ADDENDUM TO FATALITY INVESTIGATION FINDINGS & RECOMMENDATIONS REGARDING THE DEATHS OF LIAM RIVERA/MARCELLO MEADOWS-- FOLLOW UP ON INDIVIDUAL AND SYSTEM IMPROVEMENT EFFORTS

DECEMBER 2024

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE

INTRODUCTION

The Office of the Child Advocate (OCA) is issuing this Addendum to two of our recent Fatality Investigation Findings & Recommendations Reports ("Findings Reports") regarding the 2022 death by homicide of 2-year-old Liam Rivera (child abuse) and the 2023 death by homicide of 10-month-old Marcello Polino (Fentanyl intoxication). Both children and/or their caregivers were involved with state and local agencies, including the Department of Children and Families (DCF), the Judicial Branch Court Support Services Division (JB-CSSD). In Liam's case, the Office of the Chief Public Defender (OCPD) was also involved, as it is the agency through which legal counsel was assigned to represent Liam in the child protection proceeding. OCA's investigations found assigned staff at DCF and JB-CSSD had not complied with several agency policies regarding case assessment and supervision, and that the assigned counsel for Liam did not follow statutory and contractual obligations pertaining to the legal representation of children. OCA's reports identified certain systemic issues across agencies and listed several remedial recommendations. The purpose of this Addendum is to provide additional information regarding how the state agencies addressed or are addressing individual and systemic issues referenced in the Findings Reports. The Addendum also includes a summary of a recent critical incident involving Baby John, who ingested Fentanyl, as the incident review echoes themes discussed in the Findings Reports. Finally, the Addendum identifies agency strengths and areas for attention moving ahead. All three agencies have made notable efforts to respond to concerns identified in Marcello and Liam's fatality reviews.

METHODOLOGY

For purposes of this review, OCA examined all documents generated or obtained by DCF pertaining to the professional counseling or discipline of DCF staff assigned to the cases of Liam Rivera, Marcello Meadows, and Baby John. OCA requested and obtained from the Office of Labor Relations (a unit within the state's Office of Policy and Management) records related to the discipline of the staff assigned to Liam Rivera's case. Staff assigned to the cases of Marcello Meadows and Baby John were not referred to OLR. OCA reviewed relevant state law and DCF policies and conducted interviews with OLR and DCF staff/administrators. OCA reviewed DCF data regarding safety assessment, case monitoring, and case supervision in the DCF investigation and DCF "in home" child protection cases.

OCA reviewed actions taken by JB-CSSD with regard to individual employee/s and systems issues identified in the Liam and Marcello fatality reviews.

OCA reviewed actions taken by the OCPD following the OCA's fatality report regarding Liam to improve the quality of legal representation for children in child protection proceedings.

A draft of OCA's findings and recommendations was shared with the agencies. The agencies' responses are included as appendices.

RELEVANT BRIEF CASE HISTORIES

LIAM RIVERA'S DEATH IN DECEMBER 2022

In late December 2022, two-year-old Liam Rivera died due to injuries sustained from blunt force trauma. He was found by authorities buried in a park in Stamford, Connecticut. His parents were later arrested on various charges, including Intentional Cruelty to Persons, Hindering Prosecution, and Tampering with Physical Evidence. Neither parent has yet to be charged with criminal responsibility for Liam's death. As an infant, Liam was removed from his parents' care by DCF due to child abuse and neglect and the Court granted DCF's Motion for Order for Temporary Custody. The Court later ordered both Liam and his older sibling "committed" to the guardianship of DCF. Shortly thereafter Liam was diagnosed with "Failure to Thrive" — a medical diagnosis defined as "decelerated or arrested physical growth associated with abnormal growth and development,"[1] and which may be attributed to abuse or neglect.[2] Liam's father was arrested in connection with one of the injuries Liam sustained and a protective order was issued by the criminal court. Though neither parent took responsibility for all of Liam's injuries,[3] Liam was eventually returned to his mother's care by DCF, at first by DCF without court approval while he remained under commitment, and eventually with the approval of the Court and a plan for Court-ordered supervision.

Following the return of Liam to his mother's care, while under commitment and prior to court approval, a serious incident occurred wherein Liam's parents violated the court-issued protective order pertaining to Liam, and both parents lied to police and DCF. DCF investigated the incident and substantiated Liam's father for physical neglect. Following this incident DCF considered returning Liam to foster care, but ultimately chose not to.[4] Assessment and key case decisions were not documented in the case record. DCF did not timely inform the Court or Liam's attorney of the protective order violation[5]. Agency and medical records indicate that while in foster care Liam gained weight and met developmental milestones. After returning home in December 2021 his weight began to precipitously decline, and in October 2022, eight weeks before his death, Liam's pediatrician re-diagnosed him with Failure to Thrive. Liam's pediatrician alerted DCF to Liam's weight loss and the need for follow up. Liam was never brought back to the doctor and DCF did not follow up with or obtain records from his pediatrician. Liam was killed in December 2022,

[1] https://www.chop.edu/conditions-diseases/failure-thrive
[2] https://www.hopkinsmedicine.org/health/conditions-and-diseases/failure-to-thrive
[3] Neither parent was found criminally accountable for all of Liam's injuries, though his father was arrested and charged with Risk of Injury and Assault related to one of Liam's injuries. A protective order issued with Liam the protected party.
[4] There are no DCF record entries, supervisory case notes, and no meeting notes documenting this case decision nor any documentation of a plan for how to address the concerns about the children.
[5] Upon review of this draft report, DCF noted that there is no legal requirement to inform the court of all case information outside of the statutorily mandated court reports unless DCF is seeking immediate court action.

with three months remaining on the period of Court-ordered supervision. Liam's weight at autopsy was 17 pounds, five pounds less than he weighed during his last doctor's appointment. Liam was 2.5 years old at the time of his death.

OCA's investigation found that DCF assigned staff followed some but not all agency requirements regarding case monitoring and assessment in the months prior to Liam's death. OCA found that staff regularly visited the family and made referrals for counseling and parenting support services. OCA found that staff violated several agency policies pertaining to 1) providing complete and accurate information to the Juvenile Court, including omitting from court filings that Father was substantiated for physical neglect and Mother was arrested for making a false complaint of kidnapping, and for erroneously reporting Liam's weight as being in the 50th percentile when this was not supported by his medical records, 2) obtaining and updating collateral contact information, including failure to obtain medical records pertaining to the child and failure to follow up with the pediatrician after being notified of concerns about the child's weight,[6] 3) maintaining contact with Adult Probation regarding Liam's father, 4) failing to document supervision and agency follow up to a serious incident impacting the safety of a child,[7] and 5) failure to timely document key decisions by agency staff.[8] OCA also found that JB-CSSD staff did not adhere to pre-trial and probation supervision expectations with regard to Liam's father, and the attorney for Liam assigned by the OCPD did not adhere to several applicable performance expectations.

