# AUDITORS' REPORT

## PERFORMANCE AUDIT

# Department of Children and Families' Response to Children Missing from Care

FISCAL YEARS ENDED JUNE 30, 2021, 2022, AND 2023


**STATE OF CONNECTICUT**
Auditors of Public Accounts

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[Report Release Date]

## INTRODUCTION

We are pleased to submit this audit of the Department of Children and Families' Response to Children Missing from Care for the fiscal years ended June 30, 2021, 2022, and 2023. Our audit identified internal control deficiencies; instances of noncompliance with laws, regulations, or policies; and a need for improvement in practices and procedures that warrant management's attention.

The Auditors of Public Accounts wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Department of Children and Families during the course of our examination.

The Auditors of Public Accounts also would like to acknowledge the auditors who contributed to this report:

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# ABBREVIATIONS

| ABBREVIATION | DEFINITION |
|---|---|
| AWOL | Absent without leave |
| CWLA | Child Welfare League of America |
| DCF | Department of Children and Families |
| FFT-FC | Functional Family Therapy Foster Care |
| FY | Fiscal year |
| GAL | Guardian ad litem |
| GAO | Government Accountability Office |
| HART | Human Antitrafficking Response Team |
| LGBTQ+ | Lesbian, gay, bisexual, transgender, queer, questioning, or other identity |
| MDFT | Multidimensional Family Therapy |
| NCIC | National Crime Information Center at the FBI |
| NCMEC | National Center for Missing and Exploited Children |
| PHP | Partial hospitalization program |
| PRTF | Psychiatric residential treatment facility |
| RRG | Regional Resource Group |
| RTC | Residential treatment center |
| STAR | Short Term, Assessment and Respite Home |
| TGH | Therapeutic group home |
| TLC | Temporary living condition |

# STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

## About Children Missing from Care

Federal law defines a missing child as someone under 18 whose whereabouts are unknown to their legal guardian. Limited nationwide data exists on missing children, but national foster care statistics on September 30, 2021, show 1% of children in care were on runaway status. Older children in foster care are more likely to run away than their peers not in care. Factors increasing the likelihood of running away include being female, LGBTQ+, a teenager, in congregate care or having a history of trauma or placement instability. Protective factors include kinship placements, sibling placements, and strong adult support.

We analyzed data on missing children and missing from care episodes[1] recorded by the Department of Children and Families (DCF) for fiscal years 2021 through 2023. We found:

- Over 600 children under the age of 18 accounted for 3,736 missing from care episodes. The number of missing from care episodes per year increased over the period while the average days that children were missing decreased by half
- Most missing from care episodes lasted one day or less, with a median duration of one day
- Most missing children were teenagers (97%), with slightly more females (53%) than males. Black (32%) and Hispanic (37%) children were more likely to go missing from care
- Congregate care settings accounted for most missing from care episodes
- Some children went missing from care multiple times and accounted for a disproportionate percentage of all episodes, with one child accounting for 100 episodes

## Why this Audit is Important

Running away from foster care placements exposes children to risks such as human trafficking, health issues, substance use, academic struggles, and involvement with the criminal justice system. According to The National Center for Missing and Exploited Children (NCMEC) , children in foster care are particularly vulnerable to human trafficking, with 17% of all children and 27% of female children missing from care suspected of being trafficking victims.

The purpose of this audit was to evaluate the efficiency and effectiveness of the Department of Children and Families' policies and procedures for reporting, locating, and monitoring children missing from care. The audit also examined DCF's collaboration efforts with law enforcement to locate missing children.

## Results in Brief

We found that between fiscal years 2021 through 2023 there were increases in the number and frequency of missing from care episodes. We also found DCF did not perform formal assessments of common risk factors or plans to address children who go missing from care. The DCF service array did not appear

[1] An episode refers to a single instance of a child who is missing from care.

adequate to address the needs of children who habitually went missing from care. We also noted that DCF did not document or failed to provide the required notifications to police and other stakeholders and did not request or document the reason children went missing from care. DCF also did not have sufficient guidance documents for staff when responding to certain aspects of missing from care incidents, including procedures for screening all missing children for sex trafficking, and handling children who went absent from their placements, when DCF knows their location or is in communication with them. One of our recommendations is for DCF to develop detailed operational procedures and a plan with measurable benchmarks and data-driven strategies to reduce missing from care episodes and incidents of human trafficking.

Our evaluation of the Department of Children and Families' Response to Children Missing from Care disclosed the following recommendations.

## Finding 1
# DCF Has Not Formally Evaluated Missing from Care Cases to Implement Targeted Interventions to Prevent Future Incidents

### Background

DCF defines missing from care as situations in which children, who are in DCF care and custody, are not in their assigned placement (e.g., foster homes or congregate care settings). DCF categorizes children missing from care as runaway, abducted, or AWOL. Children labeled AWOL are absent from their placements, but DCF knows their location or is in communication with them. Children missing from care are at risk of harm and adverse outcomes. These risks include human trafficking, criminal victimization, untreated illnesses, injuries, substance use, increased mental health acuity, poor academic outcomes, involvement with the juvenile justice system, and weakened connections to supportive adults.

### Criteria

Section 17a-98 of the General Statutes states that DCF shall exercise careful supervision of every child under its guardianship or care and maintain sufficient contact to promote the child's safety and physical, educational, moral, and emotional development. DCF's strategic goals include to "keep children and youth safe, with focus on most vulnerable populations."

The Child Welfare League of America's *Best Practice Guidelines: Children Missing from Care* manual recommends child welfare agencies proactively address the issue of children missing from care by preparing a comprehensive plan with systemwide practices and individual responsibilities. This plan should be based on data, research, and best practices.

### Condition

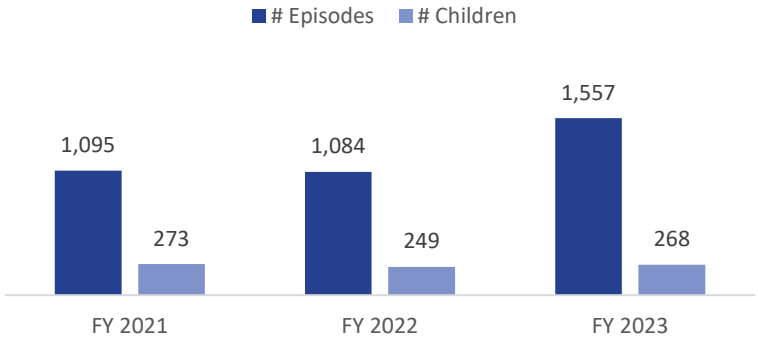
DCF could not provide us with any formal assessments, strategic plans, or goals for managing and addressing children who go missing from care. We examined various trends regarding children who were missing from DCF care from fiscal years 2021 through

2023. We found a significant increase in the number of missing from care episodes and the frequency of missing from care episodes. We found that a small number of children represented a substantial percentage of all missing from care episodes and congregate care facilities accounted for over half of all missing from care episodes. The average number of days that children were missing from care decreased over the period.

## How Many Children Went Missing from Care and How Frequently?

Number of Missing from Care Episodes and Missing Children: Exhibit 1 shows DCF reported 3,736 missing episodes representing 606 missing children under 18 years old from fiscal years 2021 through 2023. The number of episodes increased by 42% while the number of children missing from care remained consistent for the period. Children who went missing from care account for less than 5% of all children who spent time in care in fiscal year 2021 or 2022.

**Exhibit 1. DCF Reported 3,736 Missing from Care Episodes and 606 Missing Children in FY 2021-2023**




Number of Episodes per Child: Children varied in the number of times they went missing from care:

- Highest number of episodes per child: 100
- Average number of episodes per child: six
- Median number of episodes per child: two

Some children with many episodes accounted for a disproportionate percentage of all episodes. One child went missing from care 100 times, accounting for 3% of total episodes. Furthermore, 56 children (9%) went missing from care at least 16 times, representing 51% of all episodes. In contrast, 248 children, or 41% of all missing children, went missing from care once, accounting for about 7% of all episodes.

Rate of Missing from Care Episodes per 1,000 days of Care: Exhibit 2 shows the rate of missing from care episodes per 1,000 days of foster care increased by 94% from fiscal year 2020 to 2023. This rate divides the number of missing from care episodes in the fiscal year by the total number of days of foster care for all children during the fiscal year and multiplies this by 1,000. The number of missing from care episodes increased from fiscal year 2021 to 2023 while the total number of days in care decreased. DCF structured this measure based on how the federal government measures the incidence of relatively rare events, like maltreatment in foster care.

**Exhibit 2. The Rate of Missing from Care Episodes per 1,000 Days of Care Increased from SFY 2021 to 2023**

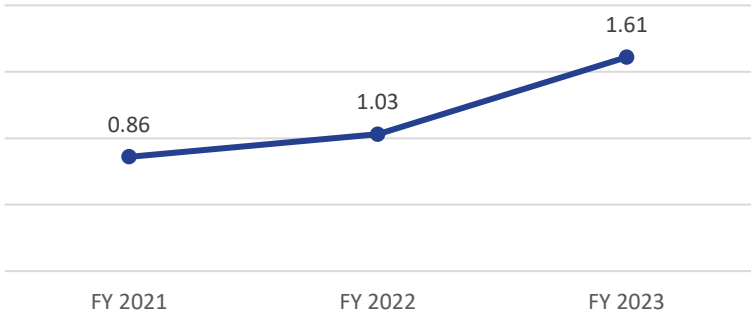



Exhibit 3 provides the demographic characteristics of the 606 missing children. More female children went missing from care than male. Most missing children were teenagers, with an average age of 16. The race and ethnicity of missing children varied.

**Exhibit 3. Demographic Characteristics of Missing Children in FY 2021-2023**

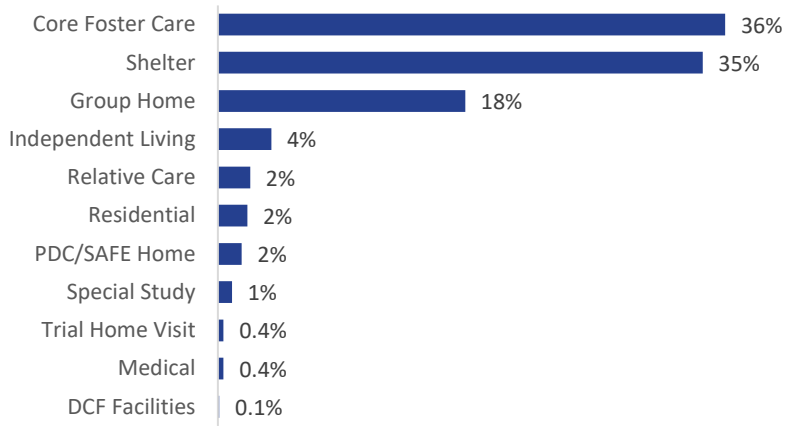
| Gender | Age | Race/Ethnicity |
|---|---|---|
| Female: 53% | 8-12: 3% | Hispanic: 37% |
| Male: 47% | 13-17: 97% | Black/African American: 32% |
| | | White: 24% |
| | | Multiracial: 6% |

## Which Placement Types had the Most Episodes?

Exhibit 4 shows that congregate care facilities[2] accounted for 61% of all episodes. Core foster homes (non-relative) reported over one-third of all missing from care episodes, while kin foster homes (relative and special study) accounted for 3%.

