



STATE OF CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES

Public Hearing Testimony
Public Health Committee
February 20, 2015



Proposed S.B. No. 258 AN ACT CONCERNING INFANT SAFE SLEEP PRACTICES

The Department of Children and Families (DCF) **provides the following comments on** Proposed S.B. No. 258, An Act Concerning Infant Safe Sleep Practices.

A DCF study of 124 fatalities between January 1, 2005 and May 31, 2014 of children ages zero to three in families with some agency involvement is prompting changes that will pinpoint families with the highest risks and increase oversight and services for these families.

A “case-control” study, just completed by DCF’s Office of Research and Evaluation, found that Sudden Infant Death Syndrome (SIDs) was the most common cause of death (28.2%), followed by medical complications (12.1%), unsafe sleep (11.2%) and physical injury (8.1%). Consistent with previous Department reviews, unsafe sleep was found to be related to the deaths in 33.9 percent of the deaths. The study analyzed 124 fatalities between January 1, 2005 and May 31, 2014 of children ages zero to three in families with some agency involvement. This analysis is prompting changes that will pinpoint families with the highest risks and increase oversight and services for these families.

The study, which compared the cases in which a child died to a control group, found the following statistically significant factors:

- Age of the child – The older the child is, the less likely the child will die. Among the 124 children who died, 65 percent were less than six months of age;
- High Risk Newborns – Children who were high-risk newborns due to medical conditions were more likely to die;
- Assessment of parent needs – Fatalities were less likely when the Department conducted comprehensive assessment of the parents’ needs;
- Caseworker visits with parents – Fatalities were less likely when there were sufficient frequency of social worker visits with parents;
- Mental health and substance abuse – Parents with these types of treatment needs were more likely to be involved in a child death; and
- Child protective services (CPS) reports – Families with more CPS reports were more likely to suffer a fatality.

National research shows it is hard to predict when a fatality will occur. However, our own research in Connecticut and experience elsewhere show there is a promising approach to preventing heart-breaking tragedies.

The Department is entering an agreement with the Eckerd Foundation, which has pioneered a “Rapid Safety Feedback” (RSF) approach to reduce child fatalities. RSF uses both qualitative reviews and predictive analytics to better identify families involved with the child protective service systems who might be at greater risk for a child fatality. This approach will further support DCF staff to prioritize

interventions and supports for the most vulnerable families that we serve. Families with the highest risk factors will receive more social worker visits with the parents, more comprehensive assessment of parental needs, and more services to meet those needs. This effort could come at no expense to the State of Connecticut for the first two years as Eckerd, a well-known private provider of social services in some regions of the country, has identified philanthropic sources to fund the first year of the program. Casey Family Programs, a national organization with expertise in child welfare, will fund the second year.

Similar strategies for increasing oversight of the most at-risk families has been effective in Florida and other jurisdictions. We have a responsibility to do everything possible to save these innocent little children.

This latest effort to understand and respond to child fatalities in Connecticut comes as the Department continues to address the largest single factor related to child deaths – unsafe sleep conditions for infants. Last year, the Department instituted a new policy to require social workers to talk with parents of children under the age of one about the importance of ensuring a safe sleep environment, to inspect the family’s sleep arrangements. Through DCF’s partnership with Cribs for Kids, two hundred “safe sleep kits,” including portable pack and plays, have been distributed by DCF, and the Department just purchased more to replenish its supply. The Department also has worked with hospitals and enhanced training of its staff and other professional staff to improve the recognition and identification of child abuse.

Finally, the Department continues to work with national organizations, including Prevent Child Abuse America and Casey, as well as state partners, including the Office of the Child Advocate, the Office of Early Childhood, the Connecticut Hospital Association and other state and local partners to develop a public awareness campaign to educate families on preventing fatalities. The messages will focus on unsafe sleep conditions, abusive head trauma, also known as shaken baby syndrome, and targeted messaging to educate parents/caregivers on appropriate responses to a crying baby. Messaging will highlight some of the common risk factors for parents and caregivers around the dangers of substance abuse while caregiving, “sofa sleeping” and other high risk behaviors that have been identified as recurring themes in cases involving fatalities.

Initiatives by DCF include:

- DCF Policy 44-12-8, Safe Sleep Environments: brochures for families, discussions with families.
- Public health campaign is being designed and developed to increase caregiver knowledge and raise public awareness of topics relevant to preventing child abuse and maltreatment.
- DCF secured technical assistance from Casey Family Programs and Prevent Child Abuse America to develop targeted messaging to raise public awareness and caregiver knowledge around recurring issues that present in case fatalities, such as unsafe sleep, abusive head trauma, and attention to caregiver choices.
- The campaign is to include targeted messages to dads and male caregivers.
- Messaging will highlight some of the common risk factors for parents and caregivers around the dangers of substance abuse while caregiving, “sofa sleeping” and other high risk behaviors that have been identified as recurring themes in cases involving fatalities.