**DEPARTMENT of CHILDREN and FAMILIES**

*Making a Difference for Children, Families and Communities*

**MEMORANDUM**

**To:** All Staff

**From:** Susan Smith, Chief of Quality and Planning

**Date:** Thursday, February 19, 2015

**Subject:** Fatality Study

I hope this memo find you well. I wanted to take this time to share information about an important report that the Department recently released

Our Office for Research and Evaluation (ORE) has conducted a study of fatalities involving children ages 0-3 who were DCF involved or whose family had prior DCF involvement at the time of the death. A copy of the study is can be obtained by clicking on this link.

ORE, in partnership with the Area Offices and the Court Monitor's Office, looked at 124 fatalities for the period of January 1, 2005 –May 31, 2015. They looked at these cases comparatively to 124 controls in which children of similar age and DCF involvement did not have a fatality. Unsafe sleeping was a leading cause of death for this population. As you are aware, the Department has promulgated policy and a practice guidance specific to assessing, documenting and supporting safe sleeping arrangements for the children on our caseloads. Clicking on those above links will take you to those materials. In addition, Pack N' Plays are available for our families who are in need of that resource to support a safe sleeping environment for an infant.

Next, we also want to alert you to some factors that the study identified as being more greatly associated with an increased risk for a fatality. They are as follows:

1. **Child Age:** Age is one of the most important factors associated with child fatalities. The older the child is, the less likely the child is to die. Children less than 6 months of age are at greater risk for a fatality.

2. **High Risk Newborn:** Children who are high risk newborns due to medical issues were more likely to experience a fatality

3. **Age of the Caregiver:** Younger parents, generally between the ages of 20-24, were more greatly associated with a case involving death of a child under the age 4.

4. **Behavioral Health:** Caregivers with behavioral health needs, particularly those that are untreated, were associated with cases where an early childhood fatality occurred

5. **Substance Abuse:** Cases where there was evidence of parent substance abuse

were more at risk for a child fatality.

6. **CPS Reports:** Families with a number of CPS reports (substantiated and unsubstantiated) were shown to be at greater risk an early childhood fatality

While we want to ensure that staff and our providers are incorporating the above increased risk factors into engagement, assessment and intervention with our families, it is important to know that the study's results neither imply nor should be construed to represent that any identified factor is inherently correlative with fatality (e.g., behavioral health needs, etc.). These factors cannot be viewed in isolation; they are typically part of a broader constellation of issues that taken together increase the risk for fatality.

Some protective factors to reduce the risk for a fatality that were identified through the study include:

**Assessment of Parents' Needs:** Conducting and documenting initial and/or ongoing comprehensive assessments of parents and children's needs, including evaluating the caregiver's interaction with the child were associated with a lesser risk for a fatality.

**Visits with Parents:** Cases in which there was sufficient frequency of visits in relationship to the case circumstances between the caseworker and parent were less likely to result in a fatality.

The Department is working with our Communities of Practice to create best practices and operationalize the recommendations that this study identified. We are also implementing a variety of initiatives, including partnership with the medical community and a public awareness safe sleep and safe care campaign, to reduce serious injuries to and death of young children.

Finally, we are looking to bring to Connecticut a very promising qualitative and quantitative approach to reduce early childhood fatalities (i.e., Eckerd's Rapid Safety Feedback (RSF)). We are very excited about this endeavor and think it will allow us to more readily identify families who may be at increased risk for a fatality, and provide earlier interventions and needed supports. You will be hearing more about RSF soon.

It is asked that Area Office leadership teams meet with staff to ensure that there is familiarity with and an understanding of the risk factors, and the interventions correlated with reducing the likelihood for a fatality.

I thank you all for your assistance and partnership regarding this important information. Should you have any questions about this study, you are welcome to contact me or ORE.

# Department of Children and Families

## Health and Wellness

## Safe Sleep Environments 44-12-8

**Policy**

The Department of Children and Families shall provide training to Social Workers, Social Work Supervisors and all other staff who visit clients' homes and engage with parents and other caregivers of children ages 0-12 months.

**See also:** Safe Sleep Environments Practice Guide.

**Assessing the Safety of an Infant's Sleep Environment**

The Social Worker shall, during each home or placement visit for an infant, ask to observe the infant's sleep environment.

The Social Worker shall engage caregivers of infants in problem solving regarding safe sleep barriers.

The Social Worker shall discuss any concerns with the caregiver and make recommendations for resolution. If a risk factor is identified during a visit and cannot be resolved, the Social Worker shall immediately consult with the Social Work Supervisor as well as the pediatrician for the infant and any home visiting or parents' support services in place.

**Assisting with Procuring Equipment**

If a caregiver is lacking safe sleeping furniture or equipment, the Social Worker, with the support of the Area Office, shall assist the family in securing such items as soon as practicable.

**Documentation**

The Social Worker shall document in the case record

- safe sleeping discussions with the caregivers
- the infant's sleeping environment
- all actions taken to resolve concerns with the infant's sleep environment.