[2] Shelter, group home, independent living (for children under 18, independent living is a type of congregate care facility), residential, PDC/SAFE home, medical, and DCF facilities.

**Exhibit 4. Congregate Care Facilites Reported More Than Half of All Missing from Care Episodes in FY 2021-2023**

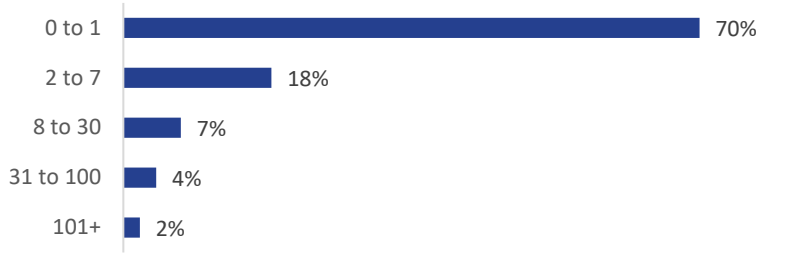



## How Long were Children Missing from Care?

Exhibit 5 shows that 70% of children were missing from care for one day or less. Overall, for fiscal years 2021 through 2023 the:

- Longest episode was 865 days.
- Average episode length was eight days.
- Median episode length was one day.

**Exhibit 5. Most Children Were Missing from Care for 0-1 Days in FY 2021-2023**




The average days missing from care decreased from 12 days in fiscal year 2021 to six days in fiscal year 2023. Similarly, children who were missing from care for more than 30 days decreased from about 8% of total episodes in fiscal year 2021 to about 4% in fiscal year 2023. All the years had a median missing from care length of one day. Average days missing from care per fiscal year were as follows:

- 2021: 12 days
- 2022: eight days
- 2023: six days

### Children Not Found

Two children were still missing from care when DCF downloaded the data report and provided it to us for the 2021 through 2023 fiscal years:

- The first child's missing from care episode closed days after DCF downloaded the report. This child was AWOL for about a year. DCF knew where the child was living but could not license the home.

- The second child was still missing from care as of April 4, 2025, with an episode lasting over two years. DCF does not know where the child is. The LINK narrative shows DCF continues to search for this child and the National Center for Missing and Exploited Children (NCMEC) published a missing child poster.

**Context**

We analyzed all 3,736 missing from care episodes reported to DCF for fiscal years 2021 through 2023 for characteristics and trends. DCF developed a measure for us to assess the scale of missing children based on the number of missing from care days per 1,000 days of foster care. We requested any assessments or strategies that DCF developed to understand or manage missing children. We examined research literature and interviewed DCF staff and stakeholders regarding reasons that children go missing from care and possible solutions.

**Effect**

By not fully understanding and assessing missing from care cases, the department squanders an opportunity to implement strategies to prevent children from going missing from care.

**Cause**

DCF allocates resources to locate missing children but has not developed a comprehensive strategy to reduce instances of children gone missing.

**Recommendation**

The Department of Children and Families should:

a) Assess missing from care episodes to identify common risk factors, evaluate the care environment, and address any systemic issues.

b) Develop a plan with measurable benchmarks and data driven strategies to reduce missing from care episodes.

**Agency Response**

"The Department agrees that the data depicts an increase in the incidents of children missing from care during the review period but disagrees with the identified "Cause" referenced in this finding. The Department has implemented several policies and procedures to respond to children who are missing from care, which are directly

related to our overall strategic planning goals of ensuring safety, permanency and well-being of children. (See, e.g., DCF Policy & Practice Guides 21-15; 21-14; 28-1; 22-1-2). In addition, the Department has recently finalized an updated Missing from Care Practice Guide, which provides additional guidance and instruction related to tracking, locating, assessing and reducing the incidents of children missing from care. Given that over 50% of the youth who are missing from care are older youth being served in congregate care settings, many with high acuity and complex needs, the Department has implemented several enhancements to its continuum of care for this population (See Response #2 below). It's also important to understand that some youth are coming into care in their late teen years without any prior/current DCF involvement following an arrest when placement by the court in a juvenile residential center (detention) or return home is not an option. However, unlike detention, DCF does not (and should not) operate or contract for locked placement settings for children.

Instead, the Department makes every effort to meet the unique needs of each child in the least restrictive setting possible. To that end, the Department has also restructured and enhanced its foster care services to provide more clinical/therapeutic supports in a family setting. The population served by DCF and our provider community has become increasingly more acute and complex requiring ongoing review and assessment of services across our placement continuum.

The Department recognizes that further analysis of Missing from Care episodes may yield findings that are not being addressed by other related initiatives already in progress. DCF Research Analysts intend to conduct a thorough literature review related to children missing from care and develop an analytical strategy for understanding and better monitoring children that run away, are absent without leave, or are otherwise missing from care. At a minimum the analysis will address factors including demographics, geography, child factors, caregiver factors, and placement type issues. Results from this analysis will be reviewed by the Quality Improvement Leadership Team (QuILT), who will also establish and monitor an improvement plan that will address policy, practice and monitoring strategies aimed at reducing the incidence of each type of missing from care episodes.

While the data in Exhibits 1 and 2 show an increase in documented incidents of missing from care episodes, it should be noted that Policy 21-15 was updated on July 15, 2022, and efforts were made to ensure that staff were aware of and fully understood the updated policy. These efforts likely had a positive impact on the documentation of missing from care episodes, which therefore accounts for a significant portion of the increase in documented incidents of children running away, being absent without leave, or otherwise missing from care. Such efforts result in more accurate and complete data but also make it difficult to assert the degree to

which the number of missing from care episodes actually increased from year to year."

**Auditors' Concluding Comments**

DCF could not furnish any formal assessments or objectives for managing and addressing cases of children who go missing from care. DCF states the needs of the children it serves are becoming more acute and complex. This trend reinforces the need for an ongoing assessment of offered services.

## Finding 2

# DCF's Service Array Appears Inadequate in Meeting the Needs of Children in Some Cases

**Background**

Exhibit 6 shows that foster care placements range from foster family homes to inpatient hospitalizations. Connecticut's Behavioral Health Partnership must approve Medicaid-funded placements. The juvenile justice system also has congregate placements that require a probation or court referral.

**Exhibit 6. Placement Types from Most to Least Restrictive**

| | |
|---|---|
| Inpatient | • Physically secured, hospital setting for children who are a danger to themselves or others and whose behaviors are psychiatric in nature<br>• Albert J. Solnit Center (South) provides prolonged or specialized services beyond what community hospitals typically provide |
| Psychiatric Residential Treatment Facility (PRTF) | • 24/7 care in a staff secured residential setting<br>• All services provided onsite<br>• PRTFs may admit children directly from the Emergency Department, as step down from inpatient, or occasionally from community as diversion from inpatient care |
| Residential Treatment Center (RTC) | • 24/7 care in a staff secured residential setting for children who do not always require line of sight supervision |

| | |
|---|---|
| | • All services provided onsite |
| Therapeutic Group Home (TGH) | • Small, homelike, staff secured setting in the community for children with psychiatric and behavioral treatment needs<br>• Child attends school in the community |
| Therapeutic Foster Care (FFT-FC) | • Intensive, structured, clinical level of care provided within a family<br>• Foster parents receive support from a private child placing agency |
| Foster Care | • Care provided within a family by foster parents who receive support from DCF |
| STAR Home | • Homelike, staff secured setting in the community that provides short term care, evaluation, and clinical and nursing services (DCF updated the model of these homes to Specialized Trauma-Informed Treatment, Assessment, and Reunification (STTAR) homes) in March 2024)<br>• STAR homes are the same level of care as foster care |

**Criteria**

Section 17a-3 of the General Statutes requires DCF to plan, create, develop, operate, or arrange for, administer, and evaluate a comprehensive statewide program of services for children in its care. DCF must ensure placements are clinically indicated and appropriate to the child's needs.

The Child Welfare League of America's *Best Practice Guidelines: Children Missing from Care* manual emphasizes that placements must meet the child's needs to promote stable and positive placement experiences. The manual recommends case workers consider the child's risk of running away and match children at higher risk to placements skilled in preventing missing from care episodes and promoting stability when the child returns.

**Condition**

Existing models of care, including placement options and services, do not meet the clinical needs of all children. DCF did not meet the needs of six female teenagers. The case records identified concerns from DCF social workers or other service providers that the children's current level of care could not keep them safe. They also

showed that the appropriate level of care was not available. The six children went missing from care 341 times over three years.[3]

We found that of these six children:

- All experienced sex trafficking victimization or juvenile justice system involvement.
- All could not access appropriate levels of care because of waitlists, high behavioral acuity, and lack of foster homes.
- All spent time in STAR homes because DCF could not find an appropriate placement. Four children had a length of stay over the target of 60 days, ranging from 77 to 175 days.
- Four could not access psychiatric residential treatment facilities or treatment centers due to their high behavioral acuity. However, their placement options were limited because they did not meet the criteria for inpatient hospitalization (the highest level of care).

Case records showed a strong commitment and effort by DCF line staff and other service providers to support these children. These concerns relate to the children's behavioral health system and not individual social work staff or providers. The Appendix contains detailed summaries of each case.

In addition, we obtained data from Carelon, the Administrative Services Organization for the Connecticut Behavioral Health Partnership, which illustrated various delays for children in DCF care or supervision receiving behavioral health care, which is more than just missing children. Based on data for fiscal years 2022 through 2024, psychiatric residential treatment facilities delayed 30 out of 133 discharges (23%) by an average of 44 to 89 days, depending on the facility. Similarly, from October 2021 through June 2024, 1,101 DCF children remained at emergency departments for longer than eight hours after receiving medical attention, and 30% of those children remained there between four to 49 days.

## Context

We reviewed LINK case narratives for 57 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023. We identified level of care concerns during our initial case record review to test for compliance. We then examined six cases in greater detail that noted level of care concerns. We did not examine all 57 cases with this level of scrutiny. As a result, the number of cases with level of care concerns may be higher. For the original selection of 57 episodes, we judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to that of overall episodes per placement

[3] They made up 1% of children missing and 9% of missing episodes. In comparison, 248 children, or 41% of all missing children, went missing once, accounting for 7% of missing episodes.

type. We only selected one episode per child if the random selection resulted in multiple episodes from one child. We also spoke with DCF service providers and stakeholders. We obtained data from Carelon regarding behavioral healthcare delays for children in DCF care.

**Effect**

Children in DCF care may have unmet clinical needs which may affect their safety and increase their missing from care episodes. Negative experiences of lingering in emergency rooms may dissuade them from seeking proper care in the future. Children who do not receive clinical care could have negative long-term impact.

**Cause**

DCF did not sufficiently reinvest in the full continuum of behavioral care. There is not sufficient capacity in all levels of care.

**Recommendation**

The Department of Children and Families should assess behavioral health service capacity across all levels of care based on the needs of the children in care. The department should develop performance measures regarding the adequacy of such care.

**Agency Response**

"The Department agrees that enhancements to the service array are always helpful in meeting the ever-changing needs of children and families. While we disagree that there is a direct causal connection between the level of care continuum and children missing from care, the Department agrees with the need to continue working with the provider community, including foster and kinship care providers, to ensure that children have timely access to appropriate and the least restrictive placement settings consistent with their individual needs and circumstances.