MARCELLO MEADOWS' DEATH IN JUNE 2023

On June 28, 2023, ten-month-old Marcello Meadows died from Fentanyl and Xylazine intoxication while in the care of his mother, who has since been criminally charged in connection with Marcello's death. Marcello had an open case with DCF until three weeks before he died. OCA's investigation into circumstances preceding Marcello's death found that DCF assigned staff regularly visited with Marcello, his sibling, and their mother; that appropriate service referrals for the family were made; and that periodic internal reviews of the case were conducted. OCA also found that assigned staff did not follow several agency policies throughout the family's case, and that DCF closed its case with the family despite concerns of ongoing substance misuse by Marcello's mother. Specifically, staff did not follow DCF policies regarding 1) background-checking of caregivers and family resources;[9] 2) engagement with Marcello's father;[10] 3) case documentation and supervision;[11] 4) ensuring that conditions for case closure were met[12] and 5)

[6] DCF Policy 20-1-1. "The Social Worker shall contact each service provider, including any professional who is assisting with assessment services, at least once per month in person or by telephone. Documented written reports and emails are also acceptable forms of provider contact."
[7] DCF Policies 8-2, 22-1-2, and 22-2-2.
[8] DCF Policy 8-2.
[9] DCF Policy 20-1. DCF Policy 22-2-2 requires that the investigative social worker "review current and prior DCF involvement with the family or case participants." DCF did not identify Father's prior significant CPS history until several months into the case. DCF did not fully assess family members who were identified as part of the safety plan.
[10] DCF Policy 20-1-1.
[11] DCF Policy 2-3-2.
[12] DCF Policy 23-1. The case was closed in June 2023, despite the mother testing positive for Fentanyl in December 2022, March 2023, and April 2023.

conducting consistent "collateral contacts" to obtain information from community providers.[13] OCA found that DCF could not locate key documents in the case, including the initial Safety Plan for Marcello.

In addition, staff did not follow important practice guidance intended to ensure safety in circumstances where a child remains at home and a safety factor has been identified. DCF's practice guidance emphasizes the importance of ensuring that everyone who is part of the plan understands their role, is able and willing to carry out their responsibilities, and understands the safety concerns. In December 2022, Marcello's father was listed as a part of the team in his safety plan despite the fact that DCF had not engaged with father in the month preceding its development and had no contact in the following five months. DCF staff did not meet the expectations for monitoring and updating Marcello's safety plan.[14]

NEAR FATALITY OF BABY JOHN IN 2024

In 2024, Baby John,[15] who was under the age of 1, suffered a near-fatal ingestion of Fentanyl while in the care of his mother. DCF closed the family's child protective service case a few weeks prior to this incident. OCA has not previously published a report regarding this near fatality. Because Baby John's case raises substantially similar findings to Marcello and Liam's cases, we include a brief summary in this Addendum.

Baby John's mother did not receive prenatal care. As a newborn, Baby John was diagnosed with Neonatal Opioid Withdrawal Syndrome (NOWS) and based on a number of concerns regarding Baby John's potential safety, the hospital made a referral to DCF. The DCF case record documents concerns that the baby's parents were using illicit substances in the hospital room, including items suspected to be associated with drug consumption.

DCF conducted a swift and appropriate investigation. DCF helped facilitate admission of Baby John and his mother to a community-based women and children's treatment facility—an appropriate intervention to support John's mother and ensure Baby John's safety. John's mother initially struggled with DCF's case plan and DCF filed Neglect Petitions with the Superior Court for Juvenile Matters on John's behalf. Baby John was assigned counsel (a contract lawyer appointed by the Office of the Chief Public Defender) to represent him in the judicial proceeding. Over time, John's mother demonstrated improvement with program expectations. She was referred for intensive community-based services. However, for reasons that remain unclear, Baby John's mother was denied entry to the recommended program. Instead, she returned to the home of Baby John's father and grandmother. Baby John, meanwhile, was adjudicated neglected, and the Court ordered six months of Protective Supervision. Baby John continued to be represented by assigned counsel.

Baby John's mother was referred to a Methadone clinic and began to receive Methadone treatment, but she was never engaged with intensive clinical services in the community as recommended at the time of discharge from the women and children's treatment facility. DCF referred the family

[13] DCF Policy 20-1-1.
[14] DCF Practice Guide 21-2-PG.
[15] Baby John is a pseudonym.

to an available but non-clinical in-home service, Intensive Family Preservation,[16] to help support the child remaining safely in the home. During the pendency of DCF's case, Baby John's father was arrested for possession with intent to sell narcotics and was placed on pretrial supervision, monitored by JB-CSSD staff. He was referred for community services and his engagement was documented to be poor. There was no communication between DCF and JB-CSSD about John's father because DCF did not know Baby John's father had been arrested (DCF conducts criminal records checks at the beginning of a case), and JB-CSSD staff do not routinely screen pretrial supervision clients for DCF involvement.

In January 2024, unbeknownst to DCF, Baby John's mother stopped Methadone services. Contrary to policy, DCF staff did not maintain regular contact with the treatment provider and obtained no records pertaining to this service. The provider did not inform DCF that services had been discontinued. In early December 2023, in response to a request for information regarding compliance with treatment, DCF was informed by the provider that they did not have a release on file. While DCF records note that the social worker faxed a release to the provider, there is no record of any follow up to obtain information after that date. Reports to DCF from the mother's in-home family preservation provider were positive and identified no safety concerns. There were no treatment plan meetings that involved DCF and the in-home provider or Methadone clinic. Two months later, in March 2024, despite having no information directly from mother's Methadone treatment provider since before December 2023, DCF reported to the Juvenile Court that Baby John's mother was compliant with services, including her treatment program, and recommended that Protective Supervision end. Based on the information provided, the Juvenile Court allowed Protective Supervision to end. DCF closed its case shortly thereafter. A few weeks later, Baby John ingested Fentanyl while in the care of his mother. Baby John's life was saved due to the administration of Naloxone by a first responder.

DCF could not provide hard copy records pertaining to Baby John's case, including signed releases of information, copies of notifications to parents that are required by statute, reports from providers, or submissions to the Court.

OCA found that Baby John's case, opened shortly before Marcello's death in 2023, was handled by some of the same DCF supervisory staff, in the same local DCF office as Marcello's case. Like Marcello's case, DCF stated that there had been no counseling or discipline of assigned staff related to this case.

With regard to John's assigned attorney, billing records reviewed by OCA indicate that the lawyer met with Baby John one time while mother was still in the women and children's treatment facility, but never visited Baby John in his home, or on any other occasion, and never requested records from DCF or any service provider. Echoing OCA's findings regarding Liam Rivera's lawyer, Baby John's lawyer did not comply with legal and contractual responsibilities for the representation of children in child protection proceedings and instead relied solely on DCF's erroneous representations that Mother was compliant with treatment. Despite or perhaps due to the lack of

[16] Intensive Family Preservation is a short-term, in-home service designed to intervene quickly to reduce immediate safety concerns, the risk of future abuse and/or neglect, and the need for out-of-home placement. It is not substance abuse treatment.

first-hand knowledge of Baby John's circumstances, the lawyer raised no objection to DCF's recommendation to end the Court's supervision of the case.

SYSTEMS ISSUES, ACTIONS TAKEN, AND OPPORTUNITIES FOR IMPROVEMENT

DCF

Correcting Lack of Adherence to Policy by Individual Staff

DCF Policy and Practice Guides require the gathering of collateral contact information, engagement with case participants, and appropriate documentation to ensure that when decisions are made, they are based on objective, accurate, and current information. In Liam, Marcello, and Baby John's cases, DCF made critical decisions based on the information that they had available at the time. However, in all 3 cases, because agency policies were not followed, critical decisions were made based upon incomplete and/or inaccurate information about critically important aspects of the case. OCA sought to understand DCF's response to the lack of adherence to policy in these matters.

In April 2023, during OCA's fatality investigation, OCA alerted the Office of the Attorney General and the DCF Legal Director to concerns OCA developed regarding inaccurate and incomplete information provided by DCF to the Juvenile Court at the time DCF sought Court approval for Liam's reunification. Errors and omissions included (but are not limited to): telling the Court that Liam was in the 50th percentile for height and weight, when in fact medical records indicated he had been losing weight since leaving foster care; inaccurately listing the injuries that led to Liam's placement in foster care; and failing to inform the Court that Liam's mother had recently been arrested for making a false statement to police with regard to the parents' violation of the criminal court issued protective order.

Following this alert, DCF administration referred the case to the Office of Labor Relations (OLR) at the Office of Policy and Management (OPM), which as of 2019, had been designated as a central hub to conduct certain human resource functions for executive branch agencies.[17]

[17] In July of 2019, the state took steps to centralize human resource functions for most executive branch agencies, including DCF. The purpose of this centralization, was "to reduce bureaucracy and implement efficiencies with the goal of improving the ability of residents to interact with the state, all while saving taxpayer dollars." Under this design, the Department of Administrative Services (DAS) became the hub for state employee recruitment, hiring, and resources within the included agencies, with the Office of Policy and Management (OPM) responsible for functions related to labor relations. The Office of Labor Relations (OLR) is housed within OPM. OCA could not locate any applicable agency policies or regulations to govern the role of OLR in its human resource investigation activities respective to the different executive branch agencies. In response to OCA's inquiry, OPM/OLR provided a copy of Executive Order # 2, issued in 2019, which among other things, caused labor relation activities to be further consolidated within OPM https://portal.ct.gov/-/media/office-of-the-governor/executive-orders/lamont-executive-orders/executive-order-no-2.pdf. The appropriations that were adopted in the 2021 session budget reflect the

Prior to OCA's release of its October 2023 fatality investigation report regarding Liam's death, DCF told OCA that OLR had concluded its investigation into the practice in Liam's case and found "no just case for [staff] discipline." No discipline of assigned staff ensued. To understand the basis for the "no just cause" finding, OCA requested all documents pertaining to the OLR/DCF investigation. OCA's review found:

- In its labor relations referral, DCF did not define the scope of the labor relations investigation and did not identify for OLR any applicable agency rules, policies, or directives that may have been violated.
- The final labor relations report does not refer to any specific guidelines for conducting DCF-related labor relations investigations.
- Though the labor relations report finalized by OLR, and reviewed by DCF prior to finalization,[18] details several concerning practices and events in Liam's case, the report does not include any analysis supporting the recommendation of "no just cause" for discipline.
- The final labor relations report does not list any applicable state agency rules, regulations, policies or directives, stating only "non-applicable" in this section of the form.

To understand the OLR investigation process, OCA conducted interviews with OLR/OPM staff and DCF. OLR/OPM staff and counsel reported that OLR staff do not make final determinations as to staff discipline. Rather, OLR described its role as "providing a service" for the requesting agency, and stated that the agency (here DCF), dictates the reason and course and final outcome of the review. OLR/OPM staff and counsel stated that most of its work pertains to defined employee misconduct, including failure to follow an agency directive.[19] OLR/OPM staff reported that they had never previously been asked to examine DCF practice in the context of a child fatality or near-fatality. They described the matter as challenging and highly unusual. OLR/OPM staff and counsel stated that they are not in a position to summarize DCF's concerns, nor are they in a position to know the range of applicable laws and policies governing DCF employee conduct in the context of a child protection case. They stated that they had to rely on DCF for that information and analysis. Both OLR and DCF staff reported to OCA that DCF had assigned a Subject Matter Expert (SME) to the Labor Relations investigation. However, OLR/OPM staff reported that while the SME was present during aspects of the labor relations investigation, the SME did not provide questions or issues to the investigators and did not provide information regarding any applicable DCF rules or regulations. The SME acknowledged the same to OCA. The SME was in the direct chain of command of the person being investigated. Finally, OLR counsel emphasized that the decision as to whether to discipline an agency employee rests with the agency head and not the

operational change and page 81-82 of the OFA budget book describes it: *See* 2021BB-20210927_FY 22 and FY 23 Connecticut Budget.pdf.

[18] Email from DCF to OCA, dated 8/8/23.

[19] Staff provided the hypothetical example of a state agency facility-based employee who documents that he or she did "rounds" on a patient or charge, but where video evidence contradicts that claim.

labor relations office, and the agency has specific knowledge as to whether the described conduct violates agency rules.

OLR acknowledged the need for greater clarity in the division of labor investigation responsibility between DCF and OLR. Counsel stated that work in this regard was underway and that OLR and DCF counsel were in communication regarding improvements to the labor relations framework pertaining to DCF employees. DCF confirmed to OCA that the agencies are making improvements to the OLR/DCF labor investigation framework to ensure a more streamlined, structured, and clear process moving forward. Proposed changes have been shared with OCA and it is this agency's understanding that new policy is close to final at this time.

To proceed with formal discipline, ranging from a formal reprimand to termination, there must be a finding of just cause. If there is not just case for formal discipline, however, the agency is not without recourse to correct staff's lack of adherence to policy. DCF has the authority to provide counseling and other supportive/corrective measures for agency staff, and DCF has extensive policies on staff counseling and professional development.[20] In response to OCA's inquiry, DCF informed OCA that in addition to there being no discipline of assigned staff, there was no record of staff counseling or targeted professional development having taken place following Liam's death and DCF's internal review of the matter. OCA requested copies of all professional supervision forms pertaining to staff assigned in Liam's case as agency policy requires documentation of professional supervision to identify performance concerns or assets and ensure ongoing staff support and accountability. OCA was again informed that no relevant documents existed. DCF acknowledged to OCA that agency policies regarding documentation of staff supervision have not consistently been followed in recent years, but the agency is reinforcing the expectations with agency personnel and is committed to implementation of these policies going forward.

As in Liam's case, OCA requested all labor relations documents, staff supervision forms, and documentation of pre-disciplinary counseling or targeted corrective action with any staff assigned to Marcello's case. DCF stated that it did not request a labor relations review, and no other responsive documents existed. OCA requested the same information related to Baby John's case and found no indication of counseling or corrective action related to gathering information from collateral contacts.

DCF is charged with making safety decisions that are complex and challenging, and, at times, lifesaving. As stated above, in all three cases, because policies were not followed, critical decisions were made with incomplete or inaccurate information. In all three circumstances, DCF was unable to produce any documentation or disclose any counseling to address the lack of adherence to agency policies or practice of the respective assigned staff. The lack of individual accountability in the face of significant lapses in adherence to agency policies and practices raises concerns regarding how such lapses are remedied, how lessons can be learned, how progressive discipline can be implemented, and the culture of accountability to the agency's expectations.

System Level Quality Assurance

[20] DCF Practice Guide 2-3-PG.

DCF systems data has confirmed that certain practice issues seen in Liam, Marcello, and Baby John's cases, require systemic improvement. DCF administrators and OCA have been meeting regularly to discuss the agency's strategies for ensuring consistent "safety practice," particularly in cases involving very young children, and enhancing quality improvement efforts. DCF has undertaken several steps in recent months to strategically focus on safety for very young children. This section outlines practice areas that need improvement and DCF's efforts to improve performance moving forward.

DCF's quality improvement staff have identified certain staff practices as relative strengths, including:

1. Information collected and documented in case investigations.
2. Services delivered to the family to protect children in the home and prevent removal.
3. Timeliness of [investigation] commencement.
4. Creating initial safety plans.

DCF quality improvement data shows concerns in other practice areas, with several key areas in ongoing services cases rated as not meeting expectations, per the In-Home Case Review conducted in November 2023 through April 2024:

1. **Case Supervision.** Reviewers identified concerns with incorporating provider input into the case record, tracking progress on case directives, and documenting supervision of the Safety Plan.
2. **Safety Assessment.** For the cases in which a Safety Plan was in place, reviewers found that visitation was not conducted per practice guide in 35% of the cases.
3. **Quantity of Visitation.** For the cases reviewed that were recently transferred from investigations, 44% met the expectation that the social worker visit once per week for the first 30 days.
4. **Quality of Visitation.** In 43% of the cases, documentation of face-to-face visits with the children did not demonstrate that a quality assessment was developed specific to addressing the reason for involvement.
5. **Provision of Services.** Reviewers found that while DCF case plans typically identified appropriate services needed by the family (90%), only 49% of cases included documentation that the identified service was actually delivered to the family during the review period.
6. **Contact with Providers**. Fewer than a third (28%) of cases included quality documentation of monthly contact with the parents' providers to review their progress with treatment goals.

DCF has indicated an intent to re-evaluate their current tool in an effort to focus on specific aspects of the work to identify and address areas needing improvement. DCF case reviews using a federal review tool have likewise demonstrated challenges in similar practice areas.

DCF administrators have expressed significant and understandable concern about recruitment and retention of qualified child welfare workers, and the impact of workforce turnover on agency performance. Acknowledging the nationwide workforce challenges for human service agencies

like DCF, OCA supports the provision of ongoing effective training and supervision to help staff retention and performance. It is worth examining how the widespread telework practice affects staff turnover, given the complex challenges of child protection work and the importance of supervisory relationships for staff retention. OCA also believes that enhanced public reporting by DCF regarding its performance on key child welfare measures may rebalance external focus on the agency's overall performance on behalf of children and families.

OCA credits DCF's reported efforts to strengthen its qualitative and performance management framework, work that was slowed by the prolonged COVID-19 pandemic and the substantial impact of that health crisis on the agency. DCF recently contracted with outside consultants (Chapin Hall from the University of Chicago) to evaluate the agency's quality improvement framework, and DCF has committed to regular production of case review reports to identify areas of practice that need improvement. The agency also recently completed a safety practice audit of cases involving children birth to five. Work with Chapin Hall has been extended for an additional year to support DCF's quality improvement activities.

Discussions with DCF have highlighted specific aspects of the agency's internal quality improvement efforts, including program supervisors dedicated to quality assurance that are embedded in each DCF region and who regularly interact with supervisors and office leaders to address staff development needs. DCF leadership reported to OCA it is maintaining a strategic focus on safety and the most vulnerable children to poor outcomes -- children under the age of five. DCF recently created a new position, the Director of Child Safety Practice and Performance, to bring heightened attention to safety practice across the agency. DCF continues to conduct real time critical incident reviews and more in-depth Special Qualitative Reviews of certain child fatalities and near-fatalities.

The Department reported that it established the Quality Improvement Leadership Team (QuILT) as a governing body to review data and determine recommendations and further strategy development for statewide implementation. This team is responsible for determining how best to improve performance and key outcomes. Per DCF report, the inaugural meeting of the QuILT was held in October 2023 and the team meets monthly to review data and reports and determine CQI strategies across the agency. DCF reported that the In-Home case review results will be reviewed and discussed at these meetings, with a focus on actionable strategies to improve the practice and review of the implementation and efficacy of those strategies. Internal reports regarding cases with safety plans will be auto-generated and available to staff and supervisors in real time, allowing supervisors quick access to cases with "safety factors" that need heightened attention. DCF administration reported to OCA that it will be reinforcing expectations that all ongoing services supervisors must monitor and maintain oversight over cases where a safety factor has been identified. DCF is developing a new safety practice supervisory tool that will be used during case supervision sessions to emphasize review of child safety, quality visitation, and needed action steps. Relevant trainings with the DCF training academy will reportedly be mandatory for all social work supervisors and program supervisors in the child welfare bureau.

DCF has outlined a comprehensive plan to assess practice across a majority of its case work. The data generated by the quality improvement tools should demonstrate the degree of staff adherence to agency expectations. The lack of individual counseling, pre-disciplinary, or disciplinary

response in Liam, Marcello, and Baby John's cases, raised substantial concern about the effectiveness of real time critical incident review and timely intervention with assigned staff. It will be imperative that information gleaned from DCF's real time QI reports guide not only general workforce support, but also plans for professional development and accountability at the individual staff level. Recent memos from DCF administration to staff have acknowledged this need and reinforced the expectation for direct supervision and case monitoring by agency supervisors. DCF does have comprehensive supervision policies and protocols. It will need to develop a quality assurance plan to ensure effective adherence to these expectations.

OLR and DCF have also committed to a specific and improved process for conducting labor relations referrals and identifying specific agency policies and employee performance areas that need review and attention.

With regard to public transparency regarding agency performance, DCF and OCA worked cooperatively on the development of new legislation (Public Act 24-126) that will build on DCF's efforts to share public information about children's safety, permanency, and wellbeing. The legislation also strengthens the role of the DCF Statewide Advisory Committee, adding several new appointments, and aligning responsibilities of that body with federal law expectations for review of DCF's performance. DCF is currently working on a child welfare "Scorecard," which should bring together key indicators regarding its performance on behalf of children and families.

DCF and OCA (alongside the Department of Mental Health and Addiction Services) have recently launched a Working Group which includes community providers and individuals with lived expertise and that is focused on improving outcomes for caregivers with substance use disorders and young children. The working group is dedicated to eliminating ingestion injuries in young children impacted by the opioid crisis.

Outlined in more detail below, DCF and JB-CSSD administrators have been collaborating to discuss critical cases, shared training opportunities for agency staff, and means to systematize more fluid and effective communication between the agencies regarding shared cases. DCF reports that this includes monthly meetings to address any legislative and/or system barriers to interbranch communication and service delivery.

OCA remains in regular discussion with DCF regarding critical aspects of its safety practice and quality improvement framework, including implementation of the new legislative requirements for external evaluation, transparency, and accountability. OCA supports DCF's goal of maintaining children safely with families wherever possible. It will be important for stakeholders, including DCF, OCA, and the DCF Statewide Advisory Council to develop consensus regarding relevant agency performance indicators and implications from quality improvement data. DCF reports that this process is under way and some data has been shared with the SAC.

DCF has joined more than 35 states and jurisdictions in the National Partnership for Child Safety (NPCS),[21] a quality improvement collaborative to focus on applying safety science to child welfare to improve safety decisions and prevent child maltreatment fatalities. Safety science focuses on

[21] https://nationalpartnershipchildsafety.org/

the factors that influence critical decision making and identifies system improvements that will have a global impact on practice. DCF staff are challenged to make safety critical decisions daily and by assessing and addressing the systems that influence those decisions, rather than the individuals making the decisions, the psychological safety of the workforce is increased, leading to more open discussion and thoughtful analysis. OCA supports this work and the need for ongoing systemic level assessments of the Department's work. However, safety decisions cannot be sound if they are not based on complete and accurate information and adherence to policies related to information gathering must be followed. Where they are not, OCA urges the Department to engage in remedial actions, such as supervision, counseling, and where appropriate progressive discipline. In this way, application of safety science would complement, not replace, the need for individual accountability when policy and practice expectations are not met.

JB-CSSD

OCA's reviews of the deaths of Liam Rivera and Marcello Meadows documented multiple areas where JB-CSSD assigned staff did not adhere to agency policies or expectations for adult pretrial or probation supervision.

As outlined above, Liam's father was arrested on at least one charge related to a suspected inflicted injury to Liam prior to his placement in DCF foster care. Liam's father was ultimately placed on probation. A protective order was put in place with Liam as the protected party. Information now indicates that Liam's father was either living with the family or spending time in the family home prior to Liam's death, unbeknownst to both DCF and JB-CSSD staff. With the assistance of JB-CSSD's internal review, OCA reported the following:

1. After Liam's father's arrest on charges of assault and risk of injury to a child, pretrial staff did not enter the father's conditions of release into the JB-CSSD case management system, and therefore conditions of release were not supervised for a period of several months.
2. Probation staff did not conduct appropriate family violence assessment on Liam's father.
3. Pretrial and probation staff did not follow agency policies for maintaining regular contact with DCF.
4. Staff did not timely verify Liam's father's address in a timely manner.
5. In May 2022, shortly after his placement on probation supervision, Liam's father absconded from supervision and remained whereabouts unknown to the agency. Probation staff did not consistently follow applicable agency requirements.

In Marcello's case, OCA found that JB-CSSD had been involved with Marcello's mother for several years due to multiple arrests for larceny. Agency notes also document persistent concerns about substance misuse, including Fentanyl. Staff did not consistently follow policies pertaining to case documentation, home visits for high-risk cases, or activities to serve Ms. Polino with the outstanding warrants. JB-CSSD had no contact with Ms. Polino and Marcello during DCF's case with the family as Ms. Polino was no longer on active probation supervision due to her "violation" status.

Following both children's deaths, JB-CSSD conducted internal reviews of the agency's involvement with the adult family members, the results of which were shared with OCA during the development of our reports. JB-CSSD reported corrective discussions with assigned staff. Regarding Liam's father, JB-CSSD prepared a written report along with a summary of several action steps undertaken by the Branch to address policy and system concerns identified in its review, including ensuring completion of domestic violence related screens in non-intimate partner family violence cases. JB-CSSD reported that it conducted an audit of all active court-imposed conditions of release to confirm that pretrial services staff are conducting supervision of such conditions, including timely communication with collateral contacts providing direct or indirect supervision of such conditions and submission of current and accurate progress reports to the court. JB-CSSD revised pretrial supervision policies to specify that cases will be supervised in accordance with any non-court session conditions of release prior to arraignment or in accordance with the conditions of release after arraignment.

Regarding its involvement with Marcello's mother, JB-CSSD documented it undertook corrective discussions with all staff involved in the case and undertook remedial actions to improve performance and future casework expectations. JB-CSSD administrators reported to OCA that they conducted statewide reviews of unserved violation of probation (VOP) warrant cases and addressed cases when expectations were not met. JB-CSSD recently reported to OCA that adult probation management and supervisory staff have continued to work on violation of probation warrant policy modifications and quality assurance measures to enhance warrant service efforts.

JB-CSSD has created a centralized policy audit unit in its administrative subdivision to audit policy across all JB-CSSD's subdivisions. The unit recently completed its first audit, a statewide review of adult probation's warrant service policy. The audit, the findings of which were provided to OCA, found areas of the policy where there was almost universal compliance and areas where compliance challenges were identified. Specifically, the audit found substantial compliance with policies regarding warrant service and arrest process, but low levels of compliance for unserved active warrants across the state. Compliance with policy expectations varied widely by office. JB-CSSD stated that audit results dictate the need for additional training, supervision, and practice standardization. The agency will enhance automation of the data collection process to ensure uniformity of data format and timeliness.

Pertaining to unserved Violation of Probation (VOP) warrants, adult probation administrative staff are reviewing every unserved felony VOP warrant for compliance with policy. Agency preliminary findings mirrored those found in the centralized warrant service policy audit.

JB-CSSD and OCA have had ongoing discussions regarding the need to strengthen probation household assessments, ensuring that persons under probation supervision are screened for DCF involvement so that supervising staff can identify risks and needs of the adult supervisee in his or her role as caretaker of a child, and to ensure that communication is maintained with DCF as a key collateral agency contact. As stated above, JB-CSSD and DCF leadership have been regularly meeting to discuss ways to increase and automate communication between the agencies on shared clients.

Regarding its handling of information about adult supervisees with children who present with signs of substance misuse, JB-CSSD has enhanced its policies regarding mandatory reports to DCF of adult substance misuse, particularly Fentanyl, when the adult supervisee is in a caregiving role. Additional training to probation staff is being provided.

JB-CSSD has also recently convened an internal working group to review probation staff training and support needs regarding assessment of adults with caregiving responsibilities, how to engage them with appropriate community support, and how to identify cases in which the reasons for JB-CSSD supervision (e.g., serious mental illness, substance use disorder) may implicate child safety. JB-CSSD reported that the work group, entitled the OCA Fatality Reports Committee, is comprised of probation officers, field supervisors, and administrative regional managers and is chaired by the Director of Adult Probation. Several of the participating probation officers are former DCF social workers. The committee is tasked with considering issues that may impact probationers with small children and making recommendations to the director. The committee so far has recommended additional trainings for probation officers. Four such trainings have been identified, which are led by DCF training staff, and have already been piloted with new probation officers:

- DCF 101
- DCF Child Safety Practice Model
- Worker Safety and Wellbeing
- Poverty is not neglect.

The committee is scheduled to meet again in the fall.

In addition to the committee work, JB-CSSD reported that its training academy is collaborating with the DCF training academy to add additional elements to the probation officer home visit training specific to signs that probation officers should look for related to children in the home (JB-CSSD will be able to use DCF simulated homes for the training). Further, DCF has indicated that they have created a new training that it intends to add to the adult probation mandatory training curriculum.

Lastly, the JB-CSSD executive director and the director of adult probation are conducting visits to the probation field offices to meet with staff and discussing recent OCA fatality and critical incident reviews, creating the expectation that more attention must be paid when a person on probation is a participant in a child's life.

OCPD –Assigned Counsel for Children

Multiple child fatality and critical incident reports issued by OCA have found that assigned attorneys for children, appointed by the OCPD, have not adhered to legal and contractual requirements for the representation of the child. Specifically, in multiple reviews OCA has found that the lawyer for the child did not visit the child frequently or in accordance with promulgated performance guidelines and contractual requirements, did not request any DCF records pertaining to the child, and/or did not attend case meetings about the child.

The role of the child's lawyer is an essential safeguard in the child welfare system and competent representation is a requirement of federal law, which mandates that states ensure children in child protection proceedings are represented by an individual who obtains a "first-hand, clear understanding of the situation and needs of the child."[22]

As one author writes:

> The [Federal law] requirement reflects the view that children have interests that may differ from the interests of their parents and the state. The idea is that even though the state has brought the action to protect the child, the voice and needs of the child may get lost in the fray of the arguments and allegations between [the parties] … the child needs an advocate should the state fail to deliver on necessary services and actions due to fiscal constraints and organizational failures.[23]

State law codifies the federal provision by requiring the appointment of "counsel knowledgeable about representing such children," and who shall be "granted immediate access to (i) records relating to the child, including, but not limited to, Department of Social Services records and medical, mental health and substance abuse treatment, law enforcement and educational records without the necessity of securing further releases, and (ii) the child, for the purpose of consulting with the child privately."[24] The OCPD Performance Guidelines for Counsel for Children, referenced in the state contracts for assigned counsel, provide that lawyers will obtain records, consult with service providers, and assess whether the child is receiving the supports and services they need.

OCA acknowledges the distinction between a state agency's oversight of employees and the OCPD's more limited role in managing contracts with independent private attorneys representing children. OCA continues to recommend enhanced resources for contract attorneys and enhanced professional development and oversight for this system. OCPD, within its available resources, has provided administrative oversight for the contract lawyers assigned to represent children and parents. OCPD contracts with and provides pre-service and in-service training for new and more experienced lawyers on a range of topics. OCPD responds to individual concerns raised about the quality of legal representation. Notwithstanding these efforts, resources to support a robust system of legal representation for children and indigent parents have been historically inadequate, leaving the ranks of assigned counsel thin and caseloads too high. OCPD reports that recent years have seen a rapid rate of attrition by lawyers for children and parents. OCPD has successfully advocated for new resources to increase compensation for assigned counsel.

Following the issuance of OCA's report regarding the death of Liam Rivera, OCPD and OCA worked cooperatively, with input from the state Judicial Branch, to develop a legislative working group that will evaluate the state's system for ensuring quality legal representation for children in child protection proceedings. OCA and OCPD will be members of this working group. OCPD is currently working with the Office of Policy and Management to receive funding to hire twenty permanent social workers to support current Child Protection assigned counsel. OCPD reported to OCA that the social workers will conduct a portion of expected visits with children, collect and

[22] Child Abuse Prevention and Treatment Act, 42 U.S.C. 5106a(b)(2)(B)(xiii).
[23] Pitchal, 2006; Taylor, 2009.
[24] Connecticut General Statute Section 46b-129a.

interpret records, review reports and other relevant materials pertaining to the child, all in furtherance of ensuring effective representation of child clients. Social workers will support the assigned lawyer on the case, but will be hired, trained, and supervised by OCPD.

OCPD updated child protection guidelines and contracts to require Assigned Counsel and Guardians ad Litem to maintain a minimum number of visits with child clients per fiscal year. GALs and assigned counsel for children will be required to attend mandatory training specific to the ethical and practical issues around the representation of children.

Finally, OCPD reported to OCA that it will continue to advocate for resources to attract and retain attorneys for children and parents. As noted above, there has been a significant decrease in the number of contract attorneys, resulting in fewer lawyers to represent a large number of parents and children in child protection cases. A recent compensation increase has helped retain and attract lawyers, but OCPD reports that issues from chronic underpayment persist, and OCPD will continue to seek additional resources to support this work.

RECOMMENDATIONS

DCF

1. OCA recommends swift implementation of the provision of Public Act 24-126. The Act requires the DCF Statewide Advisory Committee (SAC) to review DCF data pertaining to child safety, well-being, and permanency not less than twice per year and conduct an annual evaluation. OCA recommends that DCF provide to the SAC a current and comprehensive review of all existing data sources that inform DCF about child safety, well-being, and permanency, including qualitative review data gathered for quality improvement purposes.
2. Public Act 24-126 also requires that DCF include sources for all information provided to the Juvenile Court in documents filed in child protection proceedings. OCA recommends that DCF develop a quality improvement framework for this requirement.
3. DCF should modify policies to require criminal checks on caregivers throughout the life of an ongoing services case. While there are some limitations on background checking via the FBI COLECT System, pending criminal cases and convictions in Connecticut are publicly available on the Connecticut Judicial Branch website.
4. DCF must ensure that individual staff accountability (which may or may not include formal discipline), is consistent and present throughout the workforce. The safety critical work of the Department, coupled with significant employee turnover, with a primarily teleworking workforce, requires a strong agency wide framework for systemic quality assurance and appropriate measures and interventions to ensure employee performance is consistent with the expectations of agency policy. OCA recognizes the challenges of the work and workforce, which only strengthens the need to ensure that lessons are learned, inconsistencies are addressed, and staff are developed effectively. DCF must develop a quality assurance plan to support adherence to agency expectations for individual supervision and professional development.

5. DCF should continue to develop systemic quality improvement tools to monitor the degree of staff adherence to agency expectations and guide general workforce support, supervision strategies, and training. DCF should consider how systemic quality improvement tools may also be utilized for identifying the need for individual professional development and accountability.
6. OCA recommends that DCF and OLR closely monitor effective use of the labor relations structure and the impact of planned improvements. OCA recommends that any SME assigned by DCF to an OLR labor investigation not be a person in the direct chain of command of the person being investigated to ensure objectivity.

JB-CSSD

1. JB-CSSD should establish practices for when an individual enters the JB-CSSD system through any pathway to ensure that an assessment of their role within a household or as a caregiver is completed upon intake, with consideration of how their mental health or substance misuse may impact household members and children. Such practices should include consideration of whether a report to DCF is appropriate based upon such assessment. JB-CSSD should, when appropriate, also make a referral for community-based family support services.
2. JB-CSSD should expand the agency's referral network to include certain state funded/Medicaid funded contracted programs for adults with children, including fatherhood programs, home visiting, DMHAS REACH navigators, as well as services designed for parents (and their children) who are struggling with substance misuse (e.g., DMHAS PROUD program).
3. JB-CSSD should continue to develop cross agency training opportunities that not only have JB-CSSD staff learning from others, but which allow other agencies (DCF, DMHAS) to have a clear understanding on how they can work with their clients to resolve judicial/probation matters. For instance, how are state agencies collaborating when a shared client has an outstanding warrant or an order of protection?

OCPD

1. OCPD should develop a strong activity framework and training curriculum for the 20 social workers that OCPD will hire, ensuring that roles are clearly defined, and provide relevant training to assigned counsel on how to utilize this new resource.
2. OCPD should consider an enhanced quality assurance framework specific to the OCPD Performance Guidelines and contractual requirements for the representation of children.
3. OCPD should be provided with increased resources to ensure competitive compensation for assigned counsel and strengthen ability to recruit and retain qualified staff.

Appendix 1: DCF Response

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

Commissioner
Jodi Hill-Lilly, MSW

Ned Lamont
Governor

December 2024

DCF RESPONSE TO THE OCA ADDENDUM RE:
LIAM R./MARCELLO M. FATALITY INVESTIGATIONS

We continue to keep in our thoughts the families of Liam and Marcello along with their friends, neighbors, community members, service providers, attorneys and the Department staff who mourn their tragic and untimely deaths.

In the aftermath of these fatalities - consistent with our standard practice - DCF initiated its Continuous Quality Improvement (CQI) process to evaluate our work and identify opportunities for system enhancements. Attached are the prior statements issued in response to Liam and Marcello's OCA case reviews that outline the improvements we made at the time.

As recognized in this OCA Addendum, we have continued to make several additional enhancements to our work, which include but are not limited to:

1. Hold regular meetings with the DCF Commissioner and Executive Team members and the OCA to discuss the DCF's safety practice and quality improvement efforts.

2. Maintain a strategic focus on safety for the most vulnerable children - those 0-5 years of age - in our communities.

3. Completed a safety practice audit of all cases involving children 0-5 years of age remaining at home.

4. Created the Director of Child Safety Practice and Performance position.

5. Hired an outside consultant to evaluate and provide recommendations to the Agency's Quality Assurance Framework.

6. Established the Quality Improvement Leadership Team (QuILT) as a governing body to review data and provide statewide recommendations.

7. Continue to conduct real time critical incident reviews and more in-depth Special Qualitative Reviews of certain child fatalities and near-fatalities.

8. Engaged in ongoing communication with OPM/OLR to improve the process and clarify roles and responsibilities pertaining to labor relations referrals, including OPM/OLR's role in investigating and determining whether there is just cause for discipline and DCF's role in deciding the level of discipline, if any, following the OPM/OLR investigation.

9. Improved the supervisory process to reflect enhancements made to DCF's safety practice model resulting in proper oversight of employee case practice related issues to promote high quality performance, including, but not limited to, additional supervisory training and support for case consultation and safety-related supervisory response following critical incidents.

10. Supported legislation that enhances the role of DCF Statewide Advisory Committee and clarifies what can be shared publicly regarding DCF's involvement with a family.

11. Launched a Working Group with OCA and alongside DMHAS focused on improving outcomes for caregivers with substance use disorders and young children and eliminating ingestion injuries.

12. Regularly collaborate with JB-CSSD to discuss critical cases, shared training opportunities, emerging themes and improving overall communication.

We also stress that our child protection safety practice is always evolving and adjusting due to the rapid changes happening within our society that impact the lives of children and families.

DCF remains committed to transparency in how we discuss the Department's involvement with families and appreciate the OCA's role in facilitating system responses across all agencies, communities and partners involved in ensuring the safety and well-being of Connecticut's children and families.

Appendix 2: OPM/OLR Response to Addendum

Thank you for giving the Office of Policy and Management (OPM) the opportunity to comment upon the September 18, 2024, draft Addendum to the Fatality Investigation. As noted in the Addendum, the Office of Labor Relations (OLR, i.e., a Division of OPM) recommended to the Department of Children and Families (DCF) an investigation referral form and procedure changes for labor relations investigations involving potential violations of the applicable standards of care by DCF staff. The sole purpose of the investigation referral form and procedure is to ensure that DCF and its assigned Subject Matter Expert (SME) clearly delineate the scope of the investigation and all DCF policies and procedures, which may be pertinent to the investigation as OLR staff are not SMEs or trained licensed MSWs. The focused investigation referral form will provide OLR staff and DCF's SME with the parameters of the investigation, so that OPM can advise DCF as to whether there may be just cause for discipline. The investigation referral form does not, however, alter, amend, or waive the statutory powers of DCF, as the appointing authority, to make the final determination of any disciplinary action as required by the State Personnel Act. (See, Connecticut General Statutes § 5-193, et seq.) The investigation referral form and procedure have been enacted by OLR and DCF and are currently in use.

As a final clarification, OPM and OLR note that DCF only referred the Liam R. incident to OLR for investigation. DCF did not refer the Marcello M. incident to OLR for investigation.

Appendix 3: OCPD Response to Addendum

State of Connecticut
DIVISION OF PUBLIC DEFENDER SERVICES

Office of Chief Public Defender
55 Farmington Avenue, 8th Floor
Hartford, Connecticut 06105
(860) 509-6405 Telephone
(860) 509-6495 Fax

Renee Cimino
Director of Delinquency Defense
& Child Protection
renee.cimino@pds.ct.gov

December 13, 2024

Office of the Child Advocate
18-20 Trinity Street
Hartford, CT 06105

Re: Office of the Child Advocate's Fatality Investigation Findings and Recommendations (December 2024)

Dear Attorney Ghio,

In response to the concerns raised by OCA, OCPD will develop, with the approval of OPM, an emergency action plan to hire 20 permanent social workers to support current Child Protection Assigned Counsel. These qualified professional social workers will conduct half of the required visits, collect, and interpret records, reports and discovery materials as needed and on an ongoing basis in the effective representation of child clients. The social workers will answer directly to the Assigned Counsel on these cases, but be hired, trained, and supervised by OCPD as Division employees.

OCPD is also updating child protection guidelines and contracts to require Assigned Counsel guardians ad litem (GALs) to maintain a minimum number of visits with child clients per fiscal year. All new GALs/AMC will also be required to attend mandatory training specific to the ethical and practical issues around the representation of children, including AMC/GAL distinctions, duty to visit and directed representation.

OCPD continues to advocate for increases in hourly pay rates to attract attorneys to take these cases and retain the current panel. Child protection is a difficult practice area and due to low rates and attorneys leaving the practice area, OCPD has lost significant numbers of experienced child protection attorneys from our panel. The remaining attorneys are covering more courts and clients, making their practices far more challenging. Since September 2022, OCPD has worked with the Governor's Office of Policy and Management and the state legislative Appropriations Committee to adequately fund increased rates / fair compensation for all assigned counsel, with some limited success. A small increase last year has reduced the number of attorneys leaving and attracted some new ones, but the issues from underpayment persist. OCPD will continue to pursue requests for adequate payment in Fiscal Year 2025.

Very truly yours,

Attorney Renee Cimino

Appendix 4: DCF Response to Liam R. Report

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Vannessa L. Dorantes
Commissioner

Ned Lamont
Governor

September 27, 2023

DCF statement in response to child fatality in December 2022

In the aftermath of the tragic death of a two-year-old child whose family the Department was serving, the agency initiated its Continuous Quality Improvement (CQI) review process consistent with our standard practice. The purpose of the process is to review and evaluate the work leading up to the incident and identify areas in which there are opportunities for systems improvements. Continuous quality improvement is a tenet of the Department's core values, as evidenced by the March 2022 court decision to end the Juan F. Consent Decree and remove federal oversight of the Department's practice. CTDCF worked closely with the Court Monitor's Office for over 30 years to ensure that an effective CQI infrastructure was developed to identify, analyze, and refine practice to improve outcomes for children and families. Since the termination of federal oversight and in keeping with a commitment to excellence in child welfare practice, the Department contracted with Chapin Hall, an independent policy center at the University of Chicago, to complete a comprehensive overview of the Bureau of Strategic Planning and its functions to build upon the existing performance management system and propose recommendations to create a holistic CQI Practice Model. This engagement began in January of 2023 and recommendations are currently being reviewed by the DCF Executive Team.

Over the past year, through rigorous review of case work and identification of areas that could be reinforced, the Department has continued efforts to enhance its existing and ongoing work as follows:

Working with undocumented families

- The Department has recognized the need for enhanced engagement with undocumented families who come to our attention, given the increased population in CT and the unique needs of this population. Senior DCF officials met with leaders of Integrated Refugee and Immigration Services (IRIS) and Connecticut Institute of Refugees and Immigrants (CIRI), to collaborate on strategies to engage and better meet the needs of these children and families, particularly in the southern part of the state.

- DCF's Director of Immigration Practice routinely consults on cases in which one or more family members is undocumented in order to assist with culturally competent engagement, identify language and service resources to assist families and assess potential legal barriers.

Identifying and assessing failure to thrive

- DCF's Health Management and Oversight (HMO) Division includes nursing staff in each of DCF's six regions who routinely consult on cases in which a child has medical issues. The HMO Division has drafted a regional nurse standard to incorporate a child's weight and history of failure to thrive in the consult assessment and documentation. This working draft should become finalized guidance by the end of September.

- The HMO Division has partnered with Yale and Connecticut Children's to develop training to increase the awareness of a child's weight and failure to thrive on the health outcome for that child. The training will be given to DCF staff by the child abuse providers in fall 2023.

Partnering with foster parents

- CT DCF has officially become a Quality Parenting Initiative (QPI) jurisdiction. The Youth Law Center, a nationally renowned advocacy group in California whose mission is to advocate to transform foster care and juvenile justice systems, was instrumental in developing QPI. QPI is an effort to transform foster care agencies into relationship-based systems whose primary goal is to ensure that each child develops and maintains strong, positive relationships and has effective parenting while in care. All DCF child protective services and foster care staff have received training on the QPI model.

- DCF is partnering with the Connecticut Association of Foster and Adoptive Families, Fostering Communities, and other foster family advocates throughout the state to develop a Foster Care Bill of Rights legislative proposal for the 2024 Connecticut General Assembly session. The Bill of Rights will require several things, including: ensuring that communication between foster parents and DCF staff is timely and accurate, and allowing foster parent to actively participate and have input into the case planning and decision-making process regarding the foster child.

Reinforcing safety practice and in-person family contact post-pandemic

- During the Covid-19 pandemic, DCF, like all other state agencies, had to adapt its work to meet its mandates, while also adhering to public health requirements. As such, there were times when virtual, rather than in-person visitation, between a social worker and family on their caseload was permitted. In order to conduct a virtual visit, a case-triage was required, and a determination that, due to the medical needs of the family, an in-person visit was not feasible. As we exited the public

health emergency, DCF issued guidance that was clear --virtual visitation is no longer a substitute for seeing a family in-person.

- Further, Commissioner Dorantes issued guidance about expectations regarding announced vs. unannounced home visits and meaningful engagement with families. This memorandum reinforced that family engagement includes conducting quality assessments of safety, risk, strengths and needs. This is to be accomplished through face-to-face contact and direct observation. Child safety must be continuously assessed using the Department's ABCD child safety paradigm and should inform the frequency and purpose of visitation.

- In congruence with the ABCD Child Safety Practice Model, Safety Planning Practice Guidance was developed in August 2022, with facilitated discussions led by the Child Welfare Bureau, Legal Division, and the Academy for Workforce Development in December 2022 following a Statewide Safety Leadership Forum held in November 2022.

Refining trial home visits for committed children and partnering with stakeholders

- DCF has broad statutory authority to place a child under its commitment "... in a suitable foster home or in the home of a fictive kin caregiver, *relative caregiver*, or in a licensed child-caring institution or in the care and custody of any accredited, licensed or approved child-caring agency..." (C.G.S.A. 46B-129 (j)(4) emphasis added). As such, best practice dictates that there are times when a trial home visit period may be in the child's best interest in order to ensure successful reunification. Although trial home visits are described in DCF's policy, the agency is considering additional policy and/or legislation to more clearly delineate the parameters of a trial home visit for a child under commitment.

- The decision to reunify a committed child is never made by DCF in isolation. The agency works with service providers, attorneys for parents and children, foster families and the parents and children themselves on developing a timeframe and thoughtful transition. This work does not look the same for every family. The unique needs of each child and their caregivers must be considered in order to tailor a reunification plan that will ensure the highest likelihood of success.

- The Department undertook revisions of its Permanency Planning Policies and accompanying practice guidance, including new policy on Reunification and Parent/Child Visitation. This policy series will be posted by the end of September 2023.

Developing Post Consent Decree Workgroups

- DCF exited federal judicial oversight pursuant to the Juan F. consent decree in March 2022. In the aftermath, we convened Post Consent Decree Workgroups which focused on four practice areas:
    - Intake (including an analysis of our Differential Response System, commencement, frequency and contact standards, documentation, etc.)
    - Caseload Weighting (evaluating current methodology for assigning point system to different types of cases, identifying maximum caseload standards by type of case, and developing an approach that ensures complexity of cases and caseload requirements are considered upon case assignment)
    - Case Plans (creating a document that reflects our case planning process that ensures family input and voice is represented)
    - In-home/Out-of-home Visitation Standards (including an assessment of frequency of contact, by whom, and contact standards, etc.)

- With technical assistance provided by Casey Family Programs and input from a diverse population of subject matter experts within the Department, a final report with recommendations was made to the Commissioner in July 2023. The following recommendations, which are directly relevant to improving practice areas related to this matter, were approved for implementation in September 2023:
    - Revisions to the ongoing services SDM reunification assessment and risk reassessment tools.
    - Revisions to the early childhood practice guidance and High-Risk Newborn policy emphasizing the ABCD paradigm to strengthen supervision guidance and reinforce Birth to Three referral and assessment expectations.
    - Revisions to the DCF Policy on Visitation and Contact Standards, Purposeful Visitation Practice guidelines and engagement questions.

Promoting Safety Culture within DCF Workforce

- CTDCF is proud to be among 33 state, county and tribal child family serving agencies to participate in the National Partnership for Child Safety (NPCS). Formed in 2018, the mission of NPCS is to improve child safety and prevent child maltreatment and fatalities by strengthening families and promoting innovations in child protection. Supported by Casey Family Programs and the University of Kentucky, NPCS is a quality improvement collaborative formed to further key recommendations and findings of the federal Commission to Eliminate Child Abuse and Neglect Fatalities, which highlighted the importance and impact of safety science and data sharing to system change and reform.
- Safety science provides a framework and processes for child protection agencies to understand the inherently complex nature of the work and the factors that influence decision-making. It also provides a safe and supportive environment for professionals to process, share and learn from critical incidents to prevent additional tragedies. This framework is foundational to the DCF Safe and Sound employee practice model.
- Participation in the partnership allows CT DCF to use data to identify trends and protect children at risk of maltreatment or fatality. The Partnership also strengthens accountability, promotes collaboration to improve child safety outcomes by sharing data and applying a set of strategies, including implementing a standardized platform for critical incident review and reporting of data, comparing critical incident and team culture data and the sharing of cross-jurisdictional messages on practice.

The Department's case records involving families are subject to strict confidentiality laws (C.G.S.A. 17a-28), which limit what we can share publicly without infringing upon the privacy afforded to families by our state legislature. Further, the tragic passing of this young child and the circumstances surrounding his death remain under active investigation by law enforcement. The Department cannot, and will not, release any information to the public that could in any way jeopardize a full and fair investigation into the circumstances of this untimely death.

Appendix 5: DCF Response to Marcello M. Report

DCF- written response provided February 5, 2024.

In the aftermath of the June 28, 2023, passing of a 10-month-old, DCF commenced an internal Continuous Quality Improvement (CQI) review of this family's case as the Department had ended its involvement with the family on June 8, 2023.

The purpose of the CQI process is to review and evaluate the Department's work leading up to the incident and identify areas where there are opportunities for case practice and/or systems improvements. As a proud member of the National Partnership for Child Safety (NPCS), DCF employs this framework and these processes to understand the inherently complex nature of the work and the factors that influence decision-making during cases where a fatality or near fatality has occurred. It also provides a safe and supportive environment for our social work staff to process, share information and learn from critical incidents to prevent additional tragedies. This framework is foundational to our ABCD Child Safety Practice Model and Safe and Sound culture established for our employees.

Continuous Quality Improvement remains a tenet of the Department's core values, as evidenced by the March 2022 court decision to end the Juan F. Consent Decree and remove that aspect of federal oversight of the Department's practice. CTDCF worked closely with the Court Monitor's Office for over 30 years to ensure that an effective CQI infrastructure was developed to identify, analyze, and refine practice to improve outcomes for children and families. Since the termination of federal oversight under the Consent Decree, and in keeping with a commitment to excellence in child welfare practice, the Department contracted with Chapin Hall, an independent policy center at the University of Chicago, to complete a comprehensive overview of the Bureau of Strategic Planning and its functions to build upon the existing performance management system and propose recommendations to create a holistic CQI Practice Model. As previously noted, this engagement began in January of 2023.

As a result of our CQI reviews and processes, including the review in this case, we have identified system improvement opportunities as well as areas of best practice that have continued to be addressed and reinforced over the past six months. Those areas of best practice include, but are not limited to, the use of a strength-based approach to our work, supervisory support and oversight, fentanyl triage meetings, Structured Decision Making (SDM) safety assessments, multidisciplinary consultation teams, engaging with providers, and onboarding and training of new staff, including shadowing opportunities, to assist in retaining a qualified workforce and reduce turnover.

More specifically, the Department remains focused on the following practice and systemic areas for continuous improvement:

1. Assessing child safety in families where substance misuse and particularly fentanyl is present

    - We have trained all social work staff on how to administer the UNCOPE screening tool to determine the impact of substance use on child safety and well-being and to assess parental functioning to meet the needs of their children. The UNCOPE is comprised of six questions and provides a quick and simple way of identifying risk for substance use concerns when not already clearly identified as a problem. The tool can be used to screen for alcohol and/or other drugs in adults.

- Staff have also been trained on the use of Motivational Interviewing, which is an evidence-based approach to engagement that can assist in gathering additional information to inform our assessments and improve service delivery.
- Full training occurred with all area office social work, legal and administrative staff on the topic **"Enhanced Safety Guