DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Joette Katz
Commissioner

Dannel P. Malloy
Governor

January 17, 2018

The Honorable Dannel P. Malloy
Governor
State of Connecticut
State Capitol
Hartford, Connecticut 06106

Dear Governor Malloy:

The following is a written response prepared by the Department of Children and Families to the report entitled: "*Child Fatality Investigative Report: Matthew Tirado*" issued by the Office of the Child Advocate on December 12, 2017. This response is required by Section 46a-13*l*(f) of the Connecticut General Statutes, which provides, in relevant part, that "*[A]any state agency cited in a report issued by the Office of the Child Advocate, pursuant to the Child Advocate's responsibilities under this section, shall submit a written response to the report and recommendations made in the report to the Governor and the General Assembly not later than ninety days after receipt of such report and recommendations.*"

Nearly a year ago, Matthew Tirado, a 17 year old autistic child who was a client of the Department of Children and Families (DCF), died from abuse and neglect in his home. His mother has been charged in his death. The tragedy of Matthew Tirado's death in February 2017 remains with all of us at DCF. The Child Advocate's report touches on a number of long standing legal constraints within DCF and other organizations that were involved in Matthew's all too short life.

The information that the Department had in 2016 was that this was a case of educational neglect of a 17-and-a-half-year-old boy. The Department was not aware of the abuse suffered by Matthew until that became generally known after his death. That information was neither known nor available to the Department while the case was open. Matthew's mother legally denied access to Matthew thereby denying DCF's ability to know the abuse she was inflicting.

As heartbreaking as Matthew's experience was, these retrospective reviews reveal the reality for DCF and for the other entities under scrutiny: *there was no significant evidence*

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that this case was anything other than educational neglect. At no time did DCF receive a referral or develop information that Matthew Tirado was being physically neglected. When viewed in the context of the larger system of entities that have a role in enhancing and ensuring the wellbeing of Connecticut's children, it is apparent that there are neither sufficient staff nor fiscal resources to prevent every single child from falling through the safety net and, equally important, often no clear legal authority permitting these entities to act, separately or together.

The lack of access to Matthew meant that the Department was denied information that would have enabled it to force the parent to allow entry to the home or to interview the children without knowledge and permission of the mother. There is no legal authority for DCF or any other agency, including law enforcement, to compel a parent to allow a state or municipal employee into his or her home, access information such as educational and medical records or make his or her child available for interview, absent a court order. To get a court order, the state needs reasonable cause to suspect that the child is at **serious risk of *physical* harm**. DCF is allowed to interview children outside the home in the presence of a third party without the parent's knowledge only if physical abuse is alleged and the parent is the alleged perpetrator or if requesting permission of the parent will place the child at imminent risk of physical harm.[1]

In total, there were at least 26 attempts either to see or assess the children, to arrange for visits, or to summon mother to appear in juvenile court made by DCF, the child's attorney and the Juvenile Court. Since Matthew was last seen by a social worker in late March 2016, there were 8 visits to the home conducted by DCF. Each time, his mother did not come to the door.

- There were also 5 separate occasions that the social worker attempted to reach Matthew's mother via phone or text to arrange a time to visit the family in the home.
- 2 certified letters were sent. One was returned and the other, sent to notify mother of a court date, was not.
- The social worker also went to criminal court where Matthew's mother appeared in an entirely separate matter to convince her to engage in the Department's efforts to assess the family, but his mother's public defender intervened to separate the worker from mother.
- The child's attorney visited the home 3 times to see Matthew, but his mother did not answer the door on each of these visits.
- On 7 occasions, Matthew's mother was summoned to Juvenile Court for scheduled court hearings. She never appeared.

In July 2016, DCF filed educational neglect petitions on behalf of both children in the Juvenile Court. Matthew's mother simply ignored the summons; in fact she did that 7

[1] Conn. Gen. Stat. §17a-101h.

times in total. The decision to close the case was cleared by the Assistant Attorney General and permitted by the Juvenile Court.

Pursuant to our routine practice, when the Department learned of Matthew's death, we immediately initiated our own internal investigation, and in August 2017, the Department completed its own qualitative review of this tragedy to inform our own quality assurance and internal accountability in accordance with its special qualitative review process conducted by highly experienced child protection managers. These are conducted in the normal course of business when a case involves a fatality, serious maltreatment or serious practice issues. I would like to be very clear that our own internal review, completed in August, predates the OCA report by nearly 4 months. We did not wait, however, for the completion of our internal report before making other improvements to our practice.

Through the course of our review, we identified some social work case practice issues that required attention. Additionally, our review reinforces the importance of other work already underway, including:

- The Department is developing a new child protection record system through federal funding to replace the old LINK system that was instituted in 1996. This will allow social work staff to more efficiently and effectively access necessary history maintained in Department records. This work has been in progress for over 3 years and will cost over $100 million, heavily subsidized by the federal government.
- The tool (Structured Decision Making) for assessing safety and risk was re-validated by national experts. More than 400 staff have been re-trained in how to implement the tool and the Department's efforts to update the tools based on practice changes since the 2007 implementation are underway
- Cases where social work staff are denied access to the children in the home can now only be closed with direct approval from the office director.
- A petition in Juvenile Court can be withdrawn only with approval from in-house legal counsel assigned to each of our 14 Area Offices.
- The Department has clarified with the Judicial Branch that legal actions are taken after the Department's own internal legal consultation process, which are presented to the court through the AAG, our designated legal counsel in all court proceedings.

