child welfare, social or human services or juvenile justice. Members of the panel shall not be compensated for their services, but may be reimbursed for necessary expenses incurred in the performance of their duties.

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INTRODUCTION

Pursuant to Connecticut General Statutes sections 46a-131(b) and (c) the Connecticut Child Fatality Review Panel is mandated to review the circumstances of the death of any child who has received services from a state department or agency addressing child welfare, social or human services or juvenile justice.

Under federal law, Connecticut is required to establish "citizen review panels," one of which may be a fatality review panel, in order to continue to receive Child Abuse Prevention and Treatment and Adoption (CAPTA) funding from the Secretary of Health and Human Services. The Child Fatality Review Panel meets the criteria for a "citizen panel" and, as such, is required to examine policies and procedures of state and local agencies and evaluate the extent to which the agencies are effectively discharging their child protection responsibilities. Additionally, federal law requires that the Panel prepare an annual public report summarizing its activities for the year.

During the course of 1998, a total of forty-four child deaths fell within the state statutory mandate for review. These children had received some form of services from the Department

of Children and Families (DCF), the Department of Mental Retardation (DMR), the Department of Public Health (DPH), the Judicial Branch, or some combination of these agencies. Many of these children, and their families, also received services from the Department of Social Services (DSS).

Each child fatality received a preliminary review by the Child Advocate. Several of the child deaths revealed issues of a systemic nature, issues which could impact on other children in the state, and they were referred to the Child Fatality Review Panel which investigated and prepared in-depth reports in four of the cases: Andrew M., Shanice M., Ryan K., and Tabatha B. Those reports were publicly released over the course of the year.

The remaining thirty-nine child fatalities were reviewed by the Child Advocate. The following is a summary of the outcome of the review of every state-related child fatality reported to the Panel which occurred from January 1, 1998 through December 31, 1998, categorized by the state agency which provided the major share of services.

Agency: Judicial Branch, the former Office of Alternative Sanctions (OAS)

Introduction

In 1990, the Connecticut General Assembly passed Public Act 90-213. The Act established the Office of Alternative Sanctions (OAS) within the state's Judicial Branch to create and expand a statewide continuum of programs to augment the alternatives to incarceration available to the criminal justice system. The Office of Alternative Sanctions was created and sustained a full range of alternatives to incarceration for both pre- and post-conviction adult and juvenile populations. As of January 1999, OAS is now a part of Court Support Services of the Judicial Branch.

1. STEVEN B. (Date of Death - 6/17/98)

Age: 17 years, 10 months, 8 days

Circumstances of Death

Steven B. was born on August 9, 1980 and died of natural causes on June 17, 1998. The Medical Examiner determined the cause of death as sudden death associated with focal coronary atherosclerosis.

State Agency Involvement

Steven B. was arrested for possession of drugs and referred through the Office of Alternative Sanctions to a residential drug treatment program in Norwalk. Steven entered the program on October 20, 1997 and was scheduled for discharge on June 19, 1998, after successfully completing the program. His admission physical was unremarkable as was his prior medical history. While at the residential facility, he was subjected to urine analysis and last tested positive for cocaine on January 7, 1998. Thereafter, twenty drug screens were negative.

On June 17, 1998 Steven B. collapsed in a parking lot while on an off campus pass with another resident. He was transferred to a hospital where, despite medical intervention, he died. His death was not drug related.

Conclusion

Steven B. had a lengthy period of sobriety, had earned off-campus privileges, and was scheduled for discharge, presumably successfully. From the available, although limited, information provided to the Panel, it appears that Steven' s death was natural, and unrelated to his involvement with state services.

Panel Findings on Judicial Branch Involved Cases

The panel made no findings due to the nature of the child's death.

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Agency: Department of Social Services (DSS)

Introduction

The Department of Social Services (DSS) provides a broad range of services to the elderly, disabled, families, and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. The agency administers ninety legislatively-authorized programs and its expenditures account for one-third of the state budget. By statute, it is the state agency responsible for administering a number of programs under federal legislation.

1. KERIANA T. (Date of Death - 7/17/98)

Age: 2 years, 5 months, 20 days

Circumstances of Death

Keriana T. was born on January 27, 1996 and died on July 17, 1998. The Medical Examiner ruled the death a homicide caused by a subdural hematoma. Multiple healing abrasions and contusions were also observed, as well as a fracture of the left humerus. The mother's boyfriend was arrested and charged with capital felony murder in the beating of two-year-old Keriana. The nineteen-year-old mother, who was four months pregnant at the time with her fourth child, was charged with risk of injury to a minor.

State Agency Involvement

Keriana's mother was receiving services from the (DSS) even prior to Keriana's birth. At fifteen years of age, she gave birth to her first child. The hospital referred the mother and her child to DCF on October 7, 1994 because of concerns about uncertainty over her address, her age and her rejection of a parenting program. The hospital record indicates that, two months later, DCF requested the records concerning this child. No further DCF involvement is noted, although the hospital social worker continued to work with this mother.

In January 1996, at sixteen years of age and during the time that she was receiving AFDC benefits, the mother gave birth to Keriana. DSS was advised about the birth of this baby by the hospital staff. Seven months later, on September 4, 1996, the mother advised her DSS worker that she was pregnant with her third child, who was born in December of the same year. The mother met with her DSS worker on March 21, 1997 to add the infant to her AFDC benefits. An entry in the DSS record on March 24, 1997 indicates that the teen parent questionnaire was received and the case was referred to "ESW."

Keriana's sibling was also briefly hospitalized in December 1997 for bronchiolitis, failure to thrive and dehydration. A visiting nurse (VNA) performed weight checks when the child was released to her mother's care. After initially gaining

weight, the doctor requested a second referral to the VNA in April 1997 as the infant had again begun losing weight. In May 1997, the hospital social worker offered the mother a parent aide service and told her about the Family Ties and Head Start programs.

Keriana was hospitalized briefly for bronchiolitis, failure to gain weight, diaper rash and oral thrush in February 1996. She was seen again for a burn on her hand in June 1997 and for a choking incident in September 1997. In 1998, there were a series of broken medical appointments. In July 1998, Keriana was beaten to death by the mother's boyfriend.

Conclusion

There is no recorded DCF involvement in this case. It is unclear from the hospital records what happened to the initial referral made to DCF in 1994 regarding Keriana's older sibling. It is quite unfortunate that no additional referrals were made to DCF from DSS or the hospital over the course of Keriana's lifetime. During her teenage years, the mother gave birth to three children, reporting each to DSS to receive AFDC benefits. In addition, the hospital was aware, at the time information was supplied to DSS concerning the birth of her second child, that the mother was sixteen years old with two babies. The mother had not taken advantage of programs and services to which she was referred, and the babies' health was such that two referrals were made to the VNA. It is significant that two infants in the mother's care were treated for failure to thrive and that no report was made to DCF, which could have provided services under its high-risk newborn program.

2. JIOVANI O. (Date of Death - December 15, 1998)

Age: 2 months, 8 days

Circumstances of Death

Jiovani O. was born on October 23, 1998 and died on December 15, 1998. According to the Medical Examiner, the cause of the child's death was cardio respiratory arrest due to bronchopneumonia.

According to information provided to the Panel, Jiovani had been ill with a cold and congestion for two to three weeks prior to his death, and had been seen by a physician early in the illness. He was being treated with an over-the-counter congestion remedy. On December 13, 1998, Jiovani's mother had taken him to a shopping mall for an outing. As they left the mall, the mother covered the child's face with a blanket until she got on a bus to go home. When the mother uncovered the child's face, there was mucus and blood, and the child was not breathing. A passenger and bus driver administered CPR until an ambulance arrived. The child was resuscitated at the hospital, but then pronounced "brain dead". The family chose to remove life supports on December 15, 1998 and Jiovani died shortly thereafter.

State Agency Involvement

At the time of his death, Jiovani's mother, a fifteen-year-old who resided with her own mother, was receiving state assistance benefits from DSS. There were no referrals to DCF regarding this child prior to the circumstances that resulted in his death.

Several witnesses corroborated the mother's description of the events that occurred on December 13, and the medical providers reported no concerns that the death was the result of abuse or neglect. By all accounts, the mother had excellent family support and was good with the baby.

Conclusion

Despite the mother's young age, and the fact that the father (age 19) is currently incarcerated for statutory rape of the mother (who was 14 at the time of Jiovani's conception), there were no previous referrals to DCF regarding this child, who would have qualified for services under DCF's high-risk newborn program, by DSS or any other entity. Additionally, according to the DCF narrative made during the investigation of Jiovani's death, the Hotline investigator was denied access to the family by a hospital social worker who felt it was inappropriate for him to interview the mother since a doctor had stated he did not believe that neglect or abuse was involved. DCF should address this with the hospital administration as it could result in incomplete investigations in the future, particularly if DCF needs to assess the safety of other children in the home.

3. ANGELICA P. (Date of Death - 8/14/98)

Age: 10 years, 8 months, 14 days

Circumstances of Death

Angelica P. was born on January 1, 1988 and died on August 14, 1998, the victim of a homicide. The Medical Examiner found that her death was caused by blunt force injuries to the head and sharp force injuries to the neck.

State Agency Involvement

Angelica and her mother received assistance from the Department of Social Services when they first moved to Connecticut and while the mother was unable to work for health reasons. The family was no longer receiving benefits at the time of the child's death, and Angelica's death was unrelated to the services received by the family from the state.

Conclusion

The Panel made no findings due to the nature of the child's death.

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4. JAMIE H. (Date of Death - November 5, 1998)

Age: 3 months

Circumstances of Death

Jamie H. was born on August 5, 1998. According to the family, at 10:00 a.m. on November 5, 1998, Jamie's mother fed him, carefully burped him (because of a reflux problem), and put him down in his bed while she took a shower. As she was dressing, the father came home, checked on the baby and found that he was not breathing. The family called 911 and Jamie was transported to the hospital by ambulance. The emergency staff was unable to revive him. Because Jamie had a history of viral infection, the attending doctor suspected he died of viral meningitis. On autopsy, however, the Medical Examiner concluded that he died of natural causes from Sudden Infant Death Syndrome (SIDS) .

State Agency Involvement

Jamie and his family received state assistance from DSS. Additionally, in June 1998, DCF had investigated the family after receiving two referrals alleging that the mother did not properly care for Jamie's older sibling. At the time of the referral, the mother was on probation and her probation officer was carefully monitoring her, including the care she was providing to her daughter and her attendance at prenatal visits. After a thorough investigation, DCF was satisfied that the allegations of neglect were unsubstantiated.

