

DCF Response to Governor and General Assembly Regarding OCA Report re: Baby Dylan

On September 29, 2016, the Office of the Child Advocate issued an investigative report entitled “The Critical Injuries of Baby Dylan from Abuse and Neglect while in State Custody.” This response has been prepared for you pursuant to Conn. Gen. Stat. § 46a-131(f). Please note that OCA allowed us to review and comment on the draft report. While OCA did reference some of our comments in the final version, it remains problematic in several aspects, as described herein. We are happy to discuss this further at your request.

First and foremost, we want to be very clear that we fully agree with OCA that the case practice in this matter was unacceptable, necessitating significant personnel action. Administration in Region 3 and the Norwich Area Office also specifically acknowledge the significant practice failures throughout this case by staff from different disciplines at multiple levels within the Region and Area Office. Perhaps more importantly, we have thoroughly examined this case and are using it as an opportunity to apply the lessons learned to our ongoing quality assurance activities.

Without any intention of diluting the foregoing, we strongly assert that an entire system or constellation of systems cannot be defined by one case (or even a handful of cases) and, to conclude that the performance of a handful of employees in one case means there is massive system failure, as OCA did, misleads the public into assuming that all the issues identified herein exist statewide and that DCF has not made tremendous progress in many facets of child welfare over the past five years, as has been recognized at the national level. Principles of sound management require us to avoid making dramatic shifts in processes based on one case or one unique set of circumstances, particularly when the processes have been carefully vetted at the state and national levels and, overall, are resulting in a consistent statewide practice evolution.

It cannot be stressed strongly enough that data from Calendar Year (CY) 2012 – 2016 indicate that children in kinship foster homes are overwhelmingly being cared for safely. In particular, CY 2016 data show that there were over 2,100 unique, active kinship homes. Of those active kinship homes, there were 94 reports to the Careline, of which only six were substantiated (0.3%).

We recognize that OCA chooses to promote the idea, as indicated by this report and others, that DCF cannot adequately police itself and that outside oversight is required to effect meaningful change. We assert that such outside monitoring already exists in the form of that office and other entities within the advocacy community, the federal Court Monitor, the Superior Court, the attorneys and advocates for parents and children involved with DCF, the federal Administration for Children and Families and the legislature and its committees that scrutinize our work on a daily basis. We appreciate the constructive learning opportunities presented to us by those entities in areas of practice that we all agree must be continuously monitored and improved. The

reality is, however, that in an agency with over 3,000 employees and tens of thousands of cases, improvement will continue slowly but surely by careful review of data trends, staff training focusing on evolving best practices, quality supervision and management, and updated policy and practice guides. To the extent these outside entities have specific, realistic and detailed suggestions that take into account the complexity of the agency, budget processes and national best practices, we welcome hearing from them.

Finally, we would like to point out a serious flaw in OCA's methodology. While that office conducted one joint interview with the senior leadership of Region 3, there were no other on-the-record interviews of any DCF staff or managers. OCA relied almost exclusively on written documentation and, where that was lacking, that office did not conduct interviews to try to fill in the blanks. Additionally, at least one DCF employee spoke to OCA anonymously and that person's concerns were accepted at face value without any attempt to verify the veracity of the claims. While we recognize that OCA is a very small agency with a large mandate, its reports are taken very seriously by the public and we believe its methodology should be rigorous and complete.

Practice Evolution at the Area Office, Regional and Agency Levels

DCF has used this opportunity to test enhanced case practice initiatives already underway statewide and locally. Future activities are also planned because quality assurance is an ongoing effort. Some of these activities are noted below.

Kinship Placements with Children 0 to 5 Years Old

Region 3 instituted multi-disciplinary staff teams, the role of which was to conference all cases with children ages 0 to 5 years residing in informal family arrangements and licensed and not-yet-licensed kinship foster homes to review the suitability of the placements and identify and resolve any outstanding or incomplete legal, licensing, assessment or service provision activities or concerns. The initial reviews have been completed and case teamings have been held. This process has proven very valuable in a number of ways. Most importantly, the reviews thus far have revealed no placements or arrangements that are currently unsafe for the children, thereby validating the suitability of kinship placements overall. Where appropriate, follow-up activities were identified to ensure that the children's needs are being adequately met. Beyond these case-specific issues, the reviews revealed ways in which the Region can strengthen its work, such as improving documentation of suitability assessments. Work is underway, stemming from these reviews and based on forums held with staff, to help clarify roles and responsibilities and practice standards. The Region is also partnering with the DCF Academy for Workforce Development to design a learning and support opportunity for a small group of new supervisors to help them strengthen their oversight and direction. Region 3 and Area Office meetings will be held with all staff to discuss trends revealed by these reviews and to solidify next steps.