Response to Recommendations

The OCA report makes thirty-four specific recommendations, many of which apply to the Department of Children and Families. The following is DCF's response to these recommendations:

Recommendation # 1: "*Risk and Safety Assessments and resulting interventions must give appropriate weight to a child's vulnerability, whether due to age or disability. Where a threat to a child's safety or well-being is identified along with a clear vulnerability that heightens the risk of harm, the resulting case plan or safety intervention must clearly state how the child's ongoing vulnerability will be addressed and how the case plan/safety intervention will mitigate the threat to the child. Disability-related concerns should be specifically and clearly addressed in risk and safety assessment and case planning.*"[2]

DCF Response:
The Structured Decision Making (SDM) suite of tools includes specific questions designed to assess a child's vulnerability noting specifically "the vulnerability of each child needs to be considered throughout the assessment. Children ages zero through six cannot protect themselves. For older children, inability to protect themselves could result from diminished mental or physical capacity or repeated victimization". Furthermore, the suite of tools includes a specific question relative to characteristics of children in the household including medical fragility and/or developmental or physical disability.

Recommendation # 2: "*Quality assurance reviews related to case planning, risk and safety assessment, must include assessment of whether the child is uniquely vulnerable to future harm due to age or disability and whether the case plan/safety plan adequately considers the child's vulnerability/disability through appropriate supervision and intervention.*"[3]

DCF Response: The Department's various qualitative and case reviews take children's and families' individual presentations (e.g., age, physical disabilities, and intellectual disabilities) and needs into account when assessing for concerted efforts, appropriateness and efficacy. For example, tools such as the Administrative Case Review Instrument (ACRI) and the Differential Response System (DRS) explicitly assess the timeliness and accuracy of the SDM tools. Which, as noted in the above response, requires qualitative reviews to consider children's age and mental or physical disabilities that impact safety and risk. Further, tools such as the ACRI inquiry into whether areas such as case planning, frequency of visits, and services are adequately assessed and addressed congruent with children's and families' needs (i.e., developmental and disabilities).

Recommendation # 3: "*Quality assurance improvements by DCF must include systematic case reviews and sampling to determine the reliability of risk and safety assessments, with attention to highly vulnerable populations such as children with disabilities.*" [4]

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[2] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 64.
[3] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 64.
[4] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 64.

DCF Response: DCF fully acknowledges that there are some social work case practice issues that have been identified and are being addressed. For example, we use an evidence-based suite of tools called Structured Decision Making (SDM) as part of our tool kit for assessing safety and risk factors to children.

The OCA highlights scoring errors in the SDM tools for the Tirado case that resulted in inconsistent information being passed on to subsequently-assigned social work staff. This is, however, a misrepresentation of the importance of these inconsistencies. The Ombudsman corrected the scoring of the SDM tools used in the Tirado case and then reassessed DCF's case practice and legal options using the corrected scores. He determined that, even if each tool had been scored perfectly in every aspect, DCF would have taken the exact same action.

In other words, *the errors in the scoring had no impact whatsoever on the outcome of this case.* OCA's emphasis on this point and, thus, the conclusion she draws, has no merit. There was simply insufficient evidence to even suggest, much less prove, that the children were then being neglected or abused in any way other than chronic absenteeism. The most drastic action DCF could have taken based on the facts reasonably available was to file an educational neglect petition -- which it did. KT chose to avoid contact with any authorities and thereby eluded being served with court documents. Without proper service of process, the neglect petition became an exercise in futility.

That being said, as the science develops over time, safety and risk tools[5] are always being updated. We have stated publicly that we are working with CRC, the tool's developer to update SDM and provide targeted staff training. The overall scope of the project, costing in excess of $1,000,000 has begun with CRC validating the use of the existing SDM tools. As of this writing, over 400 staff have attended enhanced training sessions. As the tools are updated, CRC will be working with DCF to provide additional training and coaching to ensure model fidelity and quality assurance. After CRC completes its work, DCF's Information Services division will build the new SDM tools into DCF's electronic case record management system, CCWIS (see below). We expect that to be completed within six months of the CCWIS launch.

Recommendation # 4: "*DCF should annually track and publicly report regarding the efficacy of its risk and safety assessment practices with clear demonstration of the methodology for determining the reliability of its practice, fidelity to evidence-based*

[5] The OCA insists that DCF should be assessing "vulnerability." It is unclear to us how that might be different from risk and safety. In any event, we are not aware of any evidence-based tools for assess "vulnerability" specifically.

practice and tools, and the effectiveness of the assessment process for identifying children at risk of child abuse or neglect."[6]

DCF Response: The Departments commitment to upgrading the SDM toolkit includes a comprehensive quality assurance process.

Recommendation # 5: *"DCF should require a legal consult and an updated risk and safety assessment whenever a parent refuses access to a child or refuses to acknowledge a child's whereabouts, whenever such refusal occurs during the life of a child protection case and the child's safety cannot otherwise be established."*[7]

DCF Response: When a case is filed in the Superior Court for Juvenile Matters, as in this matter, the Department is represented by and regularly consults with the Office of the Attorney General. Legal consults are part of the attorney-client relationship.

When a case is not in the juvenile court, each Area Office is served by legal staff, including attorneys and paralegals. The duties of the attorney are set forth in DCF Policy 31-10-2. Given these numerous and complex duties, it is difficult to enumerate the many situations that may require a legal consult. Rather, staff will be reminded about the availability of legal staff to provide legal support in all the areas set forth in DCF Policy 31-10-2.