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Conclusion

Jamie's death was not related in any way to the involvement of DSS or DCF. DCF thoroughly investigated the allegations that proved to be unsubstantiated, and followed through on collateral contacts.

Panel Findings on DSS Involved Cases

The Panel does not believe that the cases with DSS involvement reviewed in this report are all-inclusive. Unfortunately, DSS does not keep records of the deaths of children on its caseload in one comprehensive database. Consequently, it is likely that there were more child fatalities in families receiving DSS services than this report reflects. Indeed many of the child deaths of children affiliated with other agencies may have received DSS services as well.

In those cases reviewed, the Panel found that improvements could be made in communication between DSS and DCF regarding concerns of at risk children. The Panel is aware that until recently, DSS was hampered by confidentiality constraints but is now part of an interagency agreement with DCF and DMR to provide a better sharing of information.

Agency: Department of Mental Retardation (DMR)

Introduction

The Department of Mental Retardation purchases or provides a wide range of support services for the over 16,500 citizens of Connecticut with mental retardation. These services include residential placements, day programs, employment assistance, case management and clinical services. Unlike other agencies, DMR's supports and services (with the exception of its Birth to Three program), are not considered entitlements for individuals with mental retardation, and the majority of its services are provided by private non-profit organizations in local communities. Within the agency, there is an established internal review process for child fatalities. It appears that a board conducts an automatic fatality review of each child placed in out of home care. This review includes close coordination between DMR staff, the medical community and the Medical Examiner's office.

Jessica R. (Date of Death - January 5, 1998)

Age: 17 years, 4 months

Circumstance of Death

Jessica R. was born on January 1, 1981 and died on January 5, 1998 while in surgery. Her cause of death was stomach perforation as a result of a preexisting medical condition. Jessica was a resident of a DMR group home at the time of her death. This case will be reviewed in the context of the Child Advocate's Task Force on Children with Special Health Care Needs.

2. Christopher G. (Date of Death - January 6, 1998)

Age: 10 years, 3 months

Circumstances of Death

Christopher G. was born on April 7, 1988 and died on January 6, 1998 of respiratory failure.

3. Robert N. (Date of Death - January 20, 1998)

Age: 1 year, 3 months

Circumstances of Death

Robert N. was born on October 20, 1996 and died on January 20, 1998 of Spinal Muscular Atrophy - Type I.

4. Kyle R. (Date of Death - January 27, 1998)

Age: 2 years 2 months

Circumstances of Death

Kyle R. was born on November 15, 1995 and was diagnosed with Down Syndrome. His cause of death is unknown. It is noted that, at the time of death, Kyle had a respiratory virus and was

on a respirator.

5. Spencer D. (Date of Death - February 5, 1998)

Age: 7 months

Circumstances of Death

Spencer D. was born on July 1, 1997 and died on February 25, 1998 of Spinal Muscular Atrophy Type I

6. Christopher B. (Date of Death - February 18, 1998)

Age: 4 years, 9 months

Circumstances of Death

Christopher B. was born on May 31, 1993 and died on February 18, 1998 of pneumonia.

7. Kayshla C. (Date of Death - February 23, 1998)

Age: 2 years, 5 months

Circumstances of Death

Kayshla C. was born on September 25, 1995 and died on February 23, 1998 of AIDS-related problems.

8. Tyrese S. (Date of Death - March 15, 1998)

Age: 7 months

Circumstances of Death

Tyrese S. was born on August 19, 1997 and died on March 15, 1998. His cause of death was hypoplastic left ventricle, a very severe cardiac malformation.

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9. Ambermichelle T. (Date of Death - April 29, 1998)

Age: 3 years, 6 months

Circumstance of Death

Amber T. was born on October 28, 1994 and died on April 29, 1998. Her cause of death was unknown; she had multiple severe medical issues according to the DMR Death Report.

10. Brooke B. (Date of Death - July 8, 1998)

Age: 12 years, 6 months

Circumstances of Death

Brooke B. was born on January 16, 1986 and died on July 8, 1998 of an aneurysm.

11. Catherine "Elizabeth" S. (Date of Death - September 8, 1998)

Age: 1 year, 2 months

Circumstances of Death

Elizabeth S. was born on July 31, 1997 and died on September 8, 1998. The child stopped breathing and went into respiratory arrest.

12. Erin P. (Date of Death - October 7, 1998)

Age: 6 months

Circumstances of Death

Erin P. was born on April 28, 1998 and died on October 7, 1998. This child had numerous medical difficulties and was being monitored for apnea. Erin could not be revived after going into respiratory arrest.

13. Bryan K. (Date of Death - October 28, 1998)

Age: 10 years, 9 months

Circumstances of Death

Bryan K. was born on January 13, 1988 and died on October 28, 1998 of pulmonary failure. Bryan K. was hospitalized and returned home on October 22, 1998 with a "do not resuscitate" order (DNR) for any respiratory emergency. He continued to

receive his nursing service, which cared for him for ninety-six hours per week, subsequently was considered for "hospice care" and his condition was diagnosed as terminal.

14. Ruthxenia A. (Date of Death - November 15, 1998)

Age: 10 years, 5 months

Circumstances of Death

Ruthxenia A. was born on June 19, 1987 and died on November 15, 1998 of adrenal

leukodystrophy, a metabolic disease.

15. Travis H. (Date of Death - November 22, 1998)

Age: 14 years

Circumstances of Death

Travis H. was born on July 18, 1984 and died on November 22, 1998. His cause of death is unknown according to the DMR Death Report. It is noted that Travis was born with many physical defects.

Panel Findings on DMR Involved Cases

Many of the DMR-involved children who died during 1998 had or were receiving services from the agency's Early Intervention and/or Birth to Three Programs. Additionally, some children, whose conditions were known to be imminently terminal, received in-home hospice services. Most of the children were critically ill and were maintained at home in the care of family at the time of death.

Agency: Department of Public Health (DPH)

Introduction

The Department of Public Health is responsible for the state's public health policies and is the center of a comprehensive network of public health services. It is a partner to local health departments for which it provides advocacy, training and certification, technical assistance and consultation, and specialty services such as risk assessment that are not available at the local level. The agency is a source of up-to-date health information, which can be used to monitor the health status of Connecticut's citizens, set health priorities, and evaluate the effectiveness of health initiatives. DPH also regulates health care programs, day care centers and hospitals throughout the state.

1. Giorgio G. (Date of Death - July 5, 1998)

Age: 1 year

Circumstances of Death

Giorgio G. was born on June 29, 1997 and died on July 5, 1998. At the time of his death, the child was in a licensed family daycare home in Meriden, Connecticut. According to the day care provider, the child became limp and was transported to a hospital where he was placed on life support and subsequently removed. The Medical Examiner found that the cause of death was undetermined with no evidence of trauma or significant disease process found at autopsy.

State Agency Involvement

The child's death took place in a DPH-licensed day care home. There was no previous relevant history of abuse, neglect or other child protection involvement regarding Giorgio's family or the day care provider.

2. SHELBY L. (Date of Death - December 8, 1998)

Age: 3 months

Circumstances of Death

Shelby L. was born on September 24, 1998 and died on December 8, 1998. At the time of death, the child was in the home of a DPH-licensed day care provider.

According to the provider, the infant was put down for a nap and found dead, face down, one hour later. The Medical Examiner determined the cause of death to be the result of Sudden Infant Death Syndrome (SIDS).

State Agency Involvement

The child's death took place in a DPH-licensed day care home. There was no previous relevant history of abuse, neglect or other child protection involvement regarding Shelby's family or the day care provider.

Panel Findings on DPH Involved Cases

The review of both child fatalities which had DPH involvement did not present any issues for the Panel to address.

Agency: Department of Children and Families (DCF)

The Department of Children and Families (DCF) is the statutorily-designated child welfare agency for the state. It has a very broad mandate with includes juvenile justice, children's mental health and child protection. Its staffing includes social workers who, in addition to providing case services directly to families, appear in both Superior Court for Juvenile Matters and the probate courts when the appropriateness of a child's home is in question.

DCF has established a process for an internal investigation of child fatalities and critical incidents (serious injuries) involving DCF-affiliated children. These cases are reviewed by the Special Reviews Unit, an internal entity which provides information and recommendations to the Commissioner. The purpose of the internal review is to conduct self-critical analysis leading to remedial measures within the agency. These internal reviews, on occasion, parallel the Child Fatality Panel's review and when the independence of the Fatality Panel is not compromised, the Panel and DCF have collaborated in interviewing witnesses and sharing information.

1. Edward C. (Date of Death - January 5, 1998)

Age: 3 years, 9 months

Circumstances of Death

Edward C. was born on March 16, 1994 to parents with significant mental health issues. Edward died of natural causes on January 5, 1998 due to metachromatic leukodystrophy (MLD), a degenerative genetic disorder that affects the white matter of the brain and the nerves.

State Agency Involvement

On March 25, 1995 this case was referred to DCF because of issues concerning the hygiene of thirteen-month-old Edward and the cleanliness of the home. The case was closed on May 31, 1995. A second referral was received by DCF on June 26, 1995 from an anonymous source with concerns about the parents' ability to properly budget for food and clothing for their son. This case was transferred to the DCF treatment unit and a parent aide was offered to the family, as well as a referral to DMR's Birth to Three program. Two other referrals were received by DCF in 1995 concerning hygiene issues and alleging medical and physical neglect of Edward. These allegations were unsubstantiated. The case was closed when the parents moved to North Carolina in December 1995 and DCF referred the family to North Carolina child protective services.

DCF received a new referral from the North Carolina agency on May 1, 1996, indicating that it had been considering filing neglect petitions because of delays in Edward's development but were unable to do so because the family had returned to

Connecticut. DCF located the family and investigated, determining with the assistance of specialists, that Edward's alleged delays were not caused by neglect, but rather by a degenerative genetic disorder.

The case was transferred to a DCF treatment worker who was successful in working with the parents. The family received a number of services including occupational therapy and physical therapy for Edward, a home health aide, skilled nursing services, and a parent aide. The child's health was monitored by his pediatrician, the DCF Regional Resource Group nurse and a home health agency.

In 1997, DCF received two new referrals concerning this family. First, in May 1997, an anonymous caller expressed concerns about hygiene issues within the family and the developmental delays of the child. Neglect was unsubstantiated and the case was closed. Then, in October 1997, DCF received a referral concerning alleged alcohol abuse by the father and domestic violence. Although the mother was seen with a bump on her lip, she denied that domestic violence was the cause and this referral, therefore, was also unsubstantiated.