It's evident that community resources are currently insufficient when youth present with these complex issues. We've bolstered the programming at STTAR programs to ensure they have increased staffing and funding for more recreational activities to engage youth pro-actively. We have also attempted to reduce overall milieu acuity but aiming to reduce census for each program but have had difficulty as this is also contingent on identifying providers willing to open additional beds so as to ensure we do not lose capacity. We've also aimed to develop and appropriately resource intensive transitional treatment centers which can serve as a program for these youth who are struggling in a community setting but not meeting the criteria for inpatient care. The challenge is that our provider network is finding that with the increasingly complex and challenging behavior of youth, they are challenged and sometimes hesitant to assume the risk and liability associated with providing these youth care.

The Department has also continued to invest and enhance Evidenced Based Practices to provide in-home and community-based services for youth with more complex needs, including, but

not limited to, Multidimensional Family Therapy (MDFT), Functional Family Therapy (FFT) and Multisystemic Therapy (MST).

In addition, the Department is partnering with the Judicial Branch-Court Support Services Division, the Department of Mental Health and Addiction Services and the Department of Developmental Services to improve services to our shared clients."

**Auditors' Concluding Comments**

DCF is responsible for addressing all the needs of the children within its care, even in increasingly complex cases.

## Finding 3

# DCF Did Not Track Whether an Episode was a Critical Incident or Significant Event

**Criteria**

Exhibit 7 shows definitions in DCF Policy 22-1-2: Notification of Exceptional Circumstances defines events, including missing from care episodes, as critical incidents or significant events.

**Exhibit 7. Exceptional Circumstances defined as Critical Incidents or Significant Events for Missing Children**

| Classification | Definition |
|---|---|
| Critical Incident | - Child abducted<br>- Child 0-12 years old is missing from care<br>- Child 13-17 years old with defined risk factors is missing from care |
| Significant Event | - Child 13-17 years old without defined risk factors is missing from care |

DCF must notify key internal and external stakeholders of critical incidents and significant events using the exceptional circumstance form. This risk assessment also informs police notification requirements in DCF Policy 21-15.

The Child Welfare League of American's *Best Practice Guidelines: Children Missing from Care* manual recommends the caseworker assess and document risk factors for each missing child and share this assessment with law enforcement.

The federal Government Accountability Office states that effective program management requires complete, reliable, and accurate data.

**Condition**

We found 55 out of 57 reviewed missing from care episodes (96%) did not have a documented exceptional circumstance form. DCF could not provide us with the individual forms or an overall number of critical incidents or significant events for any given year. DCF's missing from care aggregated report does not include the risk assessment classification. The missing from care window in LINK does not store or have a field for the risk assessment form or its outcome, and DCF does not track all exceptional circumstance forms elsewhere.

**Context**

We asked DCF administration if they track exceptional circumstance forms and reviewed their referred sources. We reviewed case narratives for 57 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023. We did not review the entire universe because DCF's missing from care aggregated report does not include exceptional circumstance form data. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to the overall proportion of episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child.

**Effect**

DCF management cannot ensure or demonstrate staff appropriately assessed a child's risk level or determined compliance with police notification requirements based on the child's risk level. DCF cannot verify it notified key required stakeholders identified in policy and procedure documents.

**Cause**

It appears that some DCF case workers did not know they are required to complete the exceptional circumstance form. LINK does not have data fields to designate missing from care episodes as critical incidents or significant events.

**Recommendation**

The Department of Children and Families should:

a) Ensure all appropriate staff and contractors are familiar with the exceptional circumstance form and when they must complete it.

b) Develop a tracking system and/or add fields in LINK to allow staff to designate the missing from care episode as a critical incident or significant event.

**Agency Response**

"The Department disagrees with the finding that it does not track or properly assess risk when a child has runaway or is missing from care. This finding appears to incorrectly focus on whether the Exceptional Circumstances (EC) form (DCF-823) is properly submitted when a child is missing from care (e.g., is the correct "Critical Incident" or "Significant Event" box checked on the form). This form was never intended to serve as a tool for aggregate data collection nor as the

only vehicle for sharing case-specific information regarding a child who is reported missing from care.

Along with following the Exceptional Circumstance policy (22-1-2) for after-hours notifications, the Careline also sends a standard set of questions/responses via email to the area office following a report that child is missing from care, which is documented in the electronic LINK record. These questions include information specifically aimed at locating the child and assessing the child's risk. Additionally, any updates or follow up completed at the Careline are documented in an after-hours narrative either by an on-call worker, social work screener or a social work supervisor

The Department is also in the process of updating and improving the EC policy and DCF 823 form. DCF Staff will be notified of the revised policy and Area office and Careline Management will ensure all staff are all trained. Central Office provider leads will disseminate and discuss EC policy with contracted providers. The Contractor will have policies, written protocols, and provide training for staff on how to respond when youth are missing from care. These policies and protocols will align and be consistent with DCF policies on children missing from care.

Lastly, the LINK system is being replaced with CT-KIND (Kid's Information Network Database) and due to be released in August 2025. The Exceptional Circumstances (EC) workflow and form are being built into CT-KIND with automated notifications and reporting capabilities to track and audit ECs."

## Auditors' Concluding Comments

The DCF policy mandates the use of a specific form, but our findings reveal department staff did not utilize it in 96% of cases. We emphasize that DCF has not conducted a thorough or systematic assessment of missing from care cases to understand the underlying causes, address systemic issues, and implement consistent, targeted interventions to prevent future incidents. Completing and maintaining the required forms or the information therein could potentially enhance the department's efforts.

# Finding 4

# Data Quality Concerns Prevent Verification of Compliance with Police Notification Requirements

## Criteria

State and federal statutes as well as DCF Policy 21-15 require that DCF report missing children to the police. Exhibit 8 shows how the required timeframes vary by the child's risk level and the fiscal year.

**Exhibit 8. Police Notification Requirements**

| Fiscal Year | Child 0-12 years old or 13-17 with risk factors (Critical Incident) | Child 13-17 years old without risk factors (Significant Event) |
|---|---|---|
| 2021 | Immediately | Within 24 hours of learning of missing child[4] |
| 2022 | Immediately | Within 24 hours of learning of missing child |
| 2023 | Immediately | After 12 hours |

The federal Government Accountability Office states that effective program management requires complete, reliable, and accurate data.

## Condition

DCF did not sufficiently document police notifications to show evidence of compliance with state and federal laws. In some instances, DCF did not promptly report critical incidents. Exhibit 9 shows our assessment of police notification compliance for the 1,544 episodes that required notification in fiscal years 2021 through 2023. We found that most (63%) of the episodes had unreliable data, and we could not calculate whether DCF reported these episodes on time. The data quality issues included missing dates and/or times for police notification or negative results for calculating the time elapsed.[5]

The exhibit also shows that for the 570 episodes without data quality concerns, 89% met timeliness requirements and 11% did not. We found that at least one quarter of the critical incidents and 10% of the significant events did not meet timeliness requirements.

[4] We used the date and time the child went missing from care to test for compliance instead of the date and time the caregiver notified DCF because DCF's aggregated report does not include when the caregiver notified DCF.

[5] A negative result would be because the police notification date and time occurred before the missing episode begin date and time, which could be an error with either piece of data.

| Exhibit 9. Most (63%) Episodes did not have Enough Data to Assess Compliance with Police Notification Requirements (n = 1,544) | | |
|---|---|---|
| | Number of Episodes | Percent of Episodes |
| **Unable to Determine (data quality issues)** | **974** | **63%** |
| | | |
| **Meets Timeliness Requirements** | **507** | **33%** |
| Critical Incidents | 33 | |
| Significant Event | 474 | |
| | | |
| **Does Not Meet Timeliness Requirements** | **63** | **4%** |
| Critical Incident | 11 | |
| Significant Event | 52 | |

**Context**

We assessed and reviewed police notification dates and times for compliance and data quality concerns for all 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023. DCF data does not include the categorization of critical incidents or significant events nor all risk factors in DCF 21-15. We considered episodes as critical incidents if the child was 12 years old or younger or had a service type DCF identified as high risk based on DCF Policy 21-15. We did not assess compliance for missing from care episodes with an episode end date but no documented time nor episodes with the episode end date and time before the episode begin date and time resulting in a negative number. We excluded 132 episodes from the analysis because of missing episode dates, for which we could not calculate the episode length. We did not include these episodes in the 1,544 episodes

**Effect**

Delays in finding missing children may increase their risk of harm. Data quality concerns prevent DCF from assessing and monitoring compliance with police notifications.

**Cause**

DCF has inadequate controls to ensure it promptly notifies the police. LINK has insufficient data quality checks to ensure workers enter reliable, accurate, and complete data.

**Recommendation**

The Department of Children and Families should:

a) Develop adequate controls to ensure the department promptly notifies the police as required by DCF Policy 21-15.

b) Develop the necessary data quality checks for its information system to ensure workers enter reliable, accurate, and complete data.

**Agency Response**

"The Department agrees with this finding as it pertains to documentation and is committed to enhancing its ability to track and ensure timely police notification when children are missing from care. While current policy (21-15) specifically requires providers to notify law enforcement and the Careline when a child in care has runaway or is otherwise missing, the Department is in the process of modifying its missing from care policy and practice guide to ensure that DCF does the required law enforcement notifications moving forward.

In addition, CT-KIND will have automated notifications, forms and workflows to inform law enforcement of missing children from care. Dashboards will assist with the timeliness of entries (documentation is to be entered within 5 business days of occurrence), alerts/notifications and tracks tasks due."

## Finding 5

# DCF Did Not Notify NCMEC as Required for Most Episodes

**Background**

The National Center for Missing and Exploited Children (NCMEC) is a nonprofit organization that serves as the national clearinghouse on missing and exploited children. NCMEC's mission is to find missing children, reduce child sexual exploitation, and prevent child victimization. NCMEC creates and disseminates missing child posters and provides specialized assistance to local police.

**Criteria**

42 USC 671(a)(35)(B) and Section 17a-8b of the General Statutes require DCF to notify NCMEC within 24 hours of when DCF learns the child is missing from care.

**Condition**

We found that DCF did not report all the required episodes to NCMEC and reported many episodes late.

Exhibit 10 shows that DCF notified NCMEC at a rate of 33%. DCF should have reported 1,305 episodes and only reported 436 episodes for fiscal years 2021 through 2023. DCF reported less than half of episodes in each fiscal year.

| Exhibit 10. DCF did not Report Missing Children to NCMEC as Required for Most Episodes | | | |
|---|---|---|---|
| Fiscal Year | Episodes requiring notification | Episodes reported | Rate episodes reported |
| 2021 | 424 | 118 | 28% |
| 2022 | 347 | 87 | 25% |
| 2023 | 534 | 231 | 43% |
| **Total** | **1,305** | **436** | **33%** |

Exhibit 11 shows DCF reported 61% of episodes late. Of the episodes DCF reported, the average and median days to report were both late for all the years, despite some improvement. We considered notifications within one day as timely because the NCMEC data did not include times.

| Exhibit 11. DCF Reported Most Episodes to NCMEC Late (n = 436) | | | |
|---|---|---|---|
| Fiscal Year | Percent Late | Average (in days) | Median (in days) |
| 2021 | 71% | 9.4 | 3 |
| 2022 | 67% | 12.1 | 2 |
| 2023 | 53% | 3.6 | 2 |
| **Total** | **61%** | **6.8** | **2** |

**Context**

We determined that 1,305 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023 lasted longer than 24 hours and required reporting to NCMEC. We compared this number to and assessed timeliness for all 436 episodes DCF reported to NCMEC in fiscal years 2021 through 2023.