Recommendation # 6: *"DCF closing check-lists should be immediately revised to require documentation regarding 1) assessment of child safety; and 2) any concerns regarding unique vulnerability of child in the home due to child's age or disability."*[8]

DCF Response: The closing checklist serves to ensure that the main components of our casework have been completed successfully resulting in the decision that child protective services involvement is no longer warranted. Concurrent with the checklist being submitted for review, the SDM Safety Assessment and Risk tools are submitted and document that the child is safe as well as any unique circumstances of the child and overall risk factors including how they will be addressed by either the family or community members moving forward once the case is closed. In the Risk Assessment, the vulnerability of the child is addressed. The Department has already implemented a procedure in that the Office Director must approve any case closure, which entails that a child not successfully being seen.

[6] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 64.
[7] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 64.
[8] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 64.

Recommendation # 7: *"OCA supports DCF's effort to rebuild its case management database and agrees that this is an urgent priority for the agency, as assessment processes outlined above require reliable and efficient mechanisms for the inputting and retrieval of critical information. Such a system does not exist today, and social work staff are greatly hampered in their ability to do time-sensitive and comprehensive case reviews regarding families who may have extensive prior involvement with the agency. In the interim, the agency may consider a practice wherein managerial or internal consultation staff assist with case record review for families with high risk of recurrent child abuse and neglect."*[9]

DCF Response: The OCA concludes that the Social Workers in the Tirado case missed critical information because DCF's case management system (the electronic database known as LINK) is too unwieldy for staff to readily identify important historical details. While we agree that the LINK system requires an extensive overhaul (discussed below), the implication that important information cannot be located is false. All of the allegedly "missed" details of this case are, in fact, available in the narratives and investigation reports. *In fact, OCA itself could not have identified these details if they did not appear in the case record.*

The real problem is that there is *too much* information in LINK for social work staff to read as thoroughly as they would like. Report after report issued by the OCA over the years criticizes DCF for failing to document more information more often. Partly as a consequence, narrative entries and investigative reports have become much longer and more detailed. A complicated case can easily consist of thousands of pages of written social work notes. This is a classic Catch-22: although social work staff now need to spend more time reading the additional pages of the case records, they actually have less time to do so because they must spend time writing more pages!

Although the OCA calls for an "immediate" solution to this problem, their suggestion seems to be to assign additional DCF staff to read case records and report back to the Social Workers handling specific cases. The OCA does not offer a suggestion as to how the existing responsibilities of the "readers" will be handled or how the State will fund hiring additional employees for this purpose.

This case once again illustrates that there are simply insufficient resources to treat every single case equally. In the Tirado case, less time was spent reviewing a voluminous case record because it was considered a lower priority case than those that contain elements of active abuse or serious physical neglect. Social Workers must have the latitude to establish such priorities when the time and resources so require.

[9] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 65.

DCF is currently engaged in a massive rebuild of its case management system, known as the Comprehensive Child Welfare Information System (CCWIS). This is a multimillion dollar and multiyear project. There is a legally-required complicated bidding process and highly technical contracting requirements, involving the OPM, the Office of the Attorney General and the Department of Administrative Services, in addition to actually building and testing the software.

DCF has moved from the planning stage to pre-production stage of this project. On November 29, 2017, DCF was approved for the funding of this system and is finalizing the contract with the system integrators that will build the software.

The CCWIS Project uses an Agile project management approach, with the primary goal of producing frequent releases of highly valuable software to frontline Social Workers. This approach is unlike the customary Waterfall project management approach that delivers software in one delivery cycle and has long lead times before the end user can benefit from the product.

The new CCWIS is being designed to have intuitive features to manage and expedite workload activities, and increased functionality to capture timely and accurate documentation. The staff labor efficiencies realized with implementation of the new CCWIS will come from a more intuitive, easier to navigate system, automation of manual data collection activities, and mobile systems for Social Workers. The CCWIS project will also have multiple data exchanges with partner agencies to share information, leading to a more complete and accurate case record. Production is scheduled to begin February of 2018.

We discussed that the new CCWIS would be one of the strategies that we would include in our Federal Performance Improvement Plan (PIP). Two meetings were held in Spring 2017 to support the development of the PIP. The OCA was invited and attended these meetings. We specifically did a presentation about the core areas that we were including in the PIP. Then Deputy Commissioner Fernando Muniz presented on the upcoming CCWIS and the impending efficiencies, and practice and data improvements that it would support.

Recommendation # 8: *"Child welfare agency workers will need specific training regarding working with families who have children with developmental or multiple disabilities, including 1) the unique vulnerability of children with disabilities to abuse and neglect; 2) signs of abuse and neglect for children with disabilities; 3) assessment and investigation practices for children who may have limited or no capacity for communication; 4) guidance regarding purposeful visits to families ; 5) guidance regarding utilization of internal and external consultation resources to assist with serving and protecting such children; and 6) guidance regarding community-based and state-agency funded resources*

that assist with case planning and service delivery for families that have children with developmental disabilities."[10]

DCF Response: The OCA reports that some DCF staff have expressed a desire for more available internal expertise in cases that involve children with disabilities. Consistent with past reports, the Child Advocate uses the Tirado case as a platform to recommend elevating a certain population of children over other populations. For example, previous reports demand that cases involving children under the age of three years or who have medical complications or who are adolescents be given higher priority than others. In reality, of course, all subsets of children deserve to receive case planning that incorporates sufficient strategies and services to meet their varied and individualized needs.