Conclusion

This case is a model for how agencies and service providers can successfully collaborate their efforts to provide for the best interests of a child. The record reflects exemplary case work by DCF. It is a tribute to the DCF caseworkers and administrators involved that this child was able to remain at home while suffering from a terminal illness. Edward died on January 5, 1998, at home, in his mother's arms. It is clear that DCF utilized all available support services and carefully monitored this medically fragile child.

2. *SHANICE M. (Date of Death - March 8, 1998)

Age: 4 years, 7 months, 13 days

Circumstances of Death

Shanice M. was born on August 23, 1993. She suffered from chronic asthma through most of her life and died on March 8, 1998 as a result of cardiac arrest brought on by this condition.

State Agency Involvement and Conclusion

The Child Fatality Review Panel issued a full report on this case, dated July 22, 1998, and reference is made to that document.

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3. DESTANEE T. (Date of Death - 3/21/98)

Age: 4 months, 16 days

Circumstances of Death

Destanee T. was born on November 5, 1997 and died on March 21, 1998. The Medical Examiner determined the cause of death as Sudden Infant Death Syndrome (SIDS). The child had been sleeping in a bassinet, but no information was documented regarding sleeping position.

State Agency Involvement

DCF first received a referral regarding Destanee from a hospital on November 5, 1997, reporting that the mother had just given birth, was intoxicated and that she had received no prenatal care. The mother admitted to drinking three or four beers three times per week during the pregnancy. Destanee was born with a cleft palate, which is often associated with prenatal alcohol use, although the medical staff observed no signs of fetal alcohol syndrome in the child.

The mother, who resided with the maternal grandmother and who now had three children under the age of five, agreed to accept a visiting nurse and to follow through with a substance abuse evaluation. DCF consulted with the Regional Resource Group nurse in planning for this infant. The DCF social worker visited the home weekly until February 19, 1998. It is unclear from the DCF record what the extent of visiting nurse involvement was or whether the DCF protocol for a high-risk newborn was followed.

After February 19, 1998, no visit was made to the home by DCF until March 17, 1998, although this was not documented in the DCF narrative until April 8, 1998, one day after the social worker, who was unaware of Destanee's death for almost three weeks, learned of the child's death during a home visit on April 7, 1998.

Conclusion

A review of this case reveals that DCF proceeded cautiously after the hospital referral by visiting Destanee weekly in her mother's home. Appropriate services were put in place and the

mother was cooperating with all DCF recommendations at the time of Destanee's untimely death. It is significant to note, however, that it is unclear whether the DCF caseworker kept abreast of the visiting nurse involvement with the family. Further, narrative entries on the LINK computer system made by the caseworker and the case work supervisor around the time of Destanee's death were not timely and were entered only after DCF learned of the child's death.

4. *<u>ANDREW M.</u> (Date of Death - March 22, 1998)

Age: 11 years, 3 months, 16 days

<u>Circumstances of Death</u>

Andrew was born on December 6, 1986 and died on March 22, 1998. According to the Medical Examiner, his death was the result of traumatic asphyxia resulting from compression of the chest by the weight of an adult, applied during a physical restraint hold at a psychiatric hospital.

<u>State Agency Involvement and Conclusion</u>

The Child Fatality Review Panel issued two full reports on this case, Part I dated May 7, 1998 and Part II dated June 19, 1998. Reference is made to those documents.

<u>CARL K.</u> (Date of Death - 3/27/98)

Age: 1 month

<u>Circumstances of Death</u>

Carl K. was born on February 27, 1998 and died one month later. According to the mother, she fed him while sitting on the couch at 4:00 a.m. on March 27, 1998 and then she and the baby fell asleep. The mother awoke two hours later and discovered the infant with his face against the back of the sofa. He was not breathing. Drug paraphernalia was found in the home and the mother admitted to using marijuana the day before her infant died. According to court records, the mother tested positive for marijuana on the day of the child's death. The Medical Examiner determined Carl's death was accidental due to positional asphyxia. At the time of his death, Carl had not been seen for any routine well child care visits.

<u>State Agency Involvement</u>

This mother first became known to DCF in October 1995 when she and two of her four children were homeless. Her two other children were residing with the maternal grandmother. The

mother admitted to a prior history of substance abuse and domestic violence with the two of her children's fathers. She located an apartment and her four children joined her there. She rejected parent aide services from DCF and refused a drug evaluation. She did agree to follow through with individual counseling. The case was closed on May 7, 1996.

Between August 1996 and January 1997, three more referrals were received by DCF on this family. In August and September, two anonymous referrals alleged that the mother had substance abuse problems, that the children were not supervised, that the mother was emotionally abusing them, and that there were concerns about the children's hygiene. These allegations were unsubstantiated. On January 23, 1997, a referral was

made claiming that two of the children had been alone in the apartment and had set a bedroom on fire. The caller also alleged that the mother had a substance abuse problem. The case was closed in April 1997, again as unsubstantiated, because the mother claimed that she was home at the time when the children were allegedly left alone and she denied that she had a substance abuse problem. The DCF record reflects that the mother had no criminal record. Despite the fact that three referrals were received in six months alleging substance abuse by the mother, DCF closed its case *after* she canceled her appointment for a substance abuse evaluation due to illness of the children and/or herself.

On January 12, 1998, DCF received a referral alleging that the mother was verbally and physically abusing her children. The mother denied these allegations. At that time, she was receiving services from the Healthy Choices program and was eight months pregnant. A referral was made by DCF for parent aide services and the case was closed again as unsubstantiated on January 21, 1998. In fact, the case was closed *before* DCF received records concerning the mother's prenatal care, the children's medical records, the children's educational records and the mother's criminal records. Requests received subsequent to case closure revealed that only one child was being followed regularly by a pediatrician.

One month after Carl's death, DCF filed neglect petitions in Superior Court for Juvenile Matters on behalf of the four surviving children. According to the petitions, the mother had been involved with Healthy Choices since October 1997 because of her history of alcohol abuse. She reported that she had been arrested for driving while intoxicated in 1996 and re-arrested for failure to appear on the DWI charge in 1997. She was involved with the Alternative Incarceration Center (AIC) from October 16, 1997 through December 8, 1997. The mother's prenatal health care provider stated that the mother did not seek prenatal care for Carl until her twenty-first week of the pregnancy. She admitted to alcohol and marijuana use during the pregnancy as well. Additionally, Carl's birth records reflect that he was "jittery" at birth.

Conclusion

While it does not appear that Carl's death was more than a tragic accident, a number of "red flags" were raised in the referrals received by DCF concerning the mother's substance abuse problems. As this Panel has previously stated, a history of three referrals over a one-year period should be reasonable cause to "team" the case by a multidisciplinary panel. At the time this case was closed in January 1998, the mother, who was eight months pregnant, and was receiving no prenatal care, had four other children, three of whom were not receiving adequate medical care. Additionally, DCF received information that the mother had a criminal history

involving alcohol use and admitted to alcohol and marijuana use while pregnant and had documentation from the school system raising concerns about one child's missing and incomplete homework.

The only DCF case work provided was a referral for a parent aide, a service the mother had failed to use in the past. Two months after the DCF case was closed, Carl died and the mother admitted to using marijuana the day before his death.

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The need for DCF involvement in this matter should have been clear in January 1998 if the case had been more thoroughly investigated and should have received ongoing oversight at least until all the records were received. The Panel can only infer that the information received after the case was closed was merely filed away, until it was later used to support the neglect petitions filed on behalf of Carl's surviving siblings after Carl's death.

6. CHINA C. - (Date of Death - April 21, 1998)

Age: 1 year, 8 months, 13 days

Circumstances of Death

China C. was born on August 8, 1996 and died on April 21, 1998. The Medical Examiner listed the cause of death as "undetermined." At the time of her death, China had small purple contusions on her face and forehead; a purple subgaleal hematoma on the back of her head; posterior ear abrasions; a rectangular scar on her back and a small rectangular scar over her occipital scalp from burns; a scar on her right arm; abrasions on her right thumb, lower leg and left toe; and a scar on her right knee.

State Agency Involvement

China's family is originally from New York State and has an extensive history with New York Child Protective Services (CPS). In March 1993, China's then one-year old sibling suffered a broken arm which allegedly occurred while his father was changing his diaper. The child was taken to Hospital A and his parents were instructed to return with him the next day. The parents waited four days until March 29, 1993, when they took him to Hospital B, which transferred him to Hospital C. At Hospital C, it was discovered that, in addition to his broken arm, he had five old rib fractures and an old leg fracture. His two-year old sister was examined and found to have a fracture of the left radius, which was at least two months old.

On March 31, 1993, a medical doctor concluded that the children exhibited signs of abuse. Osteogenesis imperfecta, or "brittle bone" disease, was ruled out as the cause of the injuries. The mother and father presented conflicting stories surrounding the events leading up to the boy's broken arm. On that same day, both children were placed in foster care in New York.

On April 5, 1993, a temporary custody hearing was held in New York and the court ordered that the children remain in foster care. One year later, the court ordered psychological evaluations, found the children at risk and recommended that the children be closely supervised. Eventually the children were adjudicated neglected and abused under the New York statutes and committed for twelve months to the care of the paternal grandmother.

During 1994 and 1995, the parents were sporadically involved with parent skills training, counseling and visitation. The children's placement with the paternal grandmother was extended and the parents had a third child, born on January 1, 1995.

In February 1996, the parents moved to Waterbury, Connecticut while the two oldest children remained in New York. There is no record that New York CPS notified its counterpart in Connecticut of the family's arrival and history. In August 1996, the parents had a fourth child, China C. The father was no longer residing in the home, and in that same month, the father's girlfriend also gave birth to a daughter.

In January 1997, the mother began therapy in Waterbury. On January 14, 1997 Connecticut DCF received its first referral on the family from the father who called and alleged that the mother was abusing drugs and not properly supervising the children. He also claimed that the two-year old Natasha had a burn on her leg and scratches on her face. A DCF case worker made a home visit to the mother two days later. The mother claimed that the child was burned while visiting the paternal grandmother in New York during November and December of 1996. By telephone, the paternal grandmother in New York denied that the child was burned while in her care. The mother and her new boyfriend agreed to substance abuse evaluations, which were negative.

According to the DCF narrative, the boyfriend and the father did not get along and the boyfriend had obtained a restraining order against the father. The mother was observed with a bruised eye in February 1997, but she denied any domestic violence. Connecticut DCF opened a treatment case on the family to provide ongoing services.