**Effect**

Failing to promptly find missing children may increase their risk of harm.

**Cause**

Some DCF staff did not know who is responsible for notifying NCMEC since it could be area office staff or Careline staff depending on the situation.

**Recommendation**

The Department of Children and Families should:

a) Ensure it informs all appropriate staff about the requirements and who is responsible to notify NCMEC.

b) Develop an internal control that ensures the department notifies NCMEC as required.

**Agency Response**

"The Department agrees that not all NCMEC notifications were completed timely and/or documented as required and supports improved documentation of these notifications. CT-KIND will have automated notifications and workflows for notifications to NCMEC. There will be the ability to capture where the child is staying, if known, even if it is not a sanctioned or licensed DCF placement. The NECMEC features will be enhanced in CT-KIND post go-live (August 2025) to include a process to share missing child information and missing child posters.

In addition, the revised Missing from Care policy and Practice Guide more clearly identifies who is responsible for these notifications and the required timeframes. These requirements are currently taught in the Introduction to Child Trafficking in Connecticut for DCF and cross-referenced in the Human Trafficking Practice Guide (21-14), which also requires notification to the Statewide Human Anti-Trafficking Response Team (HART)."

## Finding 6

# DCF does not Have Procedures for When NCMEC May Disseminate a Missing Child Poster

**Criteria**

The National Center for Missing and Exploited Children (NCMEC), the Child Welfare League of America (CWLA), and the Office of Juvenile Justice and Delinquency Prevention's joint best practice guide on responding to children missing from care states that the child welfare agency and law enforcement should develop protocols with legal counsel on information they may release to the public, including missing posters. The guide recommends preemptively addressing legal concerns so that they do not prevent a prompt release of information.

**Condition**

DCF does not have procedures to clarify when NCMEC may disseminate a missing child poster. We noted workers and administration were uncertain in two reviewed episodes on whether DCF could allow NCMEC to disseminate posters:

- DCF permitted NCMEC in one episode after deliberating for seven days.
- DCF did not permit NCMEC in one episode after deliberating for three days despite the child's attorney saying it was legal and recommending approval.

**Context**

We asked DCF administration if the department has procedures to clarify when NCMEC may disseminate a missing child poster. We reviewed case narratives for 57 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023. We did not test the entire universe. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to the proportion of overall episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child.

**Effect**

Uncertainty may lead to DCF denying NCMEC's dissemination of a missing child poster when appropriate or delay the approval to release a poster.

**Cause**

DCF did not develop procedures to clarify when NCMEC may disseminate a missing child poster.

**Recommendation**

The Department of Children and Families should develop procedures to clarify when the National Center for Missing and Exploited Children may disseminate a missing child poster.

**Agency Response**

"The Department agrees with this finding and is in the process of developing appropriate protocols with NCMEC for this purpose."

## Finding 7

# DCF Did Not Document Attorney Notifications for Most Episodes

**Background**

The child's attorney represents the child's legal interests. All children in care have an attorney.

**Criteria**

Section 46b-129(j)(4) of the Connecticut General Statutes requires DCF to notify the child's attorney in writing no later than two business days after the child goes missing from care. The federal Government Accountability Office states that effective program management requires complete, reliable, and accurate data.

**Condition**

Exhibit 12 shows that DCF did not document the date of attorney notifications in 3,329 (89%) of 3,736 missing from care episodes for fiscal years 2021 through 2023. DCF notified the attorney within two

business days[6] in 10% of all episodes or in 94% of episodes with a notification date.

**Exhibit 12. DCF Did Not Document an Attorney Notification in 89% of Episodes (n = 3,736)**

| | Number of Episodes | Percent of Episodes |
|---|---|---|
| No notification date | 3,329 | 89% |
| Timely | 381 | 10% |
| Late | 26 | 1% |

**Context**

We assessed attorney notification dates for timeliness and data quality for all 3,736 missing children episodes reported to DCF in fiscal years 2021 through 2023.

**Effect**

The child's attorney may be unaware of the missing from care episode, which may affect their ability to appropriately represent the child.

**Cause**

Some social workers appeared to not prioritize notifying the missing child's attorney. DCF management does not have a control to ensure staff complete and document notifications.

**Recommendation**

The Department of Children and Families should implement appropriate internal controls to ensure staff notify the child's attorney as required by statute and properly document such notification.

**Agency Response**

"The Department agrees that not all attorney notifications were properly documented. Given that most children return to care within 1 day, the mandatory attorney/GAL notification may not be captured in the LINK record. However, the Department agrees with the importance of timely documentation of any required attorney/GAL notifications and will make efforts to improve in this area. In addition, CT-KIND will have automated notifications, forms and workflows to inform attorneys/GALs of children missing from care."

[6] Our analysis for business days takes into consideration weekends but not holidays.

## Finding 8

# DCF Did Not Track Guardian Ad Litem Notifications

**Background**

The courts appoint the child's guardian ad litem (GAL) to represent the child's best interests. Only some children in care have a guardian ad litem.

**Criteria**

Section 46b-129(j)(4) of the General Statutes requires DCF to notify the child's guardian ad litem, if applicable, in writing no later than two business days after the child goes missing from care. The federal Government Accountability Office states that effective program management requires complete, reliable, and accurate data.

**Condition**

DCF did not track or systematically document guardian ad litem notifications for missing children.

**Context**

We asked DCF administration if the department tracks guardian ad litem notifications and reviewed missing from care data for fiscal years 2021 through 2023.

**Effect**

DCF cannot readily determine if workers notified the child's guardian ad litem. The child's guardian ad litem may be unaware of the missing from care episode, which may affect their ability to represent the child's best interests.

**Cause**

DCF does not have a field in LINK or other means to readily track guardian ad litem notifications when a child goes missing from care.

**Recommendation**

The Department of Children and Families should develop a field in LINK or other means to track guardian ad litem notifications when a child goes missing from care.

**Agency Response**

"See Response to #7 above."

# Finding 9

# Caregiver Notifications to DCF Not Always Timely or Accurately Recorded

## Criteria

Exhibit 13 shows that the requirements in DCF Policy 21-15 for the caregiver to notify DCF about a missing child vary by the child's risk level and fiscal year.

**Exhibit 13. Caregiver Notification to DCF Requirements**

| Fiscal Year | Child 0-12 years old or 13-17 with risk factors | Child 13-17 years old without risk factors |
|---|---|---|
| 2021 | Immediately | Within one hour of time missing from care |
| 2022 | Immediately | Within one hour of time missing from care |
| 2023 | Immediately after notifying police | When caregiver determines child is missing from care |

The federal Government Accountability Office states that effective program management requires complete, reliable, and accurate data.

## Condition

Exhibit 14 shows that we found caregivers notified DCF late in 15 out of 57 reviewed episodes (26%). We considered reports timely if caregivers notified DCF no later than one hour after the child went missing from care for all risk levels and years.

We also found data quality concerns in 13 out of 57 reviewed episodes (23%). Seven had no date or time, and six had dates and times before the missing from care episode began.

**Exhibit 14. Caregiver Notification Timeliness to DCF (n = 57)**

| | Number of Episodes | Percent of Episodes |
|---|---|---|
| Timely | 29 | 51% |
| Late | 15 | 26% |
| Data Quality Issue | 13 | 23% |

**Context**

We reviewed case narratives in LINK for 57 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023. We did not test the entire universe because DCF's missing from care aggregated report does not include caregiver notifications. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to the proportion of overall episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child. We determined a notification to DCF was late after one hour when the child went missing from care for children either with or without risk factors for consistency.

**Effect**

DCF cannot respond promptly to a missing child if the caregiver does not promptly notify DCF. Data quality concerns prevent an accurate picture of compliance with the required standard.

**Cause**

DCF staff informed us that some caregivers appear unaware of the time requirement to notify DCF when a child goes missing from care.

**Recommendation**

The Department of Children and Families should develop internal controls to ensure that:

a) Caregivers are aware of the time requirements to notify DCF when a child goes missing from care.

b) Staff accurately record the date and time caregivers notify DCF of a missing from care episode.

**Agency Response**

"The Department believes that caregivers do a good job overall of adhering to the agency's notification requirements when a youth is missing from care. Very often when a youth is struggling, there is ongoing communication between the caregiver and the Social Worker occurring via phone call, text message, email, etc. that may not always be reflected in the electronic case record. We will continue to enhance caregiver notification and data quality through the foster care division and provider partners with training and ongoing support.

CT-KIND will have automated caregiver notifications via the provider portal or email for placement issues or when children are missing from care."

## Finding 10

# Insufficient Documentation of DCF Efforts to Locate Children Missing from Care in a Few Cases

**Criteria**

42 USC 671(a)(35)(A)(i) requires DCF to develop and implement specific protocols to expeditiously find any child missing from care. 42 USC 671(a)(35)(B) requires DCF to notify the police when a child goes missing from care.

DCF Policy 21-15 provides search requirements when a child goes missing from care. DCF Policy 21-15 (Effective January 2, 2019) requires that DCF staff, facility staff, foster parents, and/or private child placing agency staff search while the child is missing from care. DCF Policy 21-15 (Effective July 15, 2022) requires the care provider and DCF search for the child for critical incidents (a child who is under 13 years of age or has a medical condition or cognitive disability, etc.). The care provider must search for the child and discuss a plan with DCF to locate the child for significant events (all other missing children who do not have a critical incident factor). The policy states search efforts may include:

- looking in the community where the child lives
- contacting the child on their cell phone
- contacting the child's family and/or friends
- checking the child's social media accounts.

**Condition**

DCF did not document police notification, search efforts by the care provider, or any DCF and care provider discussion of a search plan in two out of 52 reviewed missing from care episodes (4%) that required a police notification. In addition, DCF search procedures lack specificity:

- DCF search procedures do not clearly require the DCF worker to search for children who are 13-17 without risk factors (a medical condition or cognitive disability, etc.).

- DCF search procedures do not define expectations for search efforts when a child is missing from care for an extended period, besides requiring "ongoing" efforts.

**Context**

We reviewed case narratives in LINK for 57 of the 3,736 missing from care episodes reported to DCF in FY 2021 through 2023. We did not test the entire universe because DCF's missing from care aggregated report does not include search effort documentation besides police notification dates and times. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type

and randomly selected episodes in approximate proportion to the proportion of overall episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child. We excluded five of the 57 cases because they did not require a police notification, and the brevity of these episodes may have impacted the necessity to perform search efforts.

**Effect**

DCF cannot ensure staff and other parties appropriately searched for missing children. Delays in finding missing children may increase their risk of harm.

**Cause**

DCF lacks sufficient controls to ensure staff appropriately search for the child and document their efforts.

**Recommendation**

The Department of Children and Families should:

a) Develop controls to ensure staff appropriately search for the child and document their efforts.

b) Modify its procedures to increase and clarify specific requirements for locating missing children.

**Agency Response**

"The Department agrees that documentation regarding DCF's efforts may have been insufficient in a few cases. However, it appears this finding applies to 2 cases reviewed, which is not representative of DCF's overall efforts to locate children missing from care. It should be noted that CT-KIND will have text fields to document diligent efforts in locating missing children from care with the ability to capture their address, if known, even if it is not a sanctioned or licensed DCF placement."