As an agency, we are studying the feasibility of expanding these practices statewide within existing appropriations and consistent with national best practices. Relevant policy and practice guides will be updated as expansions are adopted on a statewide basis.

Emphasis on Children 0 to 5 Years Old in Case Planning

Statewide, as part of our evolving practice initiatives, the special vulnerability of the 0-5 population is the subject of the Early Childhood Practice policy and Practice Guide, released this spring, and has been highlighted at Quality Improvement Teams and other meetings statewide.

The Region 3 Behavioral Health Program Manager is leading efforts to further apply the best practice standards set forth in the Early Childhood Practice policy and Practice Guide. The process began with a gap assessment determined from insights gleaned from the age 0-5 reviews and from interviews with all CPS managers about their expectations of Social Workers and Supervisors when working with young children. Based on this assessment, along with a review of the Early Childhood Practice Guide and Early Childhood Tool Kit, and with input from Regional leadership and staff who are part of the QI teams, a “Practice Considerations” is being developed that will serve as a field guide for staff statewide. Training and other implementation steps are being planned.

In 2015 and 2016, DCF held multiple-day trainings on Infant Mental Health for DCF staff and partners. (Region 3 staff and, specifically, the FASU manager and supervisor on Dylan’s case attended in 2016.) A major component of this training is the focus on caregiver/infant interaction and overt and subtle caregiver behavior.

Enhanced Supervisory and Managerial Oversight on Cases

Beginning earlier this summer, the Norwich Area Office Director began requiring that CPS Program Managers attend some Considered Removal Meetings¹ for children to ensure fidelity to the CFT-CRM model and to provide immediate input at the managerial level.

Although there is currently no mandate for ongoing Social Work Supervisors to make field visits with or in lieu of assigned Social Work staff, DCF endorses and encourages joint visits when possible to support staff development or when there are concerns about the well-being of the child.

Finally, it was determined that, in some pockets of the state, it was not clear to all management that DCF Policy 7-22, “Supervision,” applies to all staff, not just child protection staff. Relevant to this report, FASU managers have been reminded of the need for documented supervisory conferences on the timetable set forth in that policy. In addition, we are renewing our contract with Yale for additional consultation and training on this Supervision model.

¹ A Considered Removal Meeting is a meeting facilitated by DCF in any case in which it appears that a child must be removed from his or her home for safety reasons. The parents, the child, if age appropriate, and the family’s service providers, attorneys, relatives and friends who may be resources are invited to brainstorm about safe alternatives to traditional foster care. See DCF Policy 34-10-1.

Case Documentation

Timely and quality case documentation has always been required by this agency, and individual employee performance evaluations and Human Resources investigations over time reflect our efforts to correct lapses in this area. The Commissioner released an All Staff memo on September 20, 2016 reiterating these expectations. We will continue to address failure to document in a timely and useful manner as individual performance expectations.

Suitability v. License-ability of an Out-of-Home Placement

Contrary to OCA's assertion, DCF has no outstanding "key questions" regarding the difference between the suitability of a particular placement for the child needs as opposed to the ability of the foster placement to meet state licensing regulations. DCF has for some years employed the "firewall" concept to ensure that CPS staff are held accountable for thoroughly identifying and assessing the suitability of potential kinship resources for placement prior to seeking a core foster care placement. Once that occurs, FASU's role is to determine immediate license-ability elements required by state and federal law and, later, to complete the full licensing process.