On February 27, 1997, the Connecticut case worker spoke with a New York case worker who stated that the two older children had been abused and agreed to fax the documentation to DCF. In April 1997, the mother attended counseling only occasionally, was advised by the New York court to complete the required counseling. In May 1997, DCF closed its case without resolving the cause of the burn to the two-year old. At that time, the mother claimed that she was no longer with her boyfriend and that she planned to return to New York. She did not follow through with the DCF referral to the Family Services Nursery. Although the father was the source of the initial neglect allegations, no visits were made to his home by DCF, even though the children spent time at his home and New York child protection records had confirmed the abuse perpetrated on his two oldest children.

Two months after case closure, DCF received a hospital referral alleging that the father's girlfriend was in the hospital for an appendectomy and that the father was demanding that she

return home prematurely to care for the children. Upon DCF investigation, bruises were noted on the father's girlfriend and an additional referral was received from the hospital because of the poor weight gain of China's one-year old half sister, Felicia. This time, DCF substantiated neglect.

On July 21, 1997, the father again reported the mother and her boyfriend to DCF, alleging that they were drug involved and that the mother's boyfriend had threatened the father with a gun. The mother denied all the allegations and claimed that she was moving back to New York. This case was closed as unsubstantiated.

In August 1997, the New York court awarded custody of the two oldest children to the paternal grandmother. The father returned to New York to live with his mother and the Connecticut case on his and his girlfriend's daughter's poor weight gain was closed with a report made by DCF to the New York CPS.

DCF learned that the family had returned to Connecticut when it received another referral in March 1998. The referral alleged that a five-month old boy, the child of mother and her boyfriend, and a two-year old nephew were both burned. According to the referral, the boyfriend was boiling water for the baby's bottle and left the pot on the stove with the handle facing outward. He then left the kitchen to change the baby's diaper. A three-year old in the home knocked over the pot, and the boiling water burned the nephew's feet. When the boyfriend came in to assist, he placed the infant on the kitchen floor, accidentally placing his head in the boiling water. Although the police pursued this matter, they were unsuccessful in securing an arrest warrant for risk of injury to a minor. DCF determined that this was an accidental burning and closed the case with neglect unsubstantiated.

During February or March 1998, China and her half-sister were residing with their father in Waterbury when China was badly burned on her back and head. The child received no medical treatment. At that time, DCF had no knowledge of <u>these</u> burns. Two weeks later, when the mother had China for a visit, she observed the burn on her back which clearly needed treatment. She contacted the paternal grandmother, who advised her to put Noxzema on the burns and to bring China to New York. The grandmother warned the mother not to seek medical treatment, for fear of involvement with DCF and loss of custody. China was taken to New York to the grandmother's home and was returned to her mother one week later.

In March 1998, an educational neglect referral was received by New York CPS concerning the two oldest children who were in the care of their grandmother. Both had poor school attendance and were failing their grades.

Prior to closing its case in Connecticut, the DCF social worker made a visit to the mother's home on April 6, 1998. China was observed in the home, with no visible bruises or marks. Apparently at this time, her mother was concealing the burns that were on China's back and head.

On April 20, 1998, according to police records, the father's girlfriend was at home caring for the father's five children, including the two oldest who were supposed to be in the grandmother's custody. A paternal uncle and his friend were also residing in the home. The father had gone out for the evening with another new girlfriend. Both the uncle and his friend were smoking marijuana that night. The friend had made sexual advances to the father's live-in girlfriend and she had rejected him. Later, she went outside to meet the pizza delivery man. She stated that,

when she returned, she observed the friend standing over China's crib and a blanket over China's face. She did not check on China at the time.

The next morning China was discovered dead in her crib. DCF invoked a 96-hour hold on all the surviving children and filed for orders of temporary custody. The oldest daughter reported that she did not want to return to the care of the paternal grandmother as she claimed that the grandmother had hit her and her brother with belts.

Conclusion

This case demonstrates the difficulty that child protection agencies face when multiple caseworkers are involved with a family and when families migrate between states. Despite the challenges, the case illustrates the need for better coordination between states and a more thorough assessment of the entire family when making decisions concerning case closure.

It is of concern that the complete New York DCF record was not requested by Connecticut DCF until after China's death. Although now pieced together in hindsight, it is clear that the children in this home were the victims of repeated abuse or neglect while the family circumvented two child protection agencies by shuffling their children back and forth across state lines.

In March 1988, DCF was aware that the family had returned to Connecticut. DCF was also aware that the last referral concerning the father and his girlfriend was closed with "strong indicators of domestic violence." There was a suspicious burn on one child in January 1997. These aspects of the referral were not pursued when mother indicated she was relocating to New York. In addition, the older children had suffered abuse in the form of many broken bones while in the care of both parents in New York.

At a home visit on April 6, 1998, the social worker observed China but apparently made no attempt to determine who was providing primary care for this child. Such a discussion may have revealed that China was moving back and forth between the paternal grandmother in New York, the father in Waterbury and the mother's home. In addition, the social worker might have discovered that the paternal uncle, who resided in the father's home, had a prison record.

Although the father was the source of several referrals, DCF never thoroughly assessed his background or his home. The one documented visit to his home occurred on July 24, 1997. No documentation was requested from New York CPS regarding his record. No information was gathered about the paternal uncle, documented in DCF records as the person who took one child for her follow-up medical care. Presumably this is the same uncle who allegedly was caring for China when she was burned. It is well documented that the DCF case worker viewed the father as "controlling" and it is clear from a review of the record that the case worker was intimidated by this man.

The assessment tools used by DCF also inaccurately portrayed the level of domestic violence in the home and the history of involvement with the child protective agencies. For example, in January 1997, the father threw China's crib in anger and broke it while his children witnessed this outburst. A thorough review of all the records, including the number and variety of injuries to the many children, particularly the broken bones and the host of burns, and documentation of the known risks would have resulted in higher scoring on the standard assessment tools used in this case.

In sum, no professional assigned to this case took a "global view" of the circumstances and events involving these children to determine their significance until after China's death. Stronger interventions, coordination and monitoring by both Connecticut and New York child protection staff could have prevented injury to these children and quite possibly could have prevented China's death.

7. KEVIN W. (Date of Death - 5/6/98)

Age: 6 months, 8 days

Circumstances of Death

Kevin W. was born on October 29, 1997 and died on May 6, 1998. The Medical Examiner concluded that Kevin's death was accidental as a result of traumatic asphyxia due to airway obstruction.

State Agency Involvement

This matter was initially referred to DCF in April 1997 as an allegation of domestic violence and drug involvement in the home. Another caller to DCF then indicated that the initial referrer had falsely reported information to DCF. After a thorough investigation, DCF closed the case with the allegations considered unsubstantiated in May 1997. In March 1998, in connection with a separate DCF case on another of his children, the father tested positive for cocaine on two occasions. Inpatient treatment was recommended by DCF for his mental health and substance abuse issues.

On May 5, 1998, DCF received another referral with concerns about drug use in the home, domestic violence and gang involvement by the father. Before that referral could be investigated, DCF was notified of Kevin's untimely death. According to the father, on May 5, 1998, while grocery shopping, he gave seven-month-old Kevin several grapes to eat. The family returned home around 11:00 p.m. Kevin's two-year old sibling was eating grapes and throwing them on the floor and at Kevin. Although the baby was not crawling, he had the ability to grab for objects within his reach. The baby was then given a bottle and put to bed. The parents checked on the infant at 1:00 am and discovered that he was not breathing. A call was made to 911 and the family was instructed to turn the baby on his side and pat his back. Part of a grape and some spittle came out of the baby's mouth. The child was transported to the hospital and pronounced dead.

After Kevin's death DCF received additional referrals on this family. The father also has another child who is committed to the care and custody of DCF.

Conclusion

This appears to have been an accidental death. A review of the case record demonstrates good management skills by the DCF case worker investigating the initial referral. She gathered all pertinent information from the family and attempted to verify it. When she did not receive

requested information from collateral contacts, she followed up with telephone calls. This case does not appear to have been in any way preventable by additional DCF intervention. It does however, highlight the dangers of feeding young children foods on which they might choke.

8. GARRETT P. (Date of Death - 6/8/98)

Age: 1 month, 11 days

Circumstances of Death

Garrett P. was born on April 27, 1998 and died on June 8, 1998. The Medical Examiner determined that the cause of death was Sudden Infant Death Syndrome. The child had been sleeping between his parents in their bed. He was found on his side.

State Agency Involvement

This case was first referred to DCF in April and May, 1995, with issues concerning hygiene and supervision of Garrett's then eighteen-month old brother. DCF made several home visits in May 1995. After that, according to the records provided, there was a two-month gap; the next home visit was not made until July 1995. The mother was placed on a waiting list for a parent aide. The child was up-to-date in medical care and the mother moved in with the maternal grandmother. DCF closed this case on February 14, 1996.

A second referral was opened on March 6, 1996 and closed five days later. This referral alleged that the mother was sleeping with Garrett's then five-month old sister and rolled over on her, nearly suffocating her. The mother stated that the infant has been sick and that she had put her to bed on the couch near her feet so that she could better monitor her. The older boy was sleeping on the couch near his mother's face. On March 5, mother had taken the infant to Hospital A and was discharged home around 11:00 p.m. Around 3:00 a.m., the baby was gasping for air and mother took her to Hospital B, where she was admitted for a respiratory infection. She was released home on March 7, 1996. The mother refused to accept further services and the case was closed on March 11, 1996.

This family was referred to DCF again in September 1996 by an anonymous source with concerns about cleanliness of the apartment, illegal drug use in the home, the father hitting the children, and lack of food for the children. During September and October 1996, several home visits were made and the need for medical attention for the male sibling's bowed legs and lazy eye and for the female sibling were noted. For reasons unexplained in the record, there was a two-month gap in DCF visitation to the home between November 5 and January 3, 1997. After another unexplained two-month gap in visitation between February and April 29, a DCF Program Supervisor reviewed the case and noted the lack of documentation about the mother's voluntary transfer of custody in probate court of another older child to a grandmother. The Program Supervisor demanded immediate action and a home visit.

On May 2, 1997 a home visit was made. While the home appeared dirty, there was some food observed and the mother signed releases of information. No contact was attempted again for a month when, on June 6, 1997, the home was described as "deplorable" by the case worker. The case was transferred in August 1997 to a new case worker, but the narrative reflects that

the previous worker was in the process of filing neglect petitions.

At some point, the mother was whereabouts unknown and she was located through DSS records. The new case worker arranged for services with a therapeutic day care program. She also assisted the mother in obtaining furniture, toys and strollers. In January 1998, the notes from the day care program sent to DCF indicated that the girl was

"afraid of daddy" and the boy had reported that "Daddy is bad and he beats mommy." The day care program did not make an official referral through the DCF Hotline, nor is there any indication in the record that DCF investigated these statements by the children.

