

Testimony by Michael J. Soltis In Support of
Senate Bills 312 and 310: An Act Concerning the Protection of Particularly Vulnerable
Children and An Act Strengthening Child Fatality Review Procedures

Committee on Children
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Submitted by Alexandra Dufresne

Senator Bartolomeo, Representative Urban, Distinguished Members of the Committee on Children:

My name is Michael Soltis and I have been working as a Pediatric Emergency Medicine Physician at Connecticut Children's Medical Center in Hartford Connecticut for over seven years. In my role as a Pediatric Emergency Medicine Physician I am often involved in the detection, evaluation, and medical care of children who are victims of suspected physical abuse. I have also cared for several children presenting to the emergency department after being found deceased or near death who were later found to be victims of inflicted injury. During my time at Connecticut Children's I also spent about three years working part time with the Suspected Child Abuse and Neglect (SCAN) Program where I conducted evaluations of children who presented with concerns for inflicted injury. This role allowed me to gain further expertise and insight about the collaboration between medical providers, law enforcement, and child protection services in the matters of child protection. In 2010, I completed my master of science degree in Forensic Science with concentration in Advanced Investigation. As part of my studies I worked with the Office of the Child Advocate and conducted a review of homicides in children ages 0-12 years old occurring from 2001-2010 in Connecticut. I am a member of the State of Connecticut Child Fatality Review Panel, and continue to be involved with various committees focused on education of investigators and medical providers on the topics of recognition and investigation of child abuse. These are some of the ways that I have personally dedicated a significant amount of my career to the issues of child protection. **I am providing written testimony in support of Senate Bills 312 and 310 because I feel that they will clearly benefit the welfare of children in Connecticut.**

An Act Concerning the Protection of Particularly Vulnerable Children (SB 312)

When I completed my review of homicides in children 0-12 years old, it became clear that there is a select group from birth to three years of age who are at high risk to die from homicide. This reflects further analysis by the Child Fatality Review Panel and the Office of the Child Advocate identifying children birth to three years old as being particularly at risk for unexpected death. **The factors surrounding the death of a child in this age range can be complex; however Senate Bill 312 is focused on addressing what I see as the major challenges regarding this issue:**

- Recognizing that there is unique group of child who are vulnerable to unexpected death or critical injury

- Emphasis on the risk of unsafe sleep conditions and the association with unexpected infant death
- Strengthening of statewide investigation protocols and the importance of the collaboration of the Department of Children and Families with health care providers when determining whether to accept cases for investigation
- Working to set standards across regional offices regarding the determination of what constitutes abuse or neglect
- Support for in-home services with improved quality assurance to provide consistent evidence based messages to families
- Developing robust methods of data collection to allow for the analysis of trends, and tracking of outcomes relevant to the procedures implemented to protect this unique group of children

Support of the policies and procedures outline in Senate Bill 312 have the potential to greatly impact the protection of children at this vulnerable age.

An Act Strengthening Child Fatality Review Procedures (SB310)

The death of a child is always a tragic event. What I have found in my clinical practice and during the review of many child deaths with the Child Fatality Review Panel, is that there are **often a variety of individuals who have missed opportunities that could have potentially prevented the deaths of these children.**

- The process of child fatality review requires a broad independent investigation of the many factors which may have contributed to the unexpected death of a child
- This process is enhanced by the ability to call upon experts in various fields to review unique aspects of each case
- Recommendations for systematic change and prevention strategies are most effective when the results of a child fatality review can be shared with the all of the agencies and professionals involved in the case

During the review process of child deaths the Department of Children and Families is often found to have been involved with the family in these cases at some point during the child's life. **Although it is my understanding that the Department of Children and Families conducts an internal review when these situations arise, it is my opinion that they do not alone possess the scope to complete the child fatality review process as outlined above.**

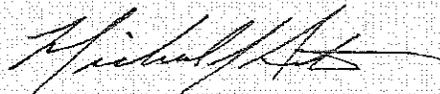
The Office of the Child Advocate is best suited to conduct child fatality review in this manner:

- They alone have the ability to collect records of the various agencies involved
- They may request expert review of the case through the support of the Child Fatality Review Panel
- They can present their findings and recommendations in a meaningful way through public reports

Conducting child fatality review in a comprehensive yet meticulous manner is a huge undertaking. The Office of the Child Advocate should be further supported in order to meet these goals.

For the reasons above, I support Senate Bills 312 and 310. Thank you for taking the time to consider my written testimony.

Respectfully submitted,



Michael J. Soltis M.D.

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