Placement with kinship resources whenever safe and appropriate has emerged as national best practice over the past decade and is reflected in state law and incentivized in federal law. (*See also* proposed federal legislation HR 5456, "The Family First Prevention Services Act.") DCF is a leader in the implementation of this national best practice as evidenced, for example, by several invitations from Casey Family Programs to speak to other states. Further, we are under no illusions that this assessment is easily made, nor are such decisions made "on a moment's notice." We fully understand and comprehend that placing a child in an unlicensed kinship foster home carries an element of risk and such decisions are not taken lightly by the staff charged with this responsibility.

While the OCA purports to have identified numerous problematic kinship homes, those that have been brought to our attention have been taken very seriously and we reassessed those homes immediately. We determined that the kinship foster parents identified by OCA as possibly problematic are, in fact, taking good care of the children.

Overdue Licenses

Regional FASU managers have been directed to bring all overdue kinship home licensing assessments to a close immediately, with homes with children ages 0 to five years old addressed first.

Waiver of Licensing Requirements

Throughout the agency, staff have been reminded that the waiver of criminal and CPS history requires the Commissioner's approval, and that waivers must be sought prior to the child's placement. This was accomplished through an All Staff Memo from the Commissioner, a meeting between the Commissioner and the Regional Administrators, and a conference call between Office of Children and Youth in Placement (OChYP) and the Regional Foster Care Managers.

Each Region has conducted an audit of all kinship homes to determine if there were any placements with outstanding criminal or CPS histories for which a waiver was required. All outstanding waivers have been addressed, and the OChYP has instituted a more robust tracking mechanism.

Enhanced Tracking Systems

A tracking log is now in place in Region 3 for all foster care regulatory waivers to ensure timely approvals and to identify any barriers to waiver approval early in the process. In addition, a tickler system is now in place to track pending license applications to ensure that barriers are addressed timely resulting in full licensure of a kinship home. This is in addition to the improved waiver tracking and monitoring processes in the OChYP.

Already-existing data is being used by the Regions as the basis for creating systems through which kinship home licensing can be better tracked and monitored. These data sources are being analyzed to improve functionality. Similarly, OChYP is studying existing data to enhance its oversight responsibilities.

In addition, OChYP has worked in partnership with the Regional staff and the Quality Improvement Council to identify and implement enhancements to its quality assurance systems. A QA instrument for case reviews of our currently-active core and kin foster homes was developed and an audit has just been completed. The Foster Care Community of Practice co-chairs will present QA enhancement recommendations at a Senior Administrator meeting in early 2017. Finally, OChYP now has a centralized electronic mailbox so that all waiver requests are submitted to one place, improving efficiency and tracking.

Intra-Office Team Building

Region 3 has facilitated a team building event among its FASU and CPS Managers and Supervisors to address strained relationships and to build healthy work partnerships between the teams.

Additionally, all Region 3 Supervisors, Managers, Regional Resource Group staff and Administrative Case Review staff attended “Cross-Systems Collaboration” forums led by the Systems Program Director and Office Director and supported by Dr. Schultz. The focus was on roles and responsibilities pertaining to the assessment of suitability and license-ability as it pertains to endorsing informal family arrangements and placement in kinship care. The resulting work product from these forums is being finalized.

Similar trainings and forums are being considered on a statewide basis.

Interpersonal conflicts, minor and serious, occur in every large organization. In particular, DCF staff are uniquely vulnerable to secondary trauma because of the very stressful nature of the work. In addition to encouraging staff to take advantage of our Employee Assistance Program, which includes an impressive array of services, we make individual and group conflict reduction and employee wellness sessions and events available to all staff on a regular basis.

Human Resources (HR)

The delay of the start of the HR investigation in this matter was solely the result of miscommunication between senior staff and is not reflective of the gravity of the employee performance issues. Once the delay was brought to HR's attention, it responded quickly and thoroughly to pull the pieces of this complex labor matter together and expedite the final results.

Individual employee deficits noted in this case relative to policy and practice standards, job responsibilities and the inappropriate use of email have been addressed through the Human Resources investigation, which has resulted in various levels of discipline, training and enhanced supervision of staff.

Since some performance concerns may exist elsewhere in the agency, the Commissioner issued two All Staff memos addressing 1) the proper assessment of kinship foster placements and the appropriate use of licensing waivers, and 2) requirements for timely and thorough electronic case record entries and the professionalism expected in business email.

Going forward, we have instituted the following HR processes, and are examining ways to verify that these practices are strictly adhered to:

- for selected cases involving a critical incident, the Commissioner or her designee will immediately review, in consultation with Regional management and, if appropriate, Human Resources, whether any staff involved in a case should be temporarily or permanently transferred off the case;
- the Commissioner or her designee shall review case practice on selected critical incidents to identify potential systems improvements; and
- non-CPS units in a position to observe case practice have been encouraged to bring any concerns about policy lapses to the attention of Human Resources. Further, we are examining a method to institute additional protocols such as a policy compliance review by a senior manager in all cases in which a critical incident is reported.

Informal Family Arrangements

OCA further takes issue with the case of another child who had previously been living with Dylan's foster family based on an informal family agreement. It appears that OCA fails to understand the legal status of that case and is conflating informal family arrangements with DCF's jurisdiction to place a child out of the home. Any family can choose to place its child temporarily with a friend or relative, even without the endorsement of a court. DCF has no legal authority whatsoever to impact those arrangements without evidence that the child is in imminent danger in the temporary home. Those homes are not licensed by DCF *because the children are not in DCF care*. Thus, this is a red herring raised by OCA that detracts from the issue of true kinship placements. Nonetheless, DCF has included cases with informal family arrangements in many of the reviews highlighted in this document.

Special Investigations Unit (SIU)

As we have discussed with OCA on prior occasions, it is unrealistic to place the responsibility for Regional case practice or facility procedures on the SIU. The OCA's conclusions regarding SIU reflect a fundamental misunderstanding of its role and purpose.

Contrary to OCA's assertions, in both SIU investigative reports involving the foster home, the investigators documented their child protective services and criminal histories, health issues and lack of sufficient income. The SIU investigators noted concerns related to Dylan's physical health and developmental delays, the family's frequent cancellation of medical and service provider appointments, and the discord between the foster parents and the biological parents. They contacted the foster parents' and Dylan's service providers and utilized experts both internal and external to DCF to inform their investigations. They documented discrepancies in the information they received from DCF staff, from the family and from providers. In the first investigation, the SIU investigator documented her recommendations regarding the foster mother's alleged substance use and her efforts to persuade the foster mother to submit to an evaluation. When the SIU investigator was unable to gain compliance within the statutory time limit to complete an investigation, that investigator ensured that the recommendations were passed on to the CPS and Licensing staff in the Region and Area Office for their follow up.

SIU staff are Social Workers whose role is to conduct child protective services investigations into allegations of suspected abuse or neglect by a person entrusted with the care of a child. SIU staff are not labor relations experts and it is not their role to "flag" DCF employee performance issues not directly related to the abuse or neglect allegation being investigated such as the lack of timely narrative entries. DCF employee policy violations and performance concerns are the responsibility of each individual employee, his or her supervisory chain of command and, if necessary, Human Resources.

Nor are SIU investigators regulatory experts in foster care licensing and cannot be expected to review a case to identify licensing issues that are not relevant to the investigation. Although SIU staff do note obvious regulatory concerns, it is not their role (nor do they have the resources) to review every Licensing file to ensure that all the proper documents are included. It is the responsibility of the FASU chain of command to identify and address regulatory concerns involving foster parents.

Administrative Case Reviews

OCA has paraphrased or omitted some of the language used by the ACR Reviewer which contains contextual information that helps to understand the Reviewer's rationale for the given rating. For example, the ACR Reviewer indicated that the rating determination was based upon the Period Under Review (PUR), which was June 12, 2015 to August 11, 2015; it did not address issues outside of this time frame. The ACR Reviewer also noted in the ACRi: "During the meetings, the foster parents reported several concerning issues when [Dylan] was initially placed. After two months these behaviors are no longer an issue. Birth to three is working with Dylan as well." *These three sentences together document what the foster parents said at the meeting; they are not*

the ACR Reviewer's opinions. Similarly, the ACRi language notes that the “ACR [meeting] discussion” was one of the sources used to support the “Strength” rating. The OCA report also omits that Dylan’ attorney, his biological parents and the foster mother participated in the ACR meeting. Inclusion of such stakeholders affords the Reviewer an opportunity to hear and take into consideration information that may not be documented in or able to be gleaned through LINK narratives. Finally, while the ACR Reviewer did rate the foster home and safety as a “strength,” this is a function of the tool’s categories for the options available to the Reviewer for the finite Period Under Review. It should not be interpreted, as OCA has, as a conclusion that DCF did a “[s]trong job of ensuring Dylan’s safety in care. . .”