DCF has a Regional Resource Group (RRG) in every Region that includes experts in education, intimate partner violence, substance use, medical and nursing and mental health. Each RRG is supervised by a senior clinical manager, who is empowered to identify additional expertise in or outside of the agency to consult on a case-by-case basis. Although the OCA strongly implies that the result of the Tirado case would have been different if only the assigned social work staff had access to someone with knowledge about autism, at the time the case was active, there was no identified need for additional expertise because the issue was chronic absenteeism, not lack of services for Matthew Tirado. In addition, KT allowed limited and, later, no access to Matthew Tirado. There was no legal way to force her to allow DCF to have Matthew Tirado evaluated by forensic and developmental experts, as the OCA asserts should have been done. Sadly, a cadre of available experts would have made no practical difference in the face of KT's intransigence.

DCF does agree that Connecticut's children with developmental delays do not have enough resources available to them and to their families. For example, although the Department of Developmental Services (DDS) is the agency mandated by law to provide this expertise and these resources, its budget is reduced by the legislature year after year. This results in parents, educators, health care professionals, attorneys and others demanding that DCF fill this gap. Since DCF is not the legal agency of cognizance, the legislature has not provided us with funding to meet these new demands. Rather than expecting DCF to absorb the budget cuts of a sister state agency and hire experts (which DDS already has) and add new services, DCF respectfully suggests that the Child Advocate focus her attention on convincing the legislature to fund DDS sufficiently to meet its statutory mandates.

[10] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 67.

Recognizing this gap, however, the DCF Academy for Workforce Development has recently added simulation training to its catalog of trainings and scenarios that include children with developmental disabilities. The Academy is also creating a traditional in-service training that specifically addresses this topic. Finally, we are currently working with OCA, DDS and other state agencies to develop additional cross-training opportunities. Thus, the OCA report misrepresents the ongoing efforts by DCF to address the unique needs of this population.

Recommendation # 9: *"DCF should ensure that assessment tools are accurately identifying children with disabilities early in the investigation process and that service and safety-related needs are directly addressed in the safety assessments and family case plans. If a child is assessed as having a disability, practice should include "asking basic follow-up questions regarding the disability's severity, age of onset, and potential causes," and appropriate referrals should be made to ensure proper assessment and service delivery if such services are not already in place."*[11]

DCF Response:
See response to Recommendation #1 that outlines the inclusive of this language in the suite of tools. It is also important to note that the comprehensive assessment process also relies on collateral contacts inclusive of pediatricians, teachers, treatment providers and others that have specific knowledge of the child and family to inform the assessment and case planning process.

Recommendation # 10: *"DCF should collect and report data regarding incidents of abuse and neglect, including critical incidents and fatalities, involving children with disabilities."*[12]

DCF Response: Contrary to the OCA's assertion, DCF does collect data regarding intellectual limitations and developmental delays in children. The Education tab in LINK also specifically collects autism data. There are a panoply of elements that are associated with these data, and they can be analyzed based upon the need or the ask. In fact, these are data (i.e., disability) that it appears the Federal NCANDS reporting used to require. It does not appear, however, that such data is currently part of the NCANDS report. The last version of the NCANDS report that included such data was 2012. The Department did submit maltreatment victim data by disability designations as required by the Feds. The hyperlink to that table in the 2012 NCANDS report is as follows:
https://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf

The OCA did not request this data from DCF at any time during the nine months that the office has been working on this report. The Department has made a

[11] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 67.
[12] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 67.

number of presentations in-state, within New England and nationally about our data over the past few years, including that regarding our abuse, neglect and fatality reporting. We even gave a presentation to the Child Fatality Review Panel about two years ago, at their request, about our fatality data collection and reporting. We have never been asked to disaggregate such data (maltreatment) by disability.

Recommendation # 11: *"DCF must have protocols for investigation and case planning that are specific to the specialized needs and unique presentations of children with disabilities, including children with intellectual and developmental disabilities and concomitant communication disorders. Families who have children with disabilities will benefit from connection to a community-based provider that is knowledgeable and experienced in working with families whose children have neurodevelopmental or other developmental disabilities, and emphasis must be placed on engagement and care coordination for the whole family. DCF's Family Assessment Response program contracts may be examined to determine if the Community Partner Agencies working with DCF-referred families can help fill this role and offer families sustained connections to relevant community-based supports."*[13]

DCF Response:
The Department recognizes that each family circumstance is different. As such, the Department applies a comprehensive approach to assessments whether through Investigation or Family Assessment Response that includes the SDM, direct contact with the family, collateral contacts and other supporting documentation. Case planning and service provision is driven by the unique and individualized needs of the child(ren) and family which does include specific evaluations and outreach to subject matter experts depending on the presenting circumstances.

Recommendation # 12: *"DCF should work with partners from the Office of Early Childhood, and the Department of Developmental Services, including the embedded Abuse Investigation division (now housed within DDS, formerly within the State's Office of Protection and Advocacy) to assist with the development of investigation, assessment, and case planning processes that are responsive to the unique needs of children with developmental disabilities. Joint agency strategies and mission statements should be developed to identify common goals in serving and protecting children with disabilities, and supporting their families' need for services."*[14]

DCF Response: See response to Recommendation #11.

[13] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 68.
[14] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 68.

Recommendation # 13: "*DCF should develop a Community of Practice, with membership internal and external to the Department, to assist with its review and revision of policies, training supports, and accountability with regard to recommendations contained in this report.*"[15]

DCF Response: Rather than creating a new Community of Practice, DCF intends to refer appropriate recommendations contained in this report to the existing Communities of Practice that have cognizance over the content of recommendation.