**Auditors' Concluding Comments**

Our Context indicates we examined 57 cases and identified two (4%) that raised concerns, highlighting broader issues within the agency. Each of these cases reflects the extent of DCF's efforts to find children missing from care.

## Finding 11

# DCF Policy Requires a Formal Reassessment of an Episode but it Does not Define Reassessment

**Criteria**

DCF Policy 21-15 (effective January 2, 2019) required DCF to complete a formal reassessment within three hours of the child going missing from care or prior to the area office's closing or next Careline shift change during the child's absence.

DCF Policy 21-15 (effective July 15, 2022) requires DCF to complete a formal reassessment "within three hours of the original call or prior to the (SIC) during the child's absence for children 0-12 years old or 13+ with risk factors."[7]

**Condition**

DCF Policy 21-15 does not define formal reassessment. DCF Policy 21-15 (effective July 15, 2022) is missing text in the middle of the requirement.

We found that 25 episodes out of 27 (93%) requiring a reassessment did not have one documented. Staff informed us they informally assess cases and frequently plan different actions to take based on circumstances. Some staff were not aware of the requirement.

**Context**

We reviewed case narratives in LINK for 57 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023. We did not test the entire universe because DCF's missing from care aggregated report does not indicate or track the completion of a formal reassessment. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to the proportion of overall episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child. We determined 27 episodes required a formal reassessment because 20 episodes in fiscal years 2021 and 2022 were longer than three hours and seven episodes in fiscal year 2023 were critical incidents and longer than three hours.

**Effect**

DCF may not properly manage a missing from care episode if the department does not define its actions or staff does not promptly review new information.

**Cause**

DCF did not train its workers on the requirements of a formal reassessment.

[7] This phrase in the policy appears to be cut off or improperly edited.

**Recommendation**

The Department of Children and Families should:

a) Ensure workers are aware of the requirement to promptly reassess missing from care cases.

b) Clarify what formal assessment means and consider revising it to better fit practice.

**Agency Response**

"The Department agrees that further definition is required regarding the reassessment plan to locate a child missing from care within 3-hours of the initial call (DCF Policy Sec. 21-15). The updated Missing from Care Practice Guide provides additional detail regarding what constitutes an appropriate reassessment process. More specifically, the reassessment includes, but is not limited to, updated and additional action steps to locate the child mutually agreed to by DCF, facility staff, foster parents and any therapeutic foster care (TFC) agency staff. This practice guide also provides additional directives regarding documentation of all activities regarding a child missing from care, including the plan and reassessment developed and updated to search for the child. In addition, CT-KIND will have dashboards with tasks due for follow up or completion. There are also Help features to assist staff in navigating the processes when children are missing from care."

## Finding 12

# Insufficient Evidence of DCF Efforts to Determine Why Children went Missing from Care and Respond to Those Reasons in Some Cases

**Criteria**

42 USC 671(a)(35)(A)(ii) requires DCF to develop and implement protocols to determine the primary factors that contributed to the child being absent from care and respond to those factors.

The Child Welfare League of America's *Best Practice Guidelines: Children Missing from Care* manual recommends completing a debriefing with the child within 24 hours of their return. The interview should cover why the child left, what happened while they were missing from care, and the child's needs. This debriefing should inform changes to the child's placement, treatment plan, and permanency plan, if appropriate, with input from the child. This guide also recommends creating a contingency plan with the child if they feel the need to leave again, including actions they can take instead of leaving and safe places they can go if they leave.

**Condition**

We found DCF did not always comply with the legal requirements regarding actions the department should take when a child returns to care.

Procedures: DCF did not have written procedures for determining and responding to the reasons why the child went missing from care upon the child's return to care unless the child experienced sex trafficking.

Why the child went missing from care: Exhibit 15 shows DCF either did not complete or document efforts to determine why the child went missing from care in 19 out of 53 reviewed episodes (36%) in which the child returned to care. We considered DCF in compliance when the child told DCF why they went missing from care, DCF asked but the child did not respond, or the child's placement provided a reason.

**Exhibit 15. DCF did not Document Why the Child Went Missing from Care in 34% of Episodes (n = 53)**

| | Number of Episodes | Percent of Episodes |
|---|---|---|
| Compliant | 34 | 64% |
| No documentation | 19 | 36% |

Response to those reasons: We could not objectively determine if DCF workers responded appropriately because they rarely explained their rationale in the case record. In most cases, the case record does not sufficiently link actions the social worker took after a child returned to care to the reasons a child went missing from care.

**Context**

We reviewed case narratives in LINK for 57 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023. We did not test the entire universe because DCF's missing from care aggregated report does not include this requirement. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to the proportion of overall episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child. In this analysis, we excluded four episodes where the child did not return to care, either because the child was still missing from care or because the child turned 18. DCF could not necessarily complete this assessment if the child did not return to care.

**Effect**

Without understanding why the child went missing from care and responding to those factors, DCF cannot effectively prevent future missing from care episodes. DCF cannot determine whether its workers complied with its debriefing and documentation

requirements without developing specific procedures to objectively test.

**Cause**

DCF did not develop procedures to determine why the child went missing from care and respond to those factors. Workers did not document prevention plans developed by congregate care or other providers in LINK.

**Recommendation**

The Department of Children and Families should:

a) Amend its policy to require workers to determine and document the factors that contributed to the child being missing from care and create a prevention plan that responds to those factors.

b) Ensure its workers receive and save prevention plans developed by congregate care or other providers in LINK.

**Agency Response**

"See Response to #11 above related to the reassessment process when children are located and returned to care. The updated Missing from Care Practice Guide will address this finding."

## Finding 13

# DCF does not Have Procedures to Address Children who are AWOL

**Background**

DCF considers children AWOL if they are in communication with their worker or the worker knows where they are but are in an unapproved placement. These children may be living with family or friends. DCF cannot license a family who does not want the department's involvement, or the parent(s) of the removed child. Other children may maintain regular contact with their workers but do not share where they are living. DCF states that it cannot force a child to return to care.

**Criteria**

Section 17a-6 of the General Statutes requires DCF to insure all children under DCF's supervision have their basic needs and service needs met. Section 17a-98 of the General Statutes states that DCF shall exercise careful supervision of every child under its guardianship or care and shall maintain sufficient contact to promote the child's safety and physical, educational, moral, and emotional development. DCF's strategic goals include to "keep children and youth safe, with focus on most vulnerable populations."

| | |
|---|---|
| **Condition** | DCF's missing from care policy does not specify procedures for AWOL children, such as harm reduction approaches or ways the department can meet the child's basic needs. We noted variation in practice with these children, which could relate to child-specific factors or staff knowledge of potential risks and mechanisms to meet the child's needs. Variations included how staff assessed caregivers, frequency of visitation, arrangement of school transportation, and provision of funds for the child's care. |
| **Context** | We reviewed DCF policies related to children missing from care. We interviewed area office staff and management about how they handle AWOL children. |
| **Effect** | DCF staff may not be aware of appropriate actions to ensure these children are as safe as possible and have their needs met. Staff may not consistently engage AWOL children. |
| **Cause** | DCF did not develop policies and procedures to meet basic needs for children who are AWOL, such as possible harm reduction techniques. |
| **Recommendation** | The Department of Children and Families should develop policies and procedures to meet basic needs for children who are AWOL. |
| **Agency Response** | "The Department disagrees with this finding. All of DCF Policies and Practice Guides that apply to children in care also apply to children who are not currently residing in their approved placement but whose whereabouts are known to the Department (i.e., AWOL). This includes all policies related to case planning, social worker visits, safety planning and service provision." |
| **Auditors' Concluding Comments** | We agree that current DCF policies and practice guides are important for children who are AWOL. However, these children can have specific needs that DCF policies do not address, especially when they are not in an approved placement. We commend staff's creative problem solving and recommend DCF provide guidance on how to handle these considerations equally and specifically to children who are AWOL. |

## Finding 14

# DCF Did Not Have Procedures to Determine Every Child's Experience While Missing from Care Including Screening for Sex Trafficking Victimization

**Criteria**

42 USC 671(a)(35)(A)(iii) requires DCF to develop and implement protocols to determine the child's experience while absent from care, including screening for potential sex trafficking victimization.

42 USC 671(a)(9)(C) requires DCF to identify, document, and provide services for all children who are at risk of being or are a sex trafficking victim.

The National Advisory Committee on the Sex Trafficking of Children and Youth in the United States' "Best Practices and Recommendations for States" states child welfare agencies must screen all children who have been missing from care each time the child returns to care following P.L. 113-183 (42 USC 671(a)(35)(A).

The Child Welfare League of America's *Best Practice Guidelines: Children Missing from Care* manual recommends completing a debriefing with the child within 24 hours of the child's return that includes what happened while the child was missing from care.

**Condition**

We found DCF lacked sufficient procedures and screening practices for detecting sex trafficking victimization.

Procedures: DCF did not have procedures to determine the child's experience while missing from care including screening all missing children for sex trafficking. DCF policies only require a sex trafficking screen if the child was missing from care for more than 72 hours or the social worker has concerns about sex trafficking.

Screening for Trafficking: Exhibit 16 shows DCF did not document a sex trafficking screening for 50 out of 53 reviewed episodes (94%) where the child returned to care upon the child's return. We could not determine whether this is a documentation issue or DCF did not screen the child for these episodes.

| Exhibit 16. DCF Did Not Document a Sex Trafficking Screen For 94% of Children (N = 53) | | |
|---|---|---|
| | Number of Episodes | Percent of Episodes |
| Yes | 3 | 6% |
| No documentation | 50 | 94% |

**Context**

We reviewed case narratives in LINK for 57 of the 3,736 missing from care episodes reported to DCF in FY 2021 through 2023. We did not test the entire universe because DCF's missing from care aggregated report does not include these requirements. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to the proportion of overall episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child. In our assessment of sex trafficking screens, we excluded four episodes where the child did not return to care, either because the child was still missing from care or because the child turned 18. DCF could not fulfill this requirement if the child did not return to care.

**Effect**

DCF cannot effectively support children and provide effective services without understanding what happened to children while they were missing from care and may not identify victimized children. DCF cannot determine or objectively test worker compliance with these requirements without developing specific procedures.

**Cause**

DCF management did not prioritize the development of procedures to determine the child's experiences while missing from care and screen all children for sex trafficking.

**Recommendation**

The Department of Children and Families should:

a) Develop procedures to determine the child's experiences while missing from care.

b) Amend policy to require sex trafficking screenings for all missing children when they return to care.

c) Ensure its workers receive and save prevention plans and sex trafficking screens completed by congregate care or other providers in LINK.

**Agency Response**

"The Department disagrees with this finding. The Department has developed policy and practice guides related to human trafficking of children, including children missing from care. However, we

agree that additional clarification regarding the scope of sex trafficking screening upon return to care, which will be included in the updated Missing from Care Practice Guide."

**Auditors' Concluding Comments**

The DCF human trafficking and missing from care policies do not address federal requirements for staff to respond to children when they return. This includes determining experiences while children were missing from care and screening all children for sex trafficking upon their return to care.

## Finding 15

# Human Antitrafficking Response Team Documentation and Data Need Improvement

**Background**

The Human Antitrafficking Response Team (HART) is a group of stakeholders led by DCF who work together to address child trafficking in Connecticut. Members include state agencies, courts, DCF staff, law enforcement, probation, mental health providers, multidisciplinary teams, and medical providers. The members typically have other responsibilities and perform HART functions on a voluntary basis.