In this case, given the PUR and the fact that the time frame for licensing the home had not yet expired, there would be little for the Reviewer to report by way of deficiencies. An ACR Reviewer bases his or her rating on the family case record information during the PUR only and on the discussion that takes place at the meeting with the stakeholders.

OCA relies on an anonymous source to further criticize the ACR function. While the OCA did have a phone conversation with ACR leadership after developing the draft report, the final report does not represent the clarifications that were provided. The OCA also did not have the benefit of speaking with either the ACR Reviewer or the ACR Program Manager to determine the information that was discussed at the actual ACR meeting that contributed to the finding and rating. Finally, DCF was not offered an opportunity to review the “internal guidelines” cited by OCA and attributed to the anonymous source.

Summary

Child welfare is a constantly-evolving field of expertise. We will continue to hold staff accountable, provide training where necessary and explore emerging national best practices. We have made huge strides during this administration and have been recognized for that nationally. We will continue to move in the same direction.

Response to OCA’s Recommendations

“As DCF moves forward with implementing a practice guide for cases involving infants and toddlers, it should consider heightened requirements for case supervision, visitation contacts and *documentation of case activities.*”

DCF Response: *This recommendation has already been implemented through the Early Childhood Practice Guide.*

“DCF should consider requiring periodic multi-disciplinary or multi-unit visitation contacts with high risk babies in both in-home and out-of-home cases, and DCF should require visitation contacts by the DCF supervisor or manager. DCF should examine its requirements for documentation and expectations related to visits with children, with an eye to the developmental stage of the child, and ensure that observations are made with regard to the child’s development[.]”

DCF Response: *In appropriate cases, DCF already utilizes supervisory, multi-disciplinary and multi-unit visitation contacts, and has flexibility to increase visitation contact based on case needs. Such contacts are unnecessary in all cases and would require significant additional staffing and other resources to implement.*

“DCF should create a case supervision tool for infant-toddler cases and ensure that it is reviewed every fourteen (14) days and addresses the child’s medical, developmental, educational and permanency needs. Supervision conferences must include attention to documentation deficiencies with a set number of days permitted for remedying any documentation concerns.”

DCF Response: *The Early Childhood Practice principles are already in effect.*

“DCF should request an immediate legal consult whenever a parent/legal guardian of a child under an Order of Temporary Custody that is vested in DCF refuses to allow provision of support services to a child, including but not limited to therapeutic and developmental support services.”

DCF Response: *This is already available through either or both the in-house legal staff and the Office of the Attorney General and usually occurs in cases in which parents are unreasonably obstructive. Again, such mandated practices in all cases are unnecessary and unrealistic and would require significant additional staffing and other resources.*

“DCF must ensure it is adequately staffing its licensing units; that such units are complying with state law and agency regulations; that documentation is adequate with regard to licensing activities; and that the role and responsibility of the licensing unit social workers is clarified with regard to assessing the safety of the child in the home during home visits.”

DCF Response: *DCF will soon be releasing its completely revised Foster Care Licensing policy and practice guidance. This, in addition to the activities highlighted earlier in this response, it will address the issues raised in this recommendation.*

“DCF must examine its expectations regarding the role and responsibility of employees in conducting ongoing assessments of the suitability and capacity of foster care providers, particularly when the preliminary assessments are done urgently and children are placed quickly--these immediate placements place a heavy reliance on the accuracy of initial assessments but also necessitate comprehensive and timely follow up and monitoring. All employees interacting with the family should know what their role is contributing to these assessments and protections for children.”