Recommendation # 14: "*DCF, in partnership with the Public Defender's Office, the Attorney General's Office, and the Judicial Branch, should review current state law and procedure to determine how best to strengthen the safety net for children who are suspected or documented victims of abuse or neglect and yet remain inaccessible to state or local officials due to parental lack of engagement and non-cooperation.*"[16]

DCF Response: DCF has drafted statutory language to amend §17a-101h and submitted a legislative proposal to the Office of Policy and Management for consideration during the 2018 session of the General Assembly. We will share this proposal with the other agencies listed in the recommendation. See DCF's response to Recommendation # 15 for additional information.

Recommendation # 15: "*Legislators should consider amending state law to permit DCF authority to interview a child where there is a reasonably felt concern for the child's safety or well-being, including where allegations have been made of physical, emotional or educational neglect. State law should also expressly allow for DCF to assess the safety and well-being of children with disabilities where there are pending allegations of abuse or neglect and where the child is not capable of communicating concerns about his or her own safety.*"[17]

DCF Response: DCF agrees with this recommendation and looks forward to collaborating with the Office of the Child Advocate in support of legislation during the upcoming legislative session. The Department has drafted statutory language to amend §17a-101h and submitted a legislative proposal to the Office of Policy and Management for consideration during the 2018 session of the General Assembly. The OCA's report, albeit belatedly, clearly recognizes this gap in child protection. It calls for statutory changes to increase DCF's authority to speak to a child privately and, if necessary, without the parents' permission, which appears to mean that she now supports the resurrection of DCF's past attempts at legislative change.

[15] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 68.
[16] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 70.
[17] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 70.

There is currently no legal authority for DCF or any other agency, including law enforcement, to require a parent to allow a state or municipal employee into his or her home, access information such as educational and medical records or make his or her child available for interview, absent a court order. To get a court order, the state needs reasonable cause to suspect that the child is at serious risk of *physical* harm. DCF is allowed to interview children outside the home in the presence of a third party without the parent's knowledge only if physical abuse is alleged and the parent is the alleged perpetrator or if requesting permission of the parent will place the child at imminent risk of physical harm.[18]

Although DCF has proposed amendments to this statute three times (2000, 2010 and 2011),[19] there has been vocal opposition from a variety of sources to the perceived imposition on parental rights, and the legislature has refused to move our proposals. This means that, unless there is *actual evidence* that a parent is physically abusing a child or that the child will be in *immediate* physical danger, a parent cannot be required to make his or her child available for an interview nor can DCF go to a school or daycare to see a child if the parent objects. VT's sole statement that her brother had been hit at some unspecified time in 2014 is not sufficient from a legal perspective to prove imminent danger. Again, in the case of Matthew Tirado and VT, DCF's hands were tied in terms of proactively working around the mother's refusal to make her children accessible. KT simply refused to respond to DCF staff assigned to her case, to school administrators and teachers, to medical providers and to the court. DCF, the school system and the children's attorney went to KT's home many times and got no response. The DCF Social Worker went so far as to track KT down at her place of employment and in traffic court, steps DCF rarely takes for public policy and social work reasons. In July 2016, DCF filed educational neglect petitions on behalf of both children in the Juvenile Court. KT simply ignored the summons and the court case was eventually closed.

Recommendation # 16: "*There should be a procedure (and forms) that children's attorneys can follow to ask the court to compel a custodial parent's presence in court and to seek orders, where necessary, to see or interview their child client.*"[20]

DCF Response: DCF defers to the Office of the Chief Public Defender regarding this recommendation.

Recommendation # 17: "*DCF, in consultation with the Attorney General's Office, should revise and clarify its policies regarding the use of internal and external legal consultation*

[18] Conn. Gen. Stat. §17a-101h.
[19] S.B. No. 342 (2000), S.B. No. 152 (2010), H.B. No. 6227 (2011).
[20] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 70.

in the development and submission of documents to the Juvenile Court that seek to end a child protection proceeding or otherwise seek judicial order affecting the safety or well-being of a child, whether during a trial, pre-trial or short calendar proceeding."[21]

DCF Response: The OCA's report makes recommendations regarding legal consultation to and representation of DCF staff. DCF finds these passages in the report objectionable.[22] Neither the Child Advocate nor anyone on her staff has ever provided direct legal services to a child welfare agency and, thus, she has no expertise in the complexity and nuance of this type of law practice. Nor does the OCA report accurately convey the full scope of work expected of the in-house DCF attorneys and the Assistant Attorneys Generals (AAGs) on a day-to-day basis.

The report reflects that during their interviews, the staff were not clear about the role of the in-house attorney and AAG. We believe this not to be the case. However, in the absence of a transcript or follow up clarification we are unable to determine the reason for the reported confusion. Nevertheless if staff are indeed confused about the roles of their attorneys, we are also perplexed. The Attorney General's Office has represented DCF in court since its inception in the 1970s. The internal DCF Office of Legal Affairs has existed since 1998. All new Social Workers are provided with multiple days of legal training, co-taught by AAGs and DCF lawyers. In-service legal trainings are provided multiple times each year, either at the DCF Workforce Academy or tailored to the needs of individual Regional and Area Offices. All of DCF's Area Offices hold legal exchanges with the juvenile courts and lawyers to discuss a range of issues identified by Social Work staff. Both in-house and AAG legal staff are available at all times on a one-to-one basis to resolve any confusion about who handles which legal tasks. Staff memos providing direction on legal issues are routinely issued. DCF does not believe the quality of legal representation is truly an important gap; nevertheless, we will issue an all staff memo with input from the AAGs to clear up any confusion that might exist.