**Criteria**

DCF Practice Guide 21-14 (Effective August 2021) requires children missing from care for more than 72 hours to receive a HART consult that includes screening using the Child Trafficking Decision Map, which assists in determining the risk level for child trafficking. The child's worker must request the consult within two business days and HART must have the consult within 72 hours of the request. Children require a HART consult and an updated Child Trafficking Decision Map every time they go missing from care for at least 72 hours.

**Condition**

DCF did not document the time of the HART notification or HART consult and could not calculate timeliness because the requirement is in hours and DCF does not record the times.

Eight out of 57 reviewed episodes required a HART consult because the episodes were longer than 72 hours. We found:

- Six (75%) had no documented HART notification date.
- Two (25%) had no documented HART consult date.
- Three (38%) had no documented HART consult narrative and it appears the consult did not occur.

- Five (63%) had no documented updated Child Trafficking Decision Map, which identifies risk and applicable services.

**Context**

We reviewed case narratives for 57 of the 3,736 missing from care episodes reported to DCF in fiscal years 2021 through 2023 to assess compliance. We did not test the entire universe because DCF's missing from care aggregated report does not include HART data. We judgmentally selected the five longest missing from care episodes. To select the remaining episodes, we stratified the episodes by placement type and randomly selected episodes in approximate proportion to the proportion of overall episodes per placement type. We only selected one episode per child if the random selection resulted in multiple episodes from one child.

**Effect**

DCF may not identify children as trafficking victims. DCF may not promptly provide the necessary supports and services.

**Cause**

It appears some DCF area office workers do not know they must notify HART for children who are missing from care for more than 72 hours or document notifying HART. The HART liaison may not have time to document the consult date, narrative, and Child Decision Map in LINK. HART liaisons complete these duties voluntarily in addition to their regular responsibilities.

**Recommendation**

The Department of Children and Families should have internal controls to ensure:

a) Area office staff know they must notify the Human Antitrafficking Response Team for children who are missing from care for more than 72 hours.

b) Accurate documentation of HART notifications and consult dates and times.

c) HART liaisons complete a new Child Trafficking Decision Map when the child is a suspected or confirmed victim.

**Agency Response**

"The Department agrees with the need to improve HART data and documentation. Notification to HART for children who are missing for more than 72 hours is included in the DCF's Human Trafficking Practice Guide (21-14) and is taught in the Introduction to Child Trafficking in CT for DCF training that is required annually.

The HART liaisons are required to do updated Decision Maps after a child is missing for more than 72-hours. The Decision Map is embedded in the HART consult note and should be entered into LINK.

In addition, Human Trafficking will be a Child Protective Services (CPS) Report type in CT-KIND. The Decision Map, protocols,

workflow, notifications and forms will all be within CT-KIND as well as enhanced reporting features."

## Finding 16

# DCF does not Have Performance Measures to Determine Success with Reducing Human Trafficking

**Criteria**

The federal Government Accountability Office (GAO) states that organizations should develop measurable objectives to enable assessment of the performance of the organization's activities. GAO also states that effective program management requires complete, reliable, and accurate data.

**Condition**

DCF does not have measures to assess its practice to reduce trafficking and respond to child victims. For example, it could track the number of care plans developed and the achievement of plan goals related to assisting victims of trafficking. We also found that while DCF has the necessary data infrastructure to collect trafficking information, it lacks accuracy. For example, DCF verified that the overall number of confirmed cases recorded in the database was too low.

**Context**

We asked the DCF administration if they have measurable ways to assess success reducing trafficking and whether the department has reliable trafficking data.

**Effect**

DCF cannot objectively determine and report on the success of its practices to reduce human trafficking and respond to child victims of trafficking.

**Cause**

DCF views success as highly individualized and did not develop overall measures to determine success in reducing trafficking. DCF did not allocate sufficient resources to support data quality.

**Recommendation**

The Department of Children and Families should:

a) Develop performance measures to enable the department to assess its practice in reducing human trafficking and enhance its decision making.

b) Improve data quality to support this effort.

**Agency Response**

"The Department disagrees with the finding that there are no performance measures related to reducing human trafficking. The Department's performance is tracked related to its overall goals of safety, permanency and well-being of all children in care. However, the Department supports improved data collection and analysis related specifically to human trafficking, which will be addressed via the CT-KIND data collection and reporting enhancements."

**Auditors' Concluding Comments**

We did not receive any performance measures specifically related to human trafficking data.

## Finding 17

# Section 17a-8b of the General Statutes is Unclear and Beyond DCF's Authority

**Criteria**

The Connecticut Legislative Commissioner's Office guide to writing statutes states that statutory language must be clear and accurate to ensure it unambiguously conveys the drafter's intent.

**Condition**

Section 17a-8b of the General Statutes does not provide exactly when DCF must report missing children to law enforcement. This statute also requires DCF to notify the FBI's National Crime Information Center (NCIC). DCF cannot report missing children to NCIC because the department does not have access. Typically, only law enforcement has the authority to add a report in NCIC.

**Context**

We asked DCF administration for their interpretation of this statute and reviewed the legislative history for Section 17a-8b.

**Effect**

DCF cannot effectively follow statutory requirements that are unclear or beyond its authority.

**Cause**

Section 17a-8b was a small part of Public Act 15-199 and its lack of clarity and reach beyond the department's authority might have been overlooked.

**Recommendation**

The Department of Children and Families should seek legislation to amend Section 17a-8b of the Connecticut General Statutes to clarify when the department must notify state and federal law enforcement consistent with its authority.

**Agency Response**

"The Department agrees that Section 17a-8b should be clarified consistent with federal law."

# OBJECTIVES, SCOPE, AND METHODOLOGY

We have audited certain operations of the Department of Children and Families' Response to Children Missing from Care. The scope of our audit included, but was not necessarily limited to, the fiscal years ended June 30, 2021, 2022, and 2023 . The objectives of our audit were to:

1. Evaluate the efficiency and effectiveness of the Department of Children and Families' policies and procedures for reporting, locating, and monitoring children missing from care; and

2. Determine if the Department of Children and Families is using best practices to collaboratively work with law enforcement to locate missing children.

Our methodology included reviewing written policies and procedures, financial records, meeting minutes, and other pertinent documents. We interviewed various department personnel and certain external parties. We also tested selected transactions. This testing was not designed to project to a population unless specifically stated.

We obtained an understanding of internal controls that we deemed significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of contracts, grant agreements, or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The accompanying program background is presented for informational purposes. We obtained this information from various available sources including, but not limited to, interviews, documents, and data provided by the department's management and state information systems. It was not subject to the procedures applied in our audit of the program. For the areas audited, we identified:

1. Deficiencies in internal controls;

2. Apparent noncompliance with laws, regulations, contracts and grant agreements, policies, or procedures; and

3. A need for improvement in management practices and procedures that we deemed to be reportable.

The State Auditors' Findings and Recommendations section of this report presents findings arising from our audit of the Department of Children and Families' Response to Children Missing from Care.

# Children Missing from Care Overview

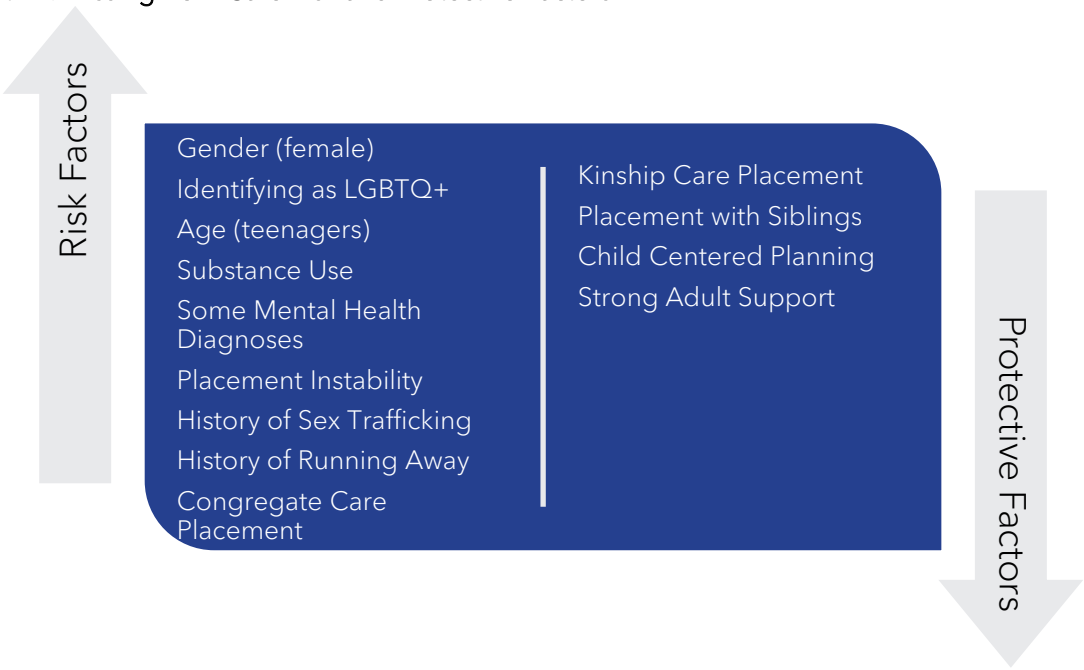
Federal law defines a missing child as "any individual less than 18 years of age whose whereabouts are unknown to such's individual's [legal guardian]." Children go missing because of family and nonfamily abductions, accidents, and runaway episodes. Runaway episodes are the most common reason. Some runaway episodes may be throwaway episodes, where the child leaves at the caregiver's volition.

Limited data exists on the prevalence of missing children both in the general population and from foster care because of varying definitions and research methodology limitations. The Adoption and Foster Care Analysis and Reporting System (AFCARS) reported 4,240 or 1% of children in care nationally were on runaway status on September 30, 2021. Analyses of 2010 national foster care data found about 30% of children 12 years or older in care had run away at some point. A 2013 study reported older children in care were 2.5 times more likely to run away than peers not in care.

### Why do Children Run from Care?

It is critical to understand risk factors and the reasons children leave care to effectively respond and prevent missing from care episodes. Exhibit 17 shows some of the characteristics researchers have identified associated with foster care run risk. Children who are female, LGBTQ+, teenagers, placed in congregate care, or who have a history of sex trafficking, placement instability, or have previous episodes of running away are more likely to run from care. Children of color may also be at increased risk, but findings are inconsistent. Substance use and mental health diagnoses may increase risk, though severity and specific diagnoses may affect actual risk. Protective factors include kinship care placements, placement with siblings, child centered planning, and strong adult support.

Exhibit 17. Missing from Care Risk and Protective Factors



Children run from care for numerous reasons. Exhibit 18 shows how researchers typically categorize the reasons children run as push or pull factors. Push factors cause the child to run *from* something whereas pull factors cause the child to run *to* something. Children also run for ambiguous reasons.

Exhibit 18. Examples of Reasons Children Run from Care

| Push Factors/"Running from" | Pull Factors/"Running to" | Ambiguous Reasons |
|---|---|---|
| • Restrictive rules or rules generally as child may be unaccustomed to supervision<br>• Bullying and problems with other children<br>• Conflict with caregiver<br>• Boredom<br>• Isolation<br>• Abuse and/or neglect | • Family of origin<br>• Friends<br>• Romantic partners<br>• Substances<br>• Seeking normalcy<br>• Seeking autonomy | • Emotional instability<br>• Difficult life experiences<br>• General unattachment |

### What are the Consequences of Running Away?

Children in foster care are a vulnerable population and leaving care may exacerbate these vulnerabilities. Running from care can lead to numerous consequences for the child, including:

- Human trafficking;
- Health problems, including sexually transmitted diseases, pregnancy, injuries, and illnesses;
- Substance use;
- Decline in mental health from increased trauma exposure;
- Criminal victimization;
- Adverse academic outcomes, including poor attendance, low grades, and not graduating high school;
- Criminal justice system involvement; and
- Weakened connections to supportive adults.

## Children Missing from Care and Human Trafficking

The issue of children missing from care closely aligns with human trafficking. Running away increases the child's risk of trafficking and trafficking increases the child's risk of running away. A history of child maltreatment is one of the strongest risk factors for sex trafficking and children in the child welfare system are particularly vulnerable. Missing children are at risk of both sex and labor trafficking.

### Human Trafficking Defined

The "Trafficking Victims Protection Act" of 2000 defines sex and labor trafficking in the United States as follows:

- Sex trafficking: A commercial sex act induced by force, fraud, or coercion or in which the person performing the act is under 18 years old. All minors who engage in sex acts in exchange for anything of value, including money, food, or shelter, are victims of sex trafficking.

- Labor trafficking: The recruitment, harboring, transportation, provision, or obtaining a person for labor using force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

### Prevalence of Trafficking Among Children Missing from Care

Children missing from care have a relatively high risk of trafficking. The National Center for Missing and Exploited Children (NCMEC) found 17% of all children and 27% of female children reported as missing from care from 2013 to 2022 were likely sex trafficking victims. Children who are LGBTQ+, persons of color, and girls are at increased risk, though trafficking can affect any child. Researchers agree reports under identify male victims and undercount trafficking overall.

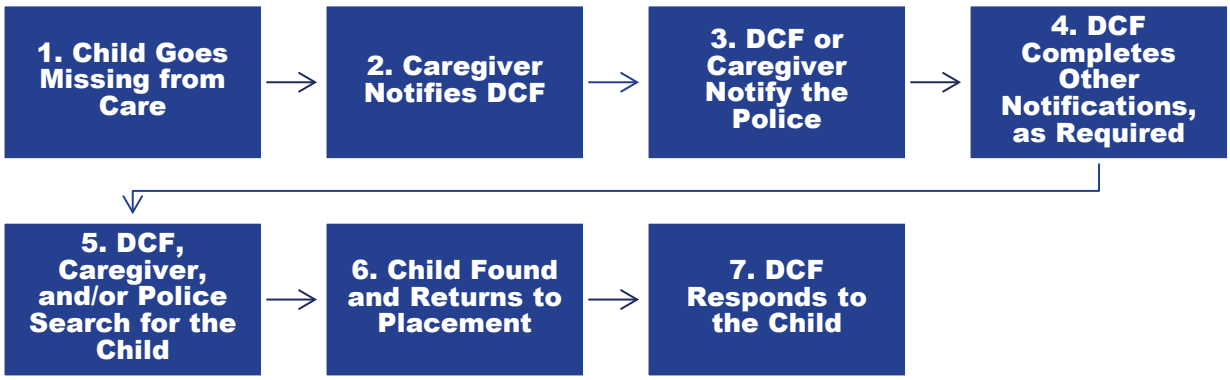
### How Children Enter into and Remain in Trafficking Situations

Children who experience trafficking are legally victims regardless of their specific circumstances. Traffickers rarely kidnap children, but rather exploit vulnerabilities. Traffickers include stereotypical pimps, family members, and romantic partners. Some children arrange sexual encounters on their own to meet unmet needs like food or shelter or more complex needs like feeling loved. Since children cannot legally consent, they remain victims and may suffer physical and psychological harm. Some traffickers specifically target children in foster care because they know these children are less likely to have supportive adults in their lives and more likely to have unmet needs. Children may remain in trafficking situations because they see the trafficker as a romantic partner or fear them. Children rarely self-identify as sex trafficking victims, but cannot legally give consent and are crime victims regardless of their perception of choice.

# Process When Children Go Missing from Care

State statutes, federal law, and DCF policy require certain actions when a child goes missing from care. This process includes steps for the initial response, the search for the child, and the response to the child when they return to care. Exhibit 19 provides an overview of this process. This section then describes each step in more detail.

Exhibit 19. Simplified Missing from Care Process Flow



## 1. Child Goes Missing from Care

The process begins when the child goes missing from care. The child might leave without permission or not return when expected. Exhibit 20 shows how DCF classifies missing episodes as AWOL, runaway, or abduction.

**Exhibit 20. DCF Missing from Care Classifications: AWOL, Runaway, and Abduction**

| | |
|---|---|
| AWOL | Child is not where they should be, but DCF knows where the child is or is communicating with them. The child may have left the residence without permission or may not have returned at a predetermined time from school, work, or an event. |
| Runaway | Child left their placement and DCF does not know where they are and cannot communicate with them. |
| Abduction | Unauthorized removal of a minor from the custody of the child's parent or guardian. |

## 2. Caregiver Notifies DCF

The child's caregiver must notify DCF when the child goes missing from care per DCF Policy 21-15. Exhibit 21 shows how the timeframe varied by the child's risk level and fiscal year during the audited period.

**Exhibit 21. Caregiver Notification to DCF Requirements**

| | Child 0-12 or 13-17 with risk factors | Child 13-17 without risk factors |
|---|---|---|
| FY 2021 | Immediately | One hour |
| FY 2022 | Immediately | One hour |
| FY 2023 | Immediately after notifying police | When caregiver determines child is missing from care |

DCF and the caregiver determine the child's risk level based on the child's age, endangerment factors, and circumstances around the disappearance. DCF designates the child as immediate response, if the child is 12 years old or younger, a risk to themselves or others, or was abducted. DCF expects the caregiver to call the police before DCF for these highest risk cases. DCF Policy 21-15 identifies the following high-risk criteria when the child:

- Has high emotional or psychiatric acuity;
- Is placed in a psychiatric residential treatment facility, crisis stabilization program, or psychiatric hospital;
- Is diagnosed with serious medical condition that requires scheduled medication and timely monitoring, such as insulin-dependent diabetes;

- Has history of sexual exploitation, or identified as high risk, suspected risk, or confirmed for human trafficking;
- Has developmental and/or cognitive delays; or
- Poses a danger to self, others, or the community.

DCF opens a Temporary Living Condition (TLC) entry in LINK upon notification from the caregiver. The TLC tab in LINK contains various details about the missing from care episode. The worker documents the date and time the child went missing from care, the type of missing from care episode, where the child went missing from care, and comments about the episode in the TLC tab.

### 3. DCF or the Caregiver Notify the Police

Exhibit 22 shows when DCF generally expects the caregiver to notify the police when a child goes missing from care, as the police usually wish to speak with the caregiver. DCF reminds the caregiver to call the police, if needed. DCF documents the police notification date and time in the TLC.

**Exhibit 22. Police Notification Requirements**

| Fiscal Year | Child 0-12 or 13-17 with risk factors | Child 13-17 without risk factors |
|---|---|---|
| 2021 | Immediately | Within 24 hours of learning of missing child |
| 2022 | Immediately | Within 24 hours of learning of missing child |
| 2023 | Immediately | After 12 hours |

### 4. DCF Completes Other Notifications, as Required

Exhibit 23 shows when DCF must complete additional notifications. The DCF Risk Management reporting system alerts additional entities inside and outside of DCF listed in DCF Policy 22-1-2. DCF documents the attorney notification in the TLC. The TLC does not have a field for the Risk Management/Exceptional Circumstance form, National Center for Missing and Exploited Children notification, or guardian ad litem notification.

**Exhibit 23. Additional Required Notifications**

| Entity | Requirement |
|---|---|
| DCF Risk Management/Exceptional Circumstance Reporting | Within 2 hours for high-risk cases<br>Within 12 hours for lower risk cases |
| National Center for Missing and Exploited Children (NCMEC) | Within 24 hours |
| Child's attorney | Within 2 business days |
| Child's guardian ad litem, if applicable | Within 2 business days |

DCF updated the NCMEC reporting time requirement in January 2023 and now must notify NCMEC within the same timeframes as the police, according to internal Careline guidance. The Careline is a 24-hour, toll-free number to report suspected child abuse or neglect in Connecticut. During non-business hours, Careline staff receive calls about children missing from care and notify the appropriate DCF staff.

### 5. DCF, Caregiver, and/or Police Search for the Child

DCF, the caregiver, and/or the police search for the child, as applicable. Careline assigns an on-call area office worker to search if DCF designates the child as requiring immediate notification and the child goes missing from care after business hours. The area office continues the search if the child is still missing from care on the next business day. DCF 21-15, effective July 15, 2022, suggests the search includes:

- Looking in the child's community;
- Contacting the child on their cell phone;
- Contacting the child's family and friends;
- Checking the child's social media accounts.

DCF administration stated workers frequently work with the child's family, as many children run to family members. DCF may also collaborate with community organizations and the child's mentors, if applicable. Some children remain in contact with their social worker via their phone. DCF also provides children with a number they can use to chat or text with Careline live.

### 6. Child Found and Returns to Placement

DCF works with the police to recover the child. The police pick the child up if the child is in an unsafe location to ensure DCF staff safety. The child may also return to placement on their own. DCF updates the TLC with the return date and time and comments about the return. DCF then closes the TLC.

### 7. DCF Responds to the Child

DCF must respond to the child when they return to placement to meet their basic needs, treatment needs, and prevent future missing from care episodes. Federal law requires DCF to:

- Determine why the child went missing from care;
- Respond to the reasons the child went missing from care as possible and appropriate;
- Determine the child's experiences while missing from care; and
- Screen the child for sex trafficking.

Workers plan with the child to prevent future missing from care episodes and document this in LINK. For example, the worker may increase visitation with the child's parents if the child leaves care to see them. Staff do not fill out a specific form or template unless DCF suspects or confirms human trafficking. DCF encourages the development of child-specific plans for children who frequently go missing from care.

A child's social worker must request a Human Anti-Trafficking Response Team (HART) consult from a HART liaison within two business days if the child is missing from care for at least 72 hours or the worker suspects trafficking, according to DCF policy as of August 2021. The HART liaison is responsible for performing an assessment and working with the child's treatment team, specialized providers, and legal representation to ensure the child receives the appropriate medical and mental health services. The consult occurs within 72 hours of the request regardless of whether DCF has found the child. At the consult, the HART liaison completes the Child Trafficking Decision Map, which is DCF's human trafficking screening tool. The child may fall into a category of at risk, high risk, suspected, or confirmed for trafficking. The consult results in a formal narrative with service recommendations informed by the child's risk level. DCF and its partners must develop a realistic safety plan with children who are at risk of, suspected, or confirmed for human trafficking.