DCF Response: *As stated throughout this report, DCF has made its expectations regarding foster care licensing clear to all staff and the new Foster Care policy will be released shortly.*

“DCF should develop an interdisciplinary team to examine its use of relative and special study foster care, keeping in mind that research supports the placement of children with caregivers who are known to them, but which can examine agency practices regarding assessment, regulatory compliance and the request for waivers, timeliness of relative licensure, support for relative caregivers, and barriers to supporting children with relatives. Focus should always remain on the rights and wellbeing of the children and not on the preferences of adults. This team should develop a public report within six (6) months. This report should specifically address compliance with state law and agency regulations, clarification of employee roles and responsibilities, as well as safeguards and additional assessments that will be utilized when the Department seeks to license a caregiver with a previous child abuse/neglect history, a significant psychiatric history or other history of significant disability, or a criminal record.”

***DCF Response:** The initiatives and activities covered in this report address this recommendation. This report, as well as policy, practice guides and data reports, are publicly available. Also attached is a decision tree showing the interaction of internal multidisciplinary units in these cases. In addition, external entities such as the RAC, SACs and the Citizen Review Team are specifically constituted for these purposes.*

“DCF should require that Administrative Case Review findings regarding a child’s unmet needs and the adequacy of a child’s case plan include specific reference to the case record, including records obtained or generated by DCF in connection with a child or family. No findings should be permitted without adequate and specific factual foundation, supervisory reviews of case reviews should pay close attention to this issue, and quality assurance outcome measures should be created to monitor this requirement. ACR reviewers must be required to note whether case record documentation is adequate.”

***DCF Response:** During the phone conversation that ACR Management had with the OCA, it was explained that the ACRI does specifically state for each item: “Indicate the source of your information.” Otherwise, we disagree with the expectations of the ACR process that OCA recommends imposing. Our case planning process far exceeds that of most other states and what is demanded by controlling federal law. Further, the ACR managers routinely sample ACRI and attend ACRI to support quality of facilitation and documentation. Documentation around expectations has also been an area of ongoing training and supervisory guidance for ACR staff. We are reviewing our policy and practice again for possible modifications that are efficient, useful and do not require additional staff and resources.*

“DCF should ensure that members of its Administrative Case Review Unit have adequate training and clear directives to effectively review the appropriateness of a child’s placement and the role of the ACR unit in reviewing kinship care placement should be clarified.”

***DCF Response:** DCF already does this. See response to previous recommendation.*

“State law should require that, within sixty days of a child coming into DCF care, DCF must submit a court filing about the children’s well-being, treatment needs identified in the Multi-disciplinary Evaluation, and the timetable for ensuring those needs are addressed.”

DCF Response: *We will begin to include this information in current required court filings.*

“DCF should evaluate and publicly report regarding the timeliness and thoroughness with which it implements the Multi-disciplinary evaluation recommendations for children in foster care. The current federal court outcome measures review only whether the MDEs are completed, but not necessarily whether the recommendations are timely and full implemented.”

DCF Response: *The current requirements by the Court Monitor have been considered the proper standard for many years. DCF does not have staffing or resources to add an additional layer of research and public reporting. Each Social Worker and his or her chain of command are responsible for ensuring that MDE recommendations are addressed in every case.*

“State law should be amended to clarify that in all cases where a child is taken into DCF’s temporary custody or placed under DCF’s guardianship that DCF submit to the Juvenile Court, within thirty (30) days of the placement, a statement regarding the agency’s assessment and findings regarding the license-ability and suitability of the caretaker for the particular child.”

DCF Response: *We will begin to include this information in current required court findings.*

“Whenever a child in DCF care is seriously injured or injured as a result of abuse or neglect there must be an immediate internal review by individuals *separate and apart* from the region itself and deadlines for the commencement and completion of Human Resources investigations and the development of remedial recommendations for practice changes, where required.”

DCF Response: *As stated above, this has been implemented in appropriate cases.*

“State law should be amended to ensure all Birth to Three providers are identified as mandatory reporters of suspected child abuse or neglect pursuant to Conn. Gen. Stat. § 17a-101.”

DCF Response: *DCF supports this statutory change.*

“DCF and the Office of Early Childhood should review its current Memorandum of Agreement to ensure protocols for effective communication and seamless service delivery for abused and neglected infants and toddlers involved with DCF or living under DCF’s guardianship. The two agencies should evaluate whether current protocols are sufficient to address the following: [multiple suggestions]”

DCF Response: *DCF has already begun discussions with OEC to revise the MOA.*