A new referral was received on January 28, 1998 concerning two small burns on the boy. Two days later, a DCF investigator interviewed the mother who claimed the boy was burned when he attempted to retrieve a toy stuck in the heater. While the narrative reflects the investigator's suspicions about the explanation, the next DCF home visit did not take place until three weeks later. Home visits were made in March and April and a decision was made to close the case after one more month, during which DCF would monitor the family's relocation to a new apartment and the pending birth of Garrett. A service agreement was signed which required the mother to obtain a new apartment, follow through with medical appointments and participate in therapy.

Garrett was born on April 27, 1998. On June 8, 1998, he had been sick with a stuffy nose and congestion for two days. According to the mother, she fed Garrett at 3:00 a.m. and then fell asleep in the bed with the infant between her and the father. At 6:30 a.m. she woke up and realized the baby was not breathing. The police responded, and CPR was administered and maintained until the infant arrived at the hospital and was pronounced dead.

After the investigation concluded that the infant died from Sudden Infant Death Syndrome, the case worker was advised to close the case. Although the case was submitted for closure on July 1, 1998, the worker did make two additional home visits after this date to assist the family with enrolling the surviving children in Head Start and obtaining furniture for the family.

Conclusion

It is of concern that, even after the Program Supervisor reviewed this matter in April 1997, case management did not appear to significantly improve. The record reflects discernible gaps between DCF visits with little follow-up to the Program Supervisor's request to look into the circumstances surrounding the probate transfer of guardianship. Further, collateral medical sources were not checked to verify the mother's statement that the children did not require specialized medical attention. There was no follow-up regarding domestic violence allegations. Finally, DCF records were not maintained in a timely manner. Although these factors clearly did not contribute to Garrett's death, the care of all of the children in the home was compromised by DCF's inconsistent monitoring of this family.

9. EDWIN R. (Date of Death - June 12, 1998)

Age: 23 days

Circumstances of Death

Edwin R. was born on May 20, 1998, one of triplets, and died less than one month later as a result of sepsis on June 12, 1998.

Agency Involvement

DCF received its first referral from the hospital on May 26, 1998 after the mother had given birth six days earlier to triplets. The referral stated that the mother admitted to heroin use throughout her pregnancy. She was hospitalized prior to the babies' birth in April 1997 because of medical complications with her pregnancy. She admitted that she was using heroin while she was in the hospital. Edwin died at the hospital. The two surviving infants continued their hospitalization in the newborn intensive care unit at a hospital in New Haven and were discharged to a foster home. While in the neonatal unit, the infants suffered from sepsis, seizures, adrenal insufficiencies, bronchopulmonary dysplasio, germinal matrix hemorrhaging, pulmonary hypertension, patent ductus arteriosus and bilateral retinopathy. The infants were adjudicated as uncared for children and committed to the care and custody of DCF on December 2, 1998.

Conclusion

DCF acted appropriately in response to the initial referral and has continued to ensure proper medical treatment for the surviving infants. DCF has also facilitated visitation for the father, who is in a drug treatment program. The mother is currently incarcerated.

10. Jonathan B. (Date of Death - June 13, 1998)

Age: 6 months, 22 days

Circumstances of Death

Jonathan B. was born prematurely on November 21, 1997 with multiple medical problems, including persistent malfunctions and infections of his ventriculoperitoneal shunts. His prognosis was poor and he was discharged home to the care of his parents for the remainder of his brief life. He died on June 13, 1998.

State Agency Involvement

At nearly fourteen years of age, Jonathan's mother was committed to the care and custody of DCF. The mother had a history of chronic depression, substance abuse, running away, and self-mutilating behavior. Her first child, a daughter, was born on October 28, 1996. At the time of that child's birth, the mother was accepting numerous therapeutic and support services from DCF aimed at helping her live independently with her child. DCF was also able to continue monitoring the health and safety of the baby.

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DCF received a referral in March 1997, when Jonathon's sibling was five months old, concerning a domestic violence incident between the mother and her boyfriend, the child's father. A DCF investigator conducted a home visit five days later, substantiated abuse and closed the case. Both the mother and father were arrested and subsequently ordered to participate in anger management classes.

On June 17, 1997, a second referral indicated that the mother had intentionally slashed her arms and was hospitalized for a psychiatric evaluation. Physical neglect was substantiated and the case was transferred to the DCF treatment unit to provide ongoing services. Upon discharge from the psychiatric hospital, the mother and child resided with the paternal grandparents and multiple service providers continued in the home. On November 21, 1997, Jonathan was born with multiple special needs.

During the time that Jonathan was at home with his sibling, concerns were raised about the mother's ability to parent two special needs children. The record describes the sibling as anemic and failing to thrive. The record also indicates that the mother changed pediatricians and that there was a conflict of opinions between the two doctors with respect to the failure to thrive diagnosis. The DCF Regional Resource Group nurse was not consulted by the social worker at the time of Jonathan's birth nor was she consulted concerning the conflict of opinions and the change of pediatricians. She was, however, contacted on March 31, 1998, to assist with locating a specialized foster home for Jonathan. The plan was later changed and it was agreed that the mother would take the infant home, after it was clear to the medical experts that his death was imminent and service providers were in place to provide necessary end-of-life supports and to monitor the home.

Conclusion

The record demonstrates that the case work and supervision of the social worker in this case were exemplary. The social worker and the supervisor were extremely conscientious in meeting with all service providers and providing the mother with an abundance of mental health and support services. Jonathan was permitted to go home with his mother due to the coordinated efforts of the medical staff at the hospital, DCF and all the treatment workers involved in the mother's case.

The Panel does note, however, that both children could have benefited from a timely referral to the DCF Regional Resource Group (RRG). As we have previously stated in our report on Shanice M., DCF should use the RRG when there is a conflict in medical opinion regarding the condition or treatment of a child. Additionally, the RRG nurse should be involved as soon as possible in all cases involving children with special health care needs.

11. DAMON C. (Date of Death - July 7, 1998)

Age: 2 months, 28 days

Circumstance of Death

Damon C. was born on April 9, 1998 and died on July 7, 1998. The Medical Examiner concluded that the infant died of natural causes from Sudden Infant Death Syndrome (SIDS). The child had been sleeping on a three-cushion couch on his side; his father was asleep at the other end.

State Agency Involvement

DCF was involved with Damon's sibling prior to his birth. In December 1989, a hospital made a referral to DCF after the then seventeen-month old girl presented with a burn on her inner thigh. The mother initially said that an iron fell on the child, but later indicated that the iron was left on the floor and the child burned herself when the mother was not in the room. DCF filed neglect petitions in January 1990. According to documentation over the next year, the mother failed to attend appointments with the parent aide and the VNA, and failed to appear in court. A court-appointed psychologist concluded in April 1990 that the mother had a depressive disorder and borderline personality disorder. He further stated that she was so full of anger and frustration it was possible that the burn to the child occurred in a fit of rage. As the mother was evasive and uncooperative with services, a social study filed on July 23, 1990 recommended adjudication and commitment to DCF. The mother continued to miss appointments and the last reference in the narrative, dated November 19, 1990, refers to a service agreement that apparently was never signed by mother. The neglect petitions were withdrawn in February 1991 because the mother had followed through with basic pediatric care.

Damon was born on April 9, 1998, over seven years later. According to the family, on July 6, 1998, the father left the apartment to buy drugs and left Damon sleeping on the sofa, in the care of neighbor #1 at 11:45 p.m. and then neighbor #2, who observed that the infant was breathing. The mother returned between 1:30 a.m. and 2:00 a.m. and later admitted that she had been out of the home for the several days prior on a "cocaine binge". According to the father, when he returned home, he fixed a bottle and went to pick the baby up, at which time he discovered that Damon was dead. Additionally, Damon received no well-child pediatric follow-up in the time between his birth and his death.

Conclusion

At the time the neglect petition was withdrawn in 1991, no explanation for the withdrawal was documented in the DCF narrative and there was no indication that the mother ever took advantage of the offered services. The narrative is silent as to what happened to the proposed service agreement as well.

While there is little question that DCF's early involvement with Damon's sibling raised issues of proper case management, case management has been much improved through the reforms made within the agency since 1991. In any event, DCF's early involvement had no relationship to the circumstances surrounding Damon's death. In fact, there was no involvement between DCF and Damon's family during his lifetime.

12. MARYANN M. (Date of Death - July 15, 1998)

Age: 14 years, 4 months

Circumstances of Death

Maryann M. was born on March 22, 1984. After she was missing for nine months, body was found wrapped in blankets and chains in a lake on July 15, 1998. The Medical Examiner determined the cause of death was asphyxia. The manner of death was determined to be a homicide.

State Agency Involvement

This family had an early history with DCF in March 1988 when Maryann and her two siblings were left with a baby-sitter and the mother did not return home. DCF invoked a 96-hour hold and was granted orders of temporary custody. The children were placed with relatives and returned to the care of their mother in June 1988. An anonymous referral concerning the children's lack of clothing was reported in January 1994. DCF closed that case the same month.

In October 1997, DCF received a school referral concerning Maryann's attendance, alleged drug use, running away, and sexual activity. The DCF investigator encouraged the mother to file a Family With Service Needs (FWSN) petition in juvenile court, which the mother did on October 8, 1997, several weeks after she was provided with the forms. On October 9, 1997, the mother filed a statement with the police alleging the statutory rape of Maryann by two men aged nineteen and twenty-one years. Maryann filed a statement on October 15, 1997 about having sex with a nineteen-year old male. Maryann then ran away on October 19, 1997, briefly returned to her mother two days later and ran away again. She never appeared in juvenile court on the FWSN petition and her body was discovered in a lake nine months later in July 1998.

Conclusion

The brief management of this case by DCF was exemplary. Unfortunately, the filing of a FWSN petition was the only avenue available to the agency to protect this out-of-control and vulnerable child.

This case raises issues deserving of a more in-depth investigation and report by the Panel. However, a timely in-depth review was not possible given their limited resources. Fortunately, the Panel's review in the case of Tabatha B. addressed the need for a secure mental health facility in Connecticut to address the issues confronting teens like Maryann. The state of Connecticut lacks a secure inpatient residential setting to treat children who, like Maryann, are

not serious offenders, but are nonetheless out of the control of their parents and are at risk of flight and, consequently, are a danger to themselves.

In the State of Rhode Island, a task force was established to study and make recommendations regarding children who run from placement. (Although Maryann was never offered placement by DCF, all of her actions indicate that, had she been, there was a high likelihood that she would have run.) Many of its recommendations can be applied to children who run from their parents, as well as children who run from placements.