# Collaboration with Law Enforcement

Law enforcement departments are an important partner in the response to children missing from care. The Child Welfare League of America's *Best Practice Guidelines: Children Missing from Care* states that law enforcement should take the lead on missing from care cases. When a person reports a child missing, law enforcement, like child welfare agencies, must follow numerous legally mandated requirements. Within two hours of receipt, law enforcement must enter the missing child report into the:

- State law enforcement system
- National Crime Information Center (NCIC), maintained by the FBI
- State Missing Children Information Clearinghouse, maintained by the Department of Emergency Services and Public Protection in Connecticut
- National Missing and Unidentified Persons System (NamUs), as of December 27, 2022.

We interviewed DCF administration, DCF staff, contracted providers, and law enforcement about their experiences working together when children go missing from care. DCF staff and contracted providers reported mixed experiences with the police. Most reported collaborative partnerships while others expressed concern with the level of police responsiveness at times and said their experience varied by town and officer. Law enforcement officers that we interviewed from various departments throughout the state did not report any concerns collaborating with DCF when children go missing from care.

# APPENDIX

Provided below are more detailed case summaries of the six children referred to in Finding 2, for whom DCF's placement array did not meet these children's needs. The case records identified concerns from DCF social workers or other service providers that the children's current level of care could not keep them safe, including from going missing from care. They also revealed the appropriate level of care was not available. These children ranged in age from 14 to 17 years old.

Child #1 was a teenager placed in a STAR home. In October, the STAR home identified the youth as unsafe in the placement due to increased AWOLs and sex trafficking. DCF could not remove the youth because she did not meet criteria for hospitalization or a psychiatric residential treatment facility, leading to continual victimization and involvement with the juvenile justice system. DCF placed the youth in a residential treatment center in March, but she disrupted due to her behavioral acuity. The court sent the youth to detention and DCF placed her in another STAR home in June, where the trafficking continued. DCF could not place the youth in another residential treatment center due to a months-long waitlist at one center and denial by another. The youth returned to detention in June and then transitioned to a therapeutic group home, where she remained until aging out of care.

Child #2 was a young teenager placed in a STAR home in December after a hospitalization since DCF could not place her in a psychiatric residential treatment facility due to waitlists. Instead, the hospital recommended an outpatient program, but the program declined the placement due to her acuity level. DCF referred the youth to outpatient therapy, which DCF noted as unrealistic. The psychiatric residential treatment facilities denied the youth due to the acuity level in February despite DCF's recommendation and she did not meet criteria for hospitalization. The youth remained at the STAR home where she struggled with juvenile justice system involvement. DCF brought the youth to the emergency room in February, but she discharged back to the STAR home because no hospitals had open beds. DCF found a therapeutic foster care placement in March, and the youth did well though disrupted to another therapeutic foster care home after several months.

Child #3 was a teenager placed in a STAR home in January. The STAR identified ongoing daily AWOLs, sex trafficking victimization, and substance use. The discharge plan included therapeutic foster care, but the therapeutic foster care agency could not find a home. The youth continued to AWOL and face daily victimization. In June and July, the youth ended up in multiple especially dangerous sex trafficking situations in other states, but the therapeutic foster care agency could not find a foster home. The youth went AWOL to her mother's home in August, where she began engaging in services.

Child #4 was a teenager placed in a therapeutic group home in December. The therapeutic group home reported the youth needed a higher level of care in March due to multiple AWOLs, substance use, juvenile justice involvement, and sex trafficking. Residential treatment centers denied the youth and DCF could not find a foster home. The youth continued facing victimization, disrupted the treatment progress of other residents, and the police also requested her removal due to safety concerns. The youth remained in the therapeutic group home through May when the court sent her to detention. DCF placed the youth in a STAR home upon release from detention. Carelon approved a psychiatric residential treatment facility for the youth, but providers denied the youth previously, and DCF could not find a foster home. In June, the STAR home said she needed a different level of care due to multiple AWOLs, aggression, and juvenile justice involvement, but DCF could not find an alternative placement. The youth went AWOL and DCF placed her with a relative, which lasted for six days. DCF agreed the youth needed a congregate placement after this disruption, but the residential treatment centers and therapeutic group homes denied the youth. DCF successfully placed the youth in a psychiatric residential treatment facility in October.

Child #5 was a teenager placed in a residential treatment center in October. In November, the residential treatment center told DCF the center could not keep the youth safe due to AWOLs, problematic sexual behaviors, and substance use. The residential treatment center expressed DCF was planning for weeks and months out whereas the residential treatment center felt the youth was not presently safe. DCF placed the youth in a STAR home in November, despite noting a STAR home would place the youth at further risk, since DCF had no other options. In December, DCF noted the youth's behaviors, including human trafficking concerns, increased since the STAR placement and the youth spent a few weeks in detention. In January, one residential treatment center, four therapeutic group homes, and the psychiatric residential treatment facilities denied the youth due to acuity. DCF requested the court to authorize a 30-day psychiatric hospitalization, but the court denied this request. The STAR requested the youth's removal because she was not safe and was placing the other youth and staff in danger due to potential sex trafficking victimization, aggressive behaviors, and substance use. DCF sent the youth to the emergency department, but the youth did not meet criteria for hospitalization. Probation had no female respite placements nor appropriate locked facilities. DCF could not remove the youth from the STAR because "there is no other place to put her" despite all providers agreeing she was unsafe. In April, the youth was in detention, denied by eight out-of-state placements and psychiatric residential treatment facilities, and did not meet criteria for hospitalization. In June, all residential treatment centers in Connecticut declined the youth. Probation placed the youth in a locked juvenile justice residential treatment center in November.

Child #6 was a teenager in a trial home visit after discharging from a residential treatment center in October. In November, the youth went AWOL and engaged in risky behavior including substance use. The family therapy clinician recommended an outpatient program because the therapist felt the youth needed a higher level of care. In December, the outpatient program and family therapy clinicians agreed the youth needed a higher level of care and the outpatient program's psychiatrist recommended a locked juvenile justice residential treatment center. The DCF worker agreed that the youth needed a higher level of care, but DCF cannot refer youth to juvenile justice placements and probation determined the youth was not a candidate for that placement. The youth did not meet criteria for hospitalization. In December, the youth went AWOL, engaged in risky criminal behavior, and was sexually assaulted. DCF placed the youth in a STAR home in January where she continued to engage in criminal behavior. In March, the court placed the youth in detention. In May, the court placed the youth in the juvenile justice residential treatment center recommended by the outpatient program's psychiatrist in December.

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# Unsafe Sleep Substantiations and Policy Recommendations

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7/2025

# NPCS Internal Group

**Team Members/Subject Matter Experts participating in creating the recommendations:**

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Director of the Academy, Tracy Davis

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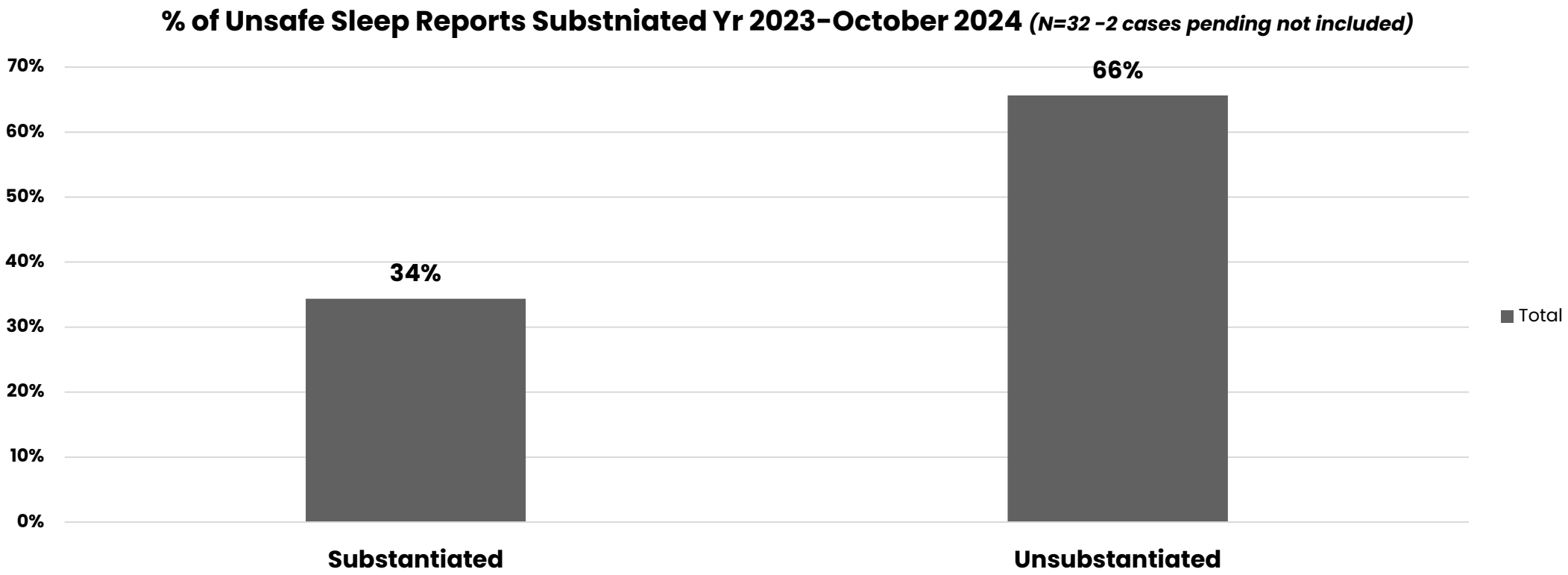
# DATA Story

- Initially identified in SQR reviews, inconsistency in substantiating unsafe sleep fatalities.
- Partnership with the NPCS also noted this trend across the nation and the Safely to First Birthday Affinity Group looked to make practice recommendations.
- Deeper dive into larger number of unsafe sleep fatalities for the year, to include cases not qualifying for an SQR, revealed disparity by race in substantiations.

# DATA Story

The Department received 34 reports of a child fatality due to unsafe sleep between January 2023 through October 2024, 66% of the reports were not substantiated for child abuse or neglect.



# NPCS Practice Recommendations

One consideration for jurisdictions is that parents' intentional or unintentional action to share a sleep surface with their child does not warrant substantiation, even if the parents have been previously educated on the ABCDs of infant safe sleep. Also - if concurrent maltreatment allegations are under investigation, such as those related to caregivers' substance use problems – engage a team-approach to thoughtfully consider if the caregiver's behavior rose to the level of maltreatment, despite the outcome. This promotes mindful child welfare practice and guards against substantiating on the basis of outcome bias.

Source: Safety to Their First Birthday Practice and Policy Brief NCPS

# Recommended Changes

## Policy change:

- NPCS Internal group invited legal partners to assist with recommendations for policy language. The recommendation is to add the following language to DCF Policy 22-3, under Notes for Physical Neglect: *"Unsafe sleep fatalities shall not form the basis for a substantiation".*
- **Communication statewide:** Communication of the data has been shared thus far with the office directors, if changes approved communication can go out statewide.
- **Training changes**: AWD will update all applicable trainings.

# Thank You

SAC 7/7/25

- **Questions?**

Have other jurisdictions experienced unintended consequence from a similar policy change?

- Will follow up, very small end # of cases
- Are those weighting in on this policy change diverse (internal/external)?
  SAC, CFRT, DCF Internal Partners

Would this potentially impact families who need parenting support having their case closed?

- no, it should not
- **Feedback?**

Group appreciated having the policy change come first to the group.

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# ACRONYMS

NCPS-National Partnership for Child Safety

AWD-Academy for Workforce Development

SQR-Special Qualitative Review