# Standards and Practice for Safe Sleep Environments

Assessing the Safety of An Infant's Sleep Environment

## PRACTICE GUIDE
## To be used in conjuction with DCF Policy 44-12-8

**Purpose**

The purpose of this Practice Guide is to provide DCF staff with evidence-based knowledge to assess the safety of an infant's sleep environment and to educate caregivers about how to create a safe infant sleep environment.

**Definitions**

**DCF staff** means Social Workers, Social Work Supervisors and all other staff that visit the home and engage with parents or caregivers of children ages 0-12 months.

**Infant** means a child younger than twelve months of age.

**Rationale**

### Sudden Infant Deaths in Connecticut: Largely Attributed to Unsafe Sleep Environment

Sudden unexpected infant death (SUID), also known as sudden unexpected death in infancy (SUDI), is a term used to describe any sudden and unexpected death, whether explained or unexplained (including SIDS), that occurs during infancy. SUID or SUDI can be attributed to suffocation, asphyxia, entrapment, infection, ingestions, metabolic diseases and trauma (accidental or non-accidental). Scene investigations can help to identify the root cause of SUID and SUDI.

Monthly reviews by the Connecticut Child Fatality Review Committee and of DCF Critical Incident reports have identified unsafe sleep conditions as a contributing factor in many recent infant deaths. These sleep-related deaths are fully preventable.

Recent evidence suggests that infants reported to child protective services have a heightened risk of SIDS and other SUID; therefore, it is crucial that DCF address these modifiable causes of sleep-related infant deaths.

In 2011, the American Academy of Pediatrics (AAP) Task Force on Sudden Infant Death Syndrome revised its recommendations for safe sleep environment for infants to include the following:

- ***always*** **place a baby on his or her back to sleep for every sleep, every nap, and with every caregiver**
- **use a firm sleep surface (never a couch or chair)**
- **infants should share a room with adult caregivers without bed-sharing.**
- **keep soft objects and loose bedding out of the crib**
- **avoid smoke exposure during pregnancy and after birth**
- **avoid alcohol and illicit drug use during pregnancy and after birth**
- **breastfeeding should be promoted**
- **use a pacifier at nap time and bedtime for infants who will take one**
- **avoid overheating.**

## PRACTICE GUIDE
## To be used in conjuction with DCF Policy 44-12-8

**Rationale (con't)**

The AAP Task Force also supported the expansion of the campaign to reduce the incidence of Sudden Infant Death to include a major focus on the safe sleep environment and ways to reduce the risks of all sleep-related infant deaths, including SIDS, suffocation and other accidental deaths.

As part of its campaign, the AAP Task Force made recommendations about other sleep situations. Key recommendations include the following:

- **use a firm sleep surface such as a crib, bassinet or portable crib or play yard that conforms with the safety standards of the Consumer Product Safety Commission**
- **do not use sitting devices such as car safety seats, strollers, swings, infant carriers and infant slings for routine sleep in the home**

**Recommendations for Practice**

DCF staff, especially Social Workers, shall provide educational information to all soon-to-be parents as well as parents of infants (birth, foster, adoptive, etc.) regarding safe sleep environments, including the 2011 recommendations of the American Academy of Pediatrics.

DCF staff, especially Social Workers, shall also advise parents of infants that the leading cause of preventable death of infants in Connecticut is death caused by unsafe sleeping conditions.

Social Workers shall

- during each home or placement visit for an infant, ask to observe the infant's sleep environment.
- engage caregivers of infants in problem solving regarding safe sleep barriers.
- discuss any concerns with the caregiver and make recommendations for resolution. If a risk factor is identified during a visit and cannot be resolved, the Social Worker shall immediately consult with the Social Work Supervisor as well as the pediatrician for the infant and any home visiting or parents' support services in place.
- if a caregiver is lacking safe sleeping furniture or equipment, assist the family in securing such items as soon as practicable with the support of the Area Office
- provide support to caregivers and families to make the sleep environment for infants as safe as possible by ensuring that families have a safe crib, portable crib or bassinet and, if not, ensure that the family is able to procure one

**Recommendations for Practice (con't)**

- emphasize regularly to caregivers that the safest sleeping environment for infants is on their back, in a crib or bassinet with a firm mattress and without bedding, blankets, bumpers or pillows, in a position proximate to the caregiver, such as next to the caregiver's bed or in the same room as the caregiver, but not in bed with a caregiver
- remind caregivers that sitting devices such as car safety seats, strollers, swings, infant carriers and infant slings are not recommended for routine sleep in the home. If an infant falls asleep in a sitting device, he or she should be moved to a crib or other appropriate flat surface as soon as is practical.
- be sensitive to cultural child-rearing practices including bed-sharing and work with families to implement best practices and maximize safety.

**Documentation**

Social Workers shall document in case record

- safe sleeping discussions with the caregivers
- the infant's sleeping environment
- all actions taken to resolve concerns with the infant's sleep environment.