The Rhode Island Task Force recommended, as does this Panel, the need for a coordinated system to identify, locate and return runaway youths. The Task Force recommended that (1) DCF identify a unit within the agency to track all runaways and their returns to placement, and to provide a uniform source of information to involved police departments; (2) DCF request that the police chiefs agree to a single protocol to be used statewide; (3) a task force be established to develop uniform policies and procedures concerning runaways; and (4) agencies use enhanced technology (e-mail and fax) to improve timeliness of reporting. Finally, the task force also recommended improved training and expansion of services.

13. *RYAN K. (Date of Death - August 12, 1998)

Age: 6 years, 6 months, 27 days

Circumstances of Death

Ryan was born on January 16, 1992 and died as a result of blunt trauma to the head on August 12, 1998.

State Agency Involvement and Conclusion

The Child Fatality Review Panel issued a full report on this case, dated September 17, 1998, and reference is made to that document.

14. BRUCE D. (Date of Death - 9/17/98)

Age: 7 months, 19 days

Circumstances of Death

Bruce D. was born on January 29, 1998 and died on September 17, 1998. The Medical Examiner determined that the cause of death was Sudden Infant Death Syndrome (SIDS). The child was found face up on the floor because his father was attempting CPR. He reportedly had been put to bed face up.

State Agency Involvement

On January 6, 1998, DCF received a referral stating that the mother, who was pregnant with twins had not been compliant with her prenatal appointments. The referrer also claimed that there was no heat or hot water in the home. The mother stated that she had been without heat since November and had been heating the apartment with an oven. Heat was restored to the apartment and the case was closed on January 8, 1998.

The case was reopened on February 6, 1998, because of further referrals alleging domestic violence and hygiene issues in the home. At a home visit by a DCF investigator on February 9, 1998, the mother stated that she had given birth to premature twins on January 29, 1998. She admitted that she had not kept up with housekeeping during her pregnancy. Mother also admitted to a history of domestic violence that last occurred in 1997 and she agreed to accept parent aide services.

On May 13, 1998, DCF received a referral from a hospital indicating that one of the twins was sent home in March 1998 and that the second infant, Bruce, was ready for discharge, but had special needs. Bruce had surgery for a large "paracranial bleed" in April 1998, and suffered from a septal defect, bilateral hernia, broncho-pulmonary dysplasia and required a tube for feeding. The DCF caseworker arranged for support services in the home and the hospital arranged for a visiting nurse. The DCF caseworker also consulted with the Regional Resource Group (RRG) nurse. The information in the record from the RRG nurse did not clearly state either the nature of the child's health problem or DCF's expectations for the mother. However, the report did reflect that the mother and the father were trained in the care and feeding of their son. The nursing staff at the hospital reported that they were pleased with the parents' interaction with the infant and comfortable with their ability to care for him at home.

On May 19, 1998, Bruce was discharged to the home. DCF continued to monitor the case and conferred with the service providers. After receiving favorable reports from the service providers, DCF closed its case in August 1998.

On September 16, 1998, the visiting nurse consulted with the pediatrician because Bruce had a fever. The parents were instructed to take his shirt off and keep him cool. The next day, the father reported that he had fed Bruce that morning and put him in his crib. Approximately fifteen minutes later, he checked on the child and found him not breathing or moving. The infant was transported to the hospital and died.

Conclusion

The entire case record indicates that DCF managed all concerns in a timely, thorough and compassionate manner. Within two days of the first referral, heat was restored to the mother's apartment. DCF immediately followed up on services for Bruce after his birth and closely monitored the service providers. When DCF did close its case, it was only after all collateral

contacts had been made and no further concerns were expressed. The case work was commendable in this matter.

15. *TABATHA B. (Date of Death - September 29, 1998)

Age: 15 years, 1 month, 11 days

Circumstance of Death

Tabatha was born on August 17, 1983 and died on September 28, 1998 as a result of asphyxiation due to suicide on September 26, 1998.

State Agency Involvement and Conclusion

The Child Fatality Review Panel issued a full report on this case, dated November 30, 1998, and reference is made to that document.

16. RAINBOW P. (Date of Death - October 9, 1998)

Age: 4 months, 13 days

Circumstances of Death

Rainbow P. was born on May 26, 1998 and died on October 9, 1998. The Medical Examiner determined that the cause of death was Sudden Infant Death Syndrome (SIDS) undetermined with a high level of antihistamine present.

State Agency Involvement

The only DCF involvement with this family occurred when, on May 13, 1998, the agency received a referral that Rainbow's mother was engaging in a Cambodian practice known as "coining" her daughter to alleviate sickness. Upon investigation, the child's pediatrician was aware of the treatments and stated that mother was not using the method as a substitute for other treatment. On July 2, 1998 the case was closed as "unsubstantiated" as it was determined that this was a cultural technique used to treat a minor condition.

Conclusion

The DCF intake worker thoroughly assessed this matter and followed through on collateral contacts. The worker was persistent in her efforts to meet with the family. The infant's death was not related to the DCF involvement with this family.

17. JASMINE C. (Date of Death - October 14, 1998)

Age: 2 months, 2 days

Circumstances of Death

Jasmine C. was born on August 11, 1998 and died on October 14, 1998. The medical

examiner deemed the cause of death as Sudden Infant Death Syndrome (SIDS). The child had been sleeping with her mother and was found wedged between the mattress and the wall.

State Agency Involvement

State involvement with this family began prior to Jasmine's birth. DCF received a referral on August 14, 1995, alleging that the mother was bringing her one-year old son out with her at "all hours of the night" and that the child slept in the same bed as mother. The mother was seven months pregnant and had not received any prenatal care at the time of the referral. Physical and emotional neglect were substantiated. A second child was born on October 4, 1995. The DCF worker confirmed that the mother had a bassinet for the infant prior to his release from the hospital. VNA services were provided. DCF believed that the mother's transient behavior put her children at risk, but this was resolved when she found stable housing in November 1995. The DCF family treatment plan dated January 1, 1996, noted that the "apartment still lacks much furniture and only contains the minimum bedding for her children." In January 1996, the DCF case worker contacted the mother's caseworker at Young Parents Program (YPP) and requested assistance in locating appropriate bedding for the children, as the older child was sleeping in a playpen and the infant in a bassinet. The mother was also encouraged to follow through with medical appointments for her children. The case was closed on August 6, 1996 with the recommendation that the YPP continue their involvement, because of the mother's young age (19) and the fact that she had two children aged two and under.

Four months later, the police referred this family to DCF because a search warrant had been executed at the family's home. Drug selling was suspected at this residence, although no narcotics were found. During the execution of the search warrant, a family friend stopped by and was arrested for possession of cocaine. The father and mother both denied drug use during a home visit from the worker. The father was on probation for a past drug-related charge. After contacting his probation officer, DCF closed its case on December 31, 1996 with physical neglect substantiated because of the drug-related arrest of the family friend in the home.

A third referral was received by DCF on July 3, 1997 alleging that the mother's boyfriend (the second child's father) was physically abusive and had recently been arrested on drug-related charges. The physical abuse was not substantiated, but emotional abuse was substantiated. During a home visit on September 17, 1997, the worker noted the smell of marijuana. The father, who was caring for the two children, admitted to smoking marijuana. The father was referred for substance abuse treatment. The family was evicted because of the drug activity in their apartment and relocated to another apartment in December 1997. The father was incarcerated in January 1998 and the mother completed a substance abuse evaluation with no recommendation for treatment in April 1998. The case was closed on May 17, 1998 after the DCF case worker noted that the mother was in "stable housing at this time" and father was incarcerated for two years. At the last home visit on April 20, 1998, the mother related that she had been laid off from her full-time employment and was actively seeking employment. At the time of this visit, the mother was five months pregnant, although her pregnancy was not apparent to the case worker and consequently not noted in the DCF record.

According to the mother, she had recently moved in with her stepmother, did not have a separate bed for her infant and was sleeping on a mattress and box spring on the floor. She

checked on the infant at 11:30 p.m. on October 13, 1998. The next morning, Jasmine's three-year old sibling woke up the mother asking where the baby was. The mother located the infant between the baseboard and the wall, towards the head of the bed. The baby had been dead "for awhile" and the EMTs did not attempt to resuscitate the baby.

Conclusion

It appears from a review of the record that the mother concealed her pregnancy from her DCF case worker as well as from her substance abuse evaluator. That information was pivotal to any determination to closing the case and without it, DCF was limited in its ability to properly assess any potential risk to closing the case.

18. Kara S. (Date of Death - October 19, 1998)

Age: 13 months, 13 days

Circumstances of Death

Kara S. was born on September 6, 1997 and died on October 19, 1998. The Medical Examiner listed the cause of death as undetermined with no evidence of physical abuse found upon autopsy.

On Thursday, October 15, 1998, according to the mother, she took Kara to the pediatrician for a cold and was given Sudafed. She was scheduled to return to the pediatrician's office the following day for Kara's one-year physical, but the mother failed

to keep this appointment. Between Friday, October 16 and Sunday, October 18, Kara was with her father. When she returned to her mother's care on Sunday at 5:00 p.m., she appeared pale, she felt hot and refused to eat. The mother was able to feed her some water, Jell-O and some grapes. She had a late nap at 5:15 p.m. and slept for one hour. At 8:30 p.m., the mother gave Kara a half teaspoon of Sudafed. She then put the baby to bed face up, with her pacifier. The mother claimed that she checked the child at 7:00 a.m. on October 19 and she was breathing. She stated she checked a half-hour later and the child was not breathing. The crib had an adult-size pillow, a blanket, an afghan quilt and a pacifier in it. No mucus or wetness was found in the crib. The mother claims she called the maternal grandmother at 7:30 a.m. However, the 911 records indicate that the maternal grandmother called 911 at 8:42 a.m. and that the mother did not call 911 until 8:43 a.m. and again at 8:50 a.m.

The mother carried the baby from her bedroom to the living room floor. Upon the arrival of the police, the child was cool to the touch and the limbs were stiff. There were signs of lividity on the infant's face, arms and exposed areas. The child was transported to the emergency room, although she was deceased well before the arrival of the ambulance to her home. She was pronounced dead at 9:09 a.m. at the hospital. Although the father arrived at the hospital at about the same time as the ambulance, the mother arrived at the hospital an hour and a half later, after going to the maternal grandmother's home to shower.

State Agency Involvement

In December 1993, the police responded to a call claiming that the mother was beating her two-year old son. Apparently there was no DCF referral on this matter and DCF only learned about this incident during the course of investigating a later referral.

On January 14, 1994, DCF received an anonymous referral with concerns of physical abuse of the child. The mother admitted to hitting her son with a belt and asked for help with parenting skills. At the time, the mother was separated from the child's father, with a divorce pending. She had been attending therapy focused on parenting issues and her divorce, but had discontinued the sessions. DCF opened the case for treatment. The mother signed a service agreement with DCF in which she agreed to refrain from physically abusing the child and agreed to accept the services of a parent aide. Over three months passed between the referral, assessment and acceptance to the Parent Aide Program. The mother's phone was disconnected in July 1994 and the case worker left a letter at the apartment for the mother and also sent a letter to be forwarded to the mother. However, the mother's whereabouts remained unknown and the case was closed.

On June 10, 1998 a referral was made to DCF by Kara's pediatrician stating that the mother had missed four visits and that the pediatrician's office had to call her each time to reschedule the visit. The doctor was concerned that there was no longer any way to contact the mother. The DCF records concerning this referral incorrectly state "NO PRIOR HISTORY" and the referral was not accepted for investigation.

Two months later, DCF received a referral stating that the mother had been physically abused by Kara's father and was currently at a shelter. She had left her son with his father, who was not Kara's father. According to DCF records, the boy told his father he wanted to go back with his mother because he was afraid for his sister. He stated that the mother was always yelling at him and slapping him for no reason and that he was worried that, without him, she would start physically abusing his sister. The boy claimed that as recently as August 4, 1998, the day before the mother placed him with his father, she had slapped him in the mouth.

Initially the case worker was unable to locate the mother, but she ran a check through DSS and determined the correct address. The first home visit took place on August 18, 1998. The mother denied any violence between her and Kara's father. She claimed that she left him after they argued over disciplining the children because the father claimed that the mother did not discipline Kara "enough". The mother later stated that, on one occasion, Kara's father tipped over a coffee table during an argument and the mother called the police. She then left the home and went to a shelter. The last DCF narrative entry prior to Kara's death indicates that the case worker was to contact all collateral service providers and determine if there were any other concerns. All the entries made concerning the August 1998 referral were made after Kara died. There is no record that any collateral investigation was done. The handwritten entry for August 31, 1998 indicates that "mother is the responsible type, [social worker] needs to see boyfriend, close case." Six weeks later, the child died.

Conclusion

Although not related to the death of Kara, a number of issues were raised in reviewing the case management of this file. It appears that minimal efforts were made by DCF to locate the mother after she left her apartment in July 1995. One of the major reasons for DCF

intervention in this case was to provide the mother with a parent aide. That goal was never accomplished. Later DCF records indicate that a case worker successfully located the mother by contacting DSS. In July 1995, however, there was apparently no attempt to contact DSS, the child's father or any other relatives in an attempt to locate the mother.

The June 1998 referral was not accepted for investigation, and the record included an incorrect notation indicating that the family had no prior history with DCF. Therefore, prior DCF involvement were not considered in the intake assessment.

Finally, it appears that DCF was well on its way to closing the family's case on August 31, 1998. There are no new entries in the record between the handwritten note of August 31, 1998 that stated "close case" and the computer entry concerning Kara's death. It is of concern that all of the computer entries for the August 1998 referral were created *after* Kara's death in October, and that the entry for August 31, 1998 includes information not contained in the handwritten narrative of the same date.

19. <u>MELANIE M.</u> (Date of Death - October 29, 1998)

Age: 3 months, 4 days

<u>Circumstances of Death</u>

Melanie M. was born on July 25, 1998 and died on October 29, 1998. The Medical Examiner determined the cause of death to be Sudden Infant Death Syndrome (SIDS). There are conflicting reports regarding the child's sleeping position, although the initial telephone notice to the Medical Examiner's office indicated that she was found on her back in her crib.

On October 29, 1998, Melanie's grandmother fed her breakfast and put her down for a nap at about 8:30 a.m.. She checked her at 9:30 a.m., and Melanie was not breathing or responding. The grandmother called 911 immediately, but Melanie could not be revived. There was no indication that the child had been neglected or abused while she was in the care of her grandmother.

<u>State Agency Involvement</u>

On July 27, 1998, a hospital made a referral to DCF stating that Melanie was born prematurely and weighed slightly over 3 ½ lbs. The infant had a positive drug screen for cocaine and the mother had five positive drug screens during her pregnancy. The mother admitted to cocaine use the day before Melanie's birth to ease the pain of a toothache. After birth, the infant demonstrated complications associated with prenatal cocaine exposure and required specialized care.

The father was incarcerated and the mother had no definite plans for housing upon discharge. She had a criminal history including a recent assault charge that resulted in a recommendation that she attend a family violence education program. DCF invoked a 96-hour hold on August 4, 1998 and an Order of Temporary Custody was granted by the court the next day. Melanie was initially placed in a foster home where she experienced difficulty sleeping and would often awake shaking uncontrollably. On September 24, 1998, DCF placed Melanie in the home of

her maternal grandmother and step-grandfather. She received services from DMR's Birth to Three program and the Visiting Nurses Association.

The mother began a drug treatment program September 17, 1998. She tested positive for cocaine on September 21 and September 23, 1998. Melanie was adjudicated as a neglected child and committed to the care and custody of DCF on October 7, 1998. The man identified as the father raised the issue of paternity and the court ordered paternity testing. On the day before her death, the Birth to Three program noted that Melanie was sucking appropriately and showed signs of improvement. Three weeks later, the child died.

Conclusion

DCF thoroughly investigated this matter and appropriately placed this infant in foster care. DCF assisted the mother in finding a drug treatment program and provided a referral to services (Birth to Three) to address delays in Melanie's development. DCF investigated the maternal grandparents and placed the child with them when Melanie was two months old. The case work and documentation indicates that DCF offered all available services to this family, while protecting the best interests of the child.

20. Justin P. (Date of Death - November 5, 1998)

Age: 2 months

Circumstances of Death

Justin P. was born on November 11, 1997 and died on January 12, 1998. The Medical Examiner determined that the cause of death was Sudden Infant Death Syndrome (SIDS). He had been put down for a nap by his daycare provider, face down on a sofa facing the rear of the sofa.

State Agency Involvement

DCF had a history with this family involving Justin's older siblings. In 1993, DCF received a referral from a hospital after one child was born testing positive for cocaine and opiates and was suffering from withdrawal. In 1994, both parents acknowledged drug addiction to heroin and cocaine and admitted to using cocaine two days before the birth of another sibling, who was born two months premature testing positive for methadone. As a consequence of DCF involvement, the father entered into inpatient substance abuse treatment in January 1995, but failed to follow through with recommended follow-up care in a day treatment program. The following month, a substance abuse evaluator recommended intensive substance abuse treatment for both parents. The mother entered a detoxification center and the father voluntarily placed his two children with DCF. The mother was discharged from the substance abuse program for her failure to follow recommended treatment.

On May 12, 1995, the father the requested return of his children. At that time the parents had failed to follow through with recommended substance abuse treatment and DCF had not seen

their current apartment. DCF invoked a 96-hour hold on the children on June 13, 1995, requested an Order of Temporary Custody from the juvenile court and filed neglect petitions. The children were adjudicated as neglected and committed to the care and custody of DCF on August 3, 1995.

During 1995 and 1996, the parents failed to follow through with recommended drug treatment and were inconsistent with visitation. On January 28, 1997 the children's commitment to DCF was extended for one year. The court advised the parents that if there were further relapses, DCF would file termination of parental rights petitions. During this one year period, the parents failed to take advantage of scheduled visitation.

The mother admitted to a relapse with heroin during her pregnancy with Justin. After the infant's birth, DCF invoked a 96-hour hold on November 12, 1997 and filed for an Order of Temporary Custody. The parents were then in counseling and the father was attending a partial hospitalization program. After a contested hearing, the court returned the infant to the parents' care in December 1997, over DCF's objection and the objection of the child's attorney. Justin was returned to his parents' care on December 12, 1997 and died one month later of natural causes while in day care.

Conclusion

It appears from the record that DCF made all possible attempts to safeguard Justin. In this case, the court returned the child to his parents over the agency's objection as well as the objection of the child's attorney. While Justin's death does not appear to be related to abuse or physical neglect, the case does highlight the potential correlation between drug use during pregnancy and the higher incidence of SIDS. Scientific research is ongoing in this area.

21. Samuel D. (Date of Death- December 18, 1998)

Age: 6 months, 8 days

Circumstances of Death

Samuel D. was born three months prematurely on June 10, 1998 with serious medical complications. Samuel was on oxygen, blood pressure medication and diuretics and also had special formula. He was a medically fragile child who died of Sudden Infant Death Syndrome (SIDS) while in a DCF foster home on December 18, 1998. He had been put to sleep face up in his crib.

State Agency Involvement

On October 13, 1998, DCF received a referral from Samuel's pediatrician who was concerned after the mother left Samuel in the care of his maternal grandmother for several days. The doctor had learned that, on October 12, 1998, the respiratory therapist went to the home to check on Samuel. When he inquired about Samuel's medication he was informed that Samuel had not received his medications in two days. In addition, the maternal grandmother ran out of Samuel's formula and was feeding him a substitute. The doctor indicated that this could have resulted in very serious consequences for Samuel, and he was requesting immediate

intervention from DCF. The DCF investigator conducted several home visits during this investigation.

On October 16, 1998, the mother returned home. Initially, the mother did not give an explanation as to why she left the home. She then explained that she was stressed living at home with her mother. She indicated that she was looking for a shelter placement. The mother disclosed that she was involved in a physically abusive relationship with the child's father, and indicated that living with the father was not an option.

On October 19, 1998, the case worker was informed that the mother and child had returned to the father's home. The mother reported that she had no other choice because all of the shelters were full. On October 19, 1998, the DCF Program Supervisor invoked a 96-hour hold. Samuel was placed in a medically fragile foster home.

On October 20, 1998, an Order of Temporary Custody was granted by the court. Two months later Samuel died.

Conclusion

While Samuel's death was not unexpected due to his multiple medical problems, the family's failure to provide adequate medical care could have been a factor in the length of his lifespan. DCF responded to the doctor's referral in a timely manner and diligently checked on the child. When it became apparent that the mother could not safely care for him, the agency appropriately sought and received a court order allowing placement in foster care.

22. Brandon I. (Date of Death - December 31, 1998)

Age: 2 years, 10 months

Circumstances of Death

Brandon I. was born on February 1, 1996 at 28 weeks gestation and suffered multiple complications of prematurity, including severe brain damage. He died on December 31, 1998 after multiple and prolonged hospitalizations and complications related to his extensive medical problems. Brandon's death was anticipated and he was ascribed a DNR (Do Not Resuscitate) status several months before his death

State Agency Involvement

The Department of Children and Families received its first report on this family on July 22, 1996. The initial report alleged domestic violence between Brandon's parents. At the time of this report, Brandon's mother was living in emergency housing with five-month-old Brandon and his brother, age 3. The DCF narratives reflect that the mother was receiving support services through emergency housing and was verbalizing plans to return to New York with her children as this was where her natural support system was. The allegations of domestic violence were denied by the parents, but the mother was described as frustrated after having recently given birth to Brandon, who was brain-damaged. Brandon's pediatrician expressed concern regarding Brandon's complex health and developmental problems and indicated that

the child would have ongoing extensive care needs.

In September 1996, a second report was made to DCF by hospital providers because Brandon had several unexplained fractures of his legs, found to be of varying ages. Ultimately, the child's father admitted to "dropping" the child and smoking marijuana while caring for the children. On September 16, 1996, a 96-hour hold was placed on both children by DCF, and an OTC was obtained on September 19. The sibling was placed in foster care at the time, and Brandon remained hospitalized while DCF searched for a foster placement that could meet his very complex needs.

The mother eventually acknowledged a history of maltreatment by Brandon's father towards the children and herself. The father was prosecuted and ultimately incarcerated. The sibling was returned to the mother's care in January 1997 and services for the mother were implemented in New York.

Brandon was committed to DCF in January 1997. His complex medical and developmental problems required very specialized foster care and ultimately he was placed in a foster home experienced in the care of medically fragile children. There were several other children in this foster home during this time, also with complex health and developmental problems. DCF and the foster parents experienced difficulties in attempting to arrange for care and support services for the children in the foster home. On several occasions, health care providers involved with Brandon expressed concerns about the foster care situation.

While Brandon was committed to DCF, his mother remained in New York. Brandon's life was fraught with multiple complications of his health problems requiring recurrent and extended hospitalizations. The case work narratives reflect ongoing debate and intermittent planning to transfer Brandon to an appropriate facility in New York where he could be closer to his family. However, his contact with his mother was sporadic, and it appears from the record that her housing and support situation remained quite unstable up until the time that Brandon died. After much discussion, on April 23, 1998, the DCF Medical Review Board authorized a "do not resuscitate" order for Brandon. Ultimately, Brandon spent the last several months of his life hospitalized. He died on December 31, 1998.

Conclusion

While it is clear that Brandon's death was in no way related to the services he received from DCF, our review of this case highlights several areas of concern. Most significantly, perhaps, is the obvious difficulty DCF experiences when placing a child with complex and specialized needs in out-of-home care. Resources are extremely limited and, from a through review of the documentation in this case, it is apparent that DCF case workers are ill-prepared to offer effective case management to children like Brandon without the intensive support of expert professionals. While the DCF Regional Resource Group nurses are available for consultation, as was previously discussed in the Shanice M. report, their involvement, availability and expertise vary tremendously.

Additionally, in this case, and as is often the case, the foster parents who ultimately did take Brandon were also responsible for the care of several other complex medically fragile children with competing needs and demands.

Another area of concern is the difficulty which the case worker had in obtaining information from providers in New York State. Communication between states is often difficult. Little is known about the circumstances of this child and his family prior to their move to Connecticut. The case worker documented tremendous difficulty obtaining Brandon's medical records from New York despite the fact that this information was critical to his continuing care. Additionally, attempts to locate potential placement resources and to continue working with the family after their return to New York were hampered by geography and a lack of familiarity with resources.

Panel Findings of DCF Involved Cases

The Panel's review of the fatalities of the twenty-three children whose families had received some form of DCF services or intervention reveals that the vast majority of these child fatalities were not preventable by the agency but, rather, resulted from accidental death, Sudden Infant Death Syndrome (SIDS), undetermined causes, or serious medical conditions. In most cases, DCF provided appropriate interventions and professional, caring and compassionate casework. In a few cases, however, the Panel was able to identify practices that could be improved and in five cases (Andrew M., China C., Ryan K., Shanice M., and Tabatha B.), better child welfare intervention might very well have affected the outcome of the case.

The Panel is cognizant of the fact that many reforms have been implemented within and increased resources allocated to DCF since the early 1990's that have promoted better case management and monitoring of at-risk children through improved assessment tools. Indeed, in at least one case reviewed, the DCF involvement with the family occurred years prior to the child's death.

DCF now conducts an internal review of all child fatalities and critical incidents and this practice reflects an awareness of the importance of fatality review in improving agency practices. This allows for remedial measures through policy and improved practice to be instituted in a timely fashion. Indeed, extensive remedial measures have been expeditiously implemented since the release of recommendations made by the Panel and DCF's internal recommendations made throughout the course of 1998.

The Future of Child Fatality Review

The purpose of child fatality review is to enable the development of prevention strategies to address identified trends and patterns of risk in child death and to improve the coordination of

services for the children and families of the state of Connecticut. After conducting fatality reviews in the forty four child deaths that fell within the parameters currently set by statute, the Panel realized that, in order to conduct meaningful fatality review, the categories of cases subject to review would need to be broadened to include a review of the death of any child placed in out of home care and any child whose death was due to unexplained or unexpected causes. This broader form of review is currently in place in most other states across the country.

As a consequence, the Child Advocate has proposed legislation that will the expand the current system of limited child fatality review to include those broader categories. This change will provide a better basis for recommending system-wide improvements for all children across the state, not just those receiving state services.

In anticipation of this change, the Child Advocate has developed a form that will gather information on each child fatality such as causes of death, mechanism of death, age at the time of death, gender, and state agency involvement and services provided. This instrument will allow the Panel to better identify systems issues and recommend remedial measures to minimize safety risks to children across the state.

PROPOSED LEGISLATION FOR 1999

<u>§ 46a-13l. Responsibilities. Child fatality review panel established</u>

(a) The Child Advocate shall:

(1) Evaluate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state;

(2) Review periodically the procedures established by any state agency providing services to children to carry out the provisions of sections 46a-13k to 46a-13q, inclusive, as amended by this act, **AND RECOMMEND AMENDMENTS** with a view toward the rights of the children;

(3) Review complaints of persons concerning the actions of any state or municipal agency providing services to children and any entity that provides services to children through funds provided by the state**, MAKE APPROPRIATE REFERRALS,** and investigate those where it appears, **IN THE DISCRETION OF THE CHILD ADVOCATE,** that a child or family may be in need of assistance from the child advocate**, OR THAT A SYSTEMIC ISSUE IS RAISED BY THE COMPLAINT.**

(4) Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed ~~either by the Family Division of the Superior Court or the Department of Children and Families~~ **BY ANY STATE AGENCY OR DEPARTMENT;**

(5) Recommend changes in state policies concerning children including changes in the system of providing juvenile justice, child care, foster care and treatment;

(6) Take all possible action including, but not limited to, conducting programs of public education, undertaking legislative advocacy**,** ~~and~~ making proposals for systemic reform and **TAKING** formal legal action, **IN ORDER** to secure and ensure the legal, civil and special rights of children who reside in this state;

(7) Provide training and technical assistance to attorneys representing children and guardians ad litem appointed by the **SUPERIOR OR PROBATE COURTS** ~~Family Division of the Superior Court to represent children in proceedings before that court~~;

(8) Periodically review the number of special needs children in any foster care or permanent care facility and recommend changes in the policies and procedures for the placement of such children;

(9) Serve or designate a person to serve as a member of the child fatality review panel established in subsection (b) of this section; and

Take appropriate steps to advise the public of the services of the Office of the Child Advocate, the purpose of the office and procedures to contact the office.

(b) There is established a child fatality review panel composed of seven members as follows: A pediatrician, appointed by the Governor; a representative of law enforcement, appointed by the president pro tempore of the Senate; the Child Advocate, or his designee; a public child

welfare practitioner, appointed by the minority leader of the Senate; a representative of a community service group appointed by the speaker of the House of Representatives; a medical examiner, appointed by the minority leader of the House of Representatives; and the Chief State's Attorney, or his designee. **THERE MAY BE UP TO TWO ADDITIONAL TEMPORARY MEMBERS, SELECTED BY A MAJORITY OF THE PANEL FOR THEIR PARTICULAR EXPERTISE OR INTEREST, TO SERVE ON THE REVIEW OF A SPECIFIC FATALITY. SAID TEMPORARY MEMBERS SHALL HAVE THE SAME DUTIES AND POWERS AS THE PERMANENT MEMBERS FOR SO LONG AS THEY REMAIN ON THE PANEL.** The chairperson shall be elected from among the panel's **PERMANENT** members. The panel shall, to the greatest extent possible, reflect the ethnic, cultural and geographic diversity of the state.

(c) The panel shall review the circumstances of the death of a child ~~who has received services from a state department or agency, addressing child welfare, social or human services or juvenile justice~~ **PLACED IN OUT-OF-HOME CARE OR WHOSE DEATH WAS DUE TO UNEXPECTED OR UNEXPLAINED CAUSES WHICH WILL ENABLE THE DEVELOPMENT OF PREVENTION STRATEGIES TO ADDRESS IDENTIFIED TRENDS AND PATTERNS OF RISK, AND IMPROVE COORDINATION OF SERVICES FOR THE CHILDREN AND FAMILIES OF THE STATE OF CONNECTICUT.** Members of the panel shall not be compensated for their services, but may be reimbursed for necessary expenses incurred in the performance of their duties. **THE LEGISLATURE SHALL APPROPRIATE FUNDS NECESSARY FOR SAID EXPENSES.**

(d)THE PANEL SHALL ISSUE AN ANNUAL CHILD FATALITY REPORT, INCLUDING FINDINGS AND RECOMMENDATIONS, TO THE GOVERNOR AND MEMBERS OF THE LEGISLATURE ON ITS REVIEW OF CHILD FATALITIES FOR THE PRECEDING YEAR.

(e) UPON REQUEST OF TWO THIRDS OF THE PANEL, REQUEST OF THE GOVERNOR, REQUEST OF THE LEGISLATURE OR AT THE CHILD ADVOCATE'S DISCRETION, THE CHILD ADVOCATE SHALL CONDUCT AN IN-DEPTH INVESTIGATION AND REVIEW AND ISSUE A REPORT WITH RECOMMENDATIONS ON THE DEATH OR CRITICAL INCIDENT OF ANY CHILD IT DEEMS NECESSARY. THE CHILD ADVOCATE'S REPORT SHALL BE PROVIDED TO THE GOVERNOR, THE LEGISLATURE, THE COMMISSIONER OF ANY STATE AGENCY CITED AND MADE AVAILABLE TO THE GENERAL Public

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