OCA's recommendations include what amounts to quadrupling the responsibilities of the in-house attorneys and AAGs. This is impossible. There are eleven DCF in-house attorneys assigned to fourteen Area Offices, supervised by one legal manager, available to provide legal consultation to over 1,200 social work staff. There are 37 AAGs assigned to handle over 6,000 petitions annually, as well as all

[21] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 70.
[22] An earlier draft of the OCA's report included a specific review of the role of the Office of the Attorney General in the Tirado case. That section is inexplicably missing from the final report. Instead, the OCA finds that DCF Social Workers are at fault for the failure of the AAG to file specific motions, request that the court take the mother into custody and make an adequate legal record, responsibilities that clearly lie with the court room attorney in any type of case. Additionally, the OCA states that DCF did not consult with the AAG regarding the final request to close the court case. In fact, the DCF manager on the case had a telephone consultation with the AAG, as documented in the case narratives available to OCA.

legally-required case reviews, hearings, pretrials, status conferences, full trials and appeals. Further, both in-house lawyers and AAGs have a myriad of responsibilities in addition to consultation and representation in specific cases. There are simply inadequate resources to take on the uninformed expectations of the OCA.

Such an increase in legal work is also unnecessary. Contrary to the OCA's assertion, there are guidelines for consulting legal staff when appropriate at every stage of a child protection case. Not every case needs ongoing legal review. Social work managers and supervisors determine when legal consultation will be helpful, depending on the complexity of the case and the experience of the assigned social work staff. Adding additional layers to this process simply to meet an OCA recommendation not only drastically increases the need for additional legal staff, but also adds literally hours of unnecessary tasks for social work staff, who are already stretched to maximum capacity.

Recommendation # 18: "*DCF, in consultation with the Attorney General's Office, should revise and clarify its policies regarding the use of internal and external legal consultation regarding any obstacle to ensuring the safety and well-being of a child. For example, whenever children who are the subject of a Juvenile Court proceeding have not been seen or assessed within a reasonable time frame, DCF should conduct a case review with its internal lawyers or the Attorney General's Office for the purpose of determining the legal strategies that may be utilized to assess the safety of the children. Such case consultations should be mandatory.*"[23]

DCF Response: See response to Recommendation #17.

Recommendation # 19: "*DCF staff should be trained regarding the use of legal resources for commencement of, strategizing regarding, and termination of child protection cases and proceedings.*"[24]

DCF Response: In a discussion of questionable relevancy to the case practice and ultimate outcome of this case, the OCA points out that DCF staff are required to have at least 30 hours of in-service training each year, and she finds fault with our tracking and record keeping in this regard. Incomplete documentation is not, of course, an indication that useful training sessions are not available to staff.

While a recent comprehensive review by the federal government found the tracking of staff training to be an area needing improvement, the training content was deemed to be of good quality. Nonetheless, DCF is in the process of making

[23] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 70.-71.
[24] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 71.

enhancements to both the statewide Learning Management System and the timecard coding process that will electronically track all staff trainings.

Recommendation # 20: *"No child welfare proceeding should be closed without having assessed the safety of the children and without children having been seen. Documentation of the child's visibility and physical safety should be included in the court record prior to closure. A closing check-list that addresses child safety and vulnerability should be reviewed by DCF and the Attorney General's Office and submitted to the court as part of any submission of a request to close a case."*[25]

DCF Response: The Department of Children and Families, Office of the Attorney General and the Judicial Branch will review this recommendation as it touches upon potential changes in a system that is jointly shared amongst these state agencies. It should be noted that the court at this point relies upon the Department to assess the safety of the children including their vulnerability and inherent in the Department's request to withdraw the petitions believes these issues have been addressed. The decision prior to coming to court is jointly discussed with the Assistant Attorney General representing the Department.

Recommendation # 21: *"No disposition of a child protection case in the Juvenile Court should be modified or vacated without an offering and finding that such modification serves the best interests of the child. Consideration should be given as to whether a statutory or Practice Book rule change is required to ensure such finding issues. Requests to modify or vacate judicial orders that protect the interests of children should be required to cite the relevant Practice Book rule or statutory sections."*[26]

DCF Response: DCF defers to the Judicial Branch regarding the need for any statutory or Practice Book rule changes.

Recommendation # 22: *"Practice Book rules should be amended to require that social studies or status reports submitted as part of the court's review of Protective Supervision be filed with the Court and the parties no later than 5 days prior to the court proceeding."*[27]

DCF Response: DCF defers to the Judicial Branch regarding the need for any Practice Book rule changes.

Recommendation # 23: *"The DCF administrative closing checklist does not have any direct reference to safety issues for particularly vulnerable children: e.g., a child under age 5 or a child with a disability. Checklists should be immediately revised to reflect existing*

[25] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 71.
[26] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 71.
[27] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 71.

directives regarding case closures and the need to ensure cases are not closed without seeing children, assessing safety, addressing uniquely vulnerable children, and ensuring appropriate internal and legal consultations."[28]

DCF Response: The closing checklist serves to ensure the main components of our casework have been completed successfully resulting in the decision that child protective services involvement is no longer warranted. Concurrent with the checklist being submitted for review, the SDM Safety Assessment and Risk tools are submitted and which document the child is safe and any unique circumstances of the child and overall risk factors including how they will be addressed by either the family or community members moving forward once the case is closed. In the Risk Assessment, the vulnerability of the child is addressed.

Recommendation # 24: *"That the Public Defender's Office review performance guidelines for lawyers to determine whether further guidance is necessary regarding the representation of children with complex disabilities, and specifically when lawyers are obligated to take protective action on behalf of their clients as contemplated by the Rules of Professional Conduct, Rule 1.14."*[29]

DCF Response: DCF defers to the Office of the Chief Public Defender regarding this recommendation.

Recommendation # 25: *"Ensure that training regarding the representation of children with disabilities is included in all pre-service training, and that training regarding advocating for the needs of children with developmental disabilities is regularly provided as in-service training for lawyers representing children in child protection proceedings."*[30]

DCF Response: DCF defers to the Office of the Chief Public Defender regarding this recommendation.

Recommendation # 26: *"Where lawyers for children encounter structural obstacles to fulfilling their obligations as counsel to a child, such concerns should be brought to the Court and/or to the Office of the Public Defender so that a plan for remedy can be devised."*[31]

DCF Response: DCF defers to the Office of the Chief Public Defender regarding this recommendation.

[28] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 71.
[29] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 72.
[30] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 72.
[31] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 72.

Recommendation # 27: *"That the Judicial Branch develop and implement use of a bench card to assist with case review and safety assessment for child protection matters involving children with disabilities."*[32]

DCF Response: DCF defers to the Judicial Branch regarding this recommendation.

Recommendation # 28: *"That the Judicial Branch canvas attorneys for children at critical points in litigation as to whether they have consulted or met with their child clients, and in the case of a client with diminished capacity, whether the lawyer has been able to obtain adequate information necessary to inform the need for protective actions consistent with the child's safety, the Rules of Professional Conduct, and state law requirements."* [33]

DCF Response: DCF defers to the Judicial Branch regarding this recommendation.

Recommendation # 29: *"Consistent with other recommendations in this report, the Court should require DCF to submit documentation regarding its safety assessment and the whereabouts of the child prior to case closure."*[34]

DCF Response: The Department of Children and Families, Office of the Attorney General and the Judicial Branch will review this recommendation as it touches upon a potential changes in a system that is jointly shared amongst these state Agencies.

Recommendation # 30: *"As part of the home-schooling application process, districts should review the child's educational history to determine whether there have been notable or persistent concerns regarding truancy, chronic absenteeism, abuse or neglect or other unmet needs that affect the child's health and safety. Whenever a district has a reasonable suspicion that a child is or has been abused and neglected, such concerns must be reported to DCF consistent with state law. DCF and SDE should assist districts with guidance regarding when a child's withdrawal from school (or chronic absenteeism) may trigger an obligation to report suspected concerns to DCF."*[35]

DCF Response: In 2011, a significant piece of legislation passed that impacted the role of educators and school personnel in reporting suspicions of child abuse and neglect. Public Act 11-93 was in fact passed as a result of a joint report of the Office of the Child Advocate and the Office of the Attorney General which identified significant flaws in the reporting of those suspicions.

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[32] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 73.
[33] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 73-74.
[34] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 74.
[35] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 77.

This act increases the obligations of the education system to fulfill their legal responsibility of reporting their suspicions of abuse and neglect, streamlines the Department's investigative process, and clarifies the information sharing that is allowed in cases of alleged abuse and neglect. The legislation also specifically calls for educators and school personnel to be trained in the mandated reporter process and sets standards for background checks involving potential school employees.

Since the passing of Public Act 11-93 and the launching of the online mandated reporter training program developed specifically for educators, the amount of DCF administered training sessions jumped from 2,400 in 2010 to an average of 45,000 trained annually online and in-person to date. The in-person training continues to be offered to schools upon request. To date over 90 DCF staff are certified through the Academy for Workforce Development to conduct such training throughout the state.

Efforts to engage and support school systems with their obligation to report suspicion of abuse and neglect is ongoing.

Recommendation # 31: *"Districts must ensure that they are compliant with state law obligations to ensure that each school-age child "is receiving equivalent instruction" as required, whether through an annual portfolio review as recommended by SDE or by another means. The SDE should take steps to ensure that districts are aware of their obligations and are complying with General Statute section 10-184 with regard to home-schooled students."*[36]

DCF Response: DCF defers to the State Department of Education and local school districts regarding this recommendation.

Recommendation # 32: *"State law and regulatory or technical guidance from the SDE, in consultation with DCF, regarding the home-schooling of children should be reviewed and amended to ensure an adequate safety net for children at high risk of or who have documented histories of abuse and neglect. Consistent with approaches taken by other states, Connecticut should consider enacting statutory-regulatory language that minimally ensures a child withdrawn from school is receiving an education and is making progress in instructed areas."*[37]

DCF Response: DCF agrees with OCA's recommendation that the legislature enact statutory changes to impose heightened regulation over home schooling -- something that we have attempted in the past with virtually no support from the advocate community. We look forward to reviewing and collaborating on a draft

[36] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 77.
[37] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 77.

bill in the coming General Session. Similarly, we hope the Juvenile Justice Policy and Oversight Committee, which includes the OCA in its membership, is willing to work with the legislature to craft a resolution addressing the enforcement gap that now exists because of its elimination of FWSN petitions.

The Tirado case in 2016 was for educational neglect. Educational neglect cases are those in which a parent fails to ensure that his or her child regularly attends school or receives an equivalent education elsewhere.[38] In Connecticut, this equivalent education is commonly referred to as "homeschooling," and there are no legally enforceable standards that permit DCF, the State Department of Education (SDE) or an individual school district to monitor whether a parent is actually providing his or her child with an adequate education.

The legislature has had opportunities over the years to impose monitoring and assessment requirements for homeschooled children but, due to successful lobbying by the CT Homeschool Network and other parent advocates, has declined to do so.[39] In a case such as the Tirado family, since no state or local agency had the authority to insist on assessing a homeschooled child's educational progress, children like Matthew Tirado, who are isolated from the community and incapable of reaching out for assistance, remain hidden from the government's view.

In addition, it is likely that, under Connecticut law, by the end of this case, Matthew, age 17.5 years, *was not required to be in school at all.* A parent may appear personally at a school district office and sign a form opting out of school enrollment for any child over the age of 16 years. There is no requirement that the child appear in person or be interviewed. Withdrawal from school at age 16 is solely at the discretion of the parent. The General Assembly could easily address this requirement as well.

Finally, the General Assembly has recently taken a step *backward* in protecting children who are chronically absent from school.[40] Although school districts are required by law to track and investigate excessive absenteeism, their sole legal remedy is to file a Family with Service Needs (FWSN) petition in Superior Court for Juvenile Matters.[41] Theoretically, the Judicial Branch then has the jurisdiction to assign a probation officer to the family and issue orders enforceable by contempt of court. In reality, the Judicial Branch often chooses not to exercise this clear legal authority.

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[38] Conn. Gen. Stat. §10-184.
[39] Proposed House Bill 5883 (2007).
[40] June Special Session, Public Act 17-2, §§ 145-148, effective July 1, 2019.
[41] Conn. Gen. Stat. §10-198a.

In VT's case, the school did file a FWSN petition, but the Juvenile Court promptly dismissed it without making any effort to see the family or gather information. According to the OCA's report, the Judicial Branch dismissed the petition because the child was "too young," even though she was a least a year older than the statutory minimum. Instead, the Judicial Branch merely passed its responsibility to this child on to DCF.

With the passage of June Special Session, Public Act 17-2 at the urging of the Juvenile Justice Policy and Oversight Committee, including the OCA and Judicial Branch representatives, the legislature has now eliminated the only legal remedy available to schools to address chronic absenteeism and truancy without identifying or funding alternatives to address this pressing issue. This is a tremendous disservice, especially to those children like Matthew and his sister who are invisible to government agencies.

Recommendation # 33: "*Districts and the SDE should create protocols that ensure that withdrawn students are actually re-enrolled in a school within a reasonable time frame, consistent with the provisions of General Statute § 10-184, and that the sending district follow up with a child's guardian when the it has not received confirmation of enrollment from a receiving district. SDE guidance should be developed, in consultation with DCF, to address concerns of persistent or prolonged non-enrollment of a child in school, particularly where there are historical or current risk factors involving the child.*"[42]

DCF Response: DCF defers to the State Department of Education regarding this recommendation.

Recommendation # 34: "*Local and state efforts to address chronic absenteeism in schools must include a specific focus on investigation and remedies that address the needs of highly vulnerable children, including children who are very young and children with complex disabilities. OCA supports and encourages districts in their efforts to determine the underlying reasons for chronic absenteeism and address such reasons with positive child and family engagement, problem-solving and high quality programming for such children. Additionally, state and local frameworks for responding to chronic absenteeism must be well-informed regarding the specialized needs of children with disabilities, their unique vulnerability to abuse or neglect, families' fears and concerns about how their children may be served in school, and strategies to positively engage families whose children have complex disabilities.*"[43]

DCF Response: DCF defers to the State Department of Education and local school districts regarding this recommendation.

[42] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 78.
[43] Office of the Child Advocate, Child Fatality Investigative Report: Matthew Tirado, December, 2017, p. 79.

Summary

It is DCF's position that, for a myriad of reasons including but not limited to fiscal and legal constraints on state and municipal agencies, tragic cases such as that of Matthew Tirado cannot be avoided 100% of the time. We firmly believe, however, that the General Assembly has several avenues available to strengthen state statutes related to the overall wellbeing of children. DCF, and other agencies, have had little success against advocacy groups in convincing legislators of the importance of these gaps in the safety net. We believe that the child advocacy community should step up and partner with government agencies to counter the parents' rights lobbyists who thus far have held sway in this area. Compromises can be reached that protect both the vulnerable children of the state and their parents' rights to raise them without undue government interference.

DCF will be exploring a range of statutory amendments to provide agencies with stronger legislative authority to address loopholes identified in this case and others. We look forward to providing these recommendations to the appropriate committees of cognizance including, but not limited to the Education Committee, the Children's Committee, and Judiciary Committee.

The area of child welfare is constantly evolving. DCF has engaged a number of experts and created many new tools to assist us in remaining on the cutting edge of these development.

I would underscore that while any tragedy involving a child has a profound impact on me and my staff, I do maintain that I am very proud of the progress that our agency has made in reforming our system in a positive direction. In fact, not only did the federal court acknowledge this progress after the Office of Child Advocate's report was released, the court understood that a system should not be judged by one case regardless of how sad or sensational. I look forward to continuing the progress in child welfare reform that Connecticut as we continue to focus on key areas including case planning and service needs that are relevant to every single child we serve.

Sincerely,

Joette Katz
Commissioner

JK/jmh

cc: Garey E. Coleman, Senate Clerk, Connecticut General Assembly
Frederick J. Jortner, House Clerk, Connecticut General Assembly
Members of the Committee on Children, Connecticut General Assembly
Sarah Eagan, Office of the Child Advocate
Office of Legislative Research
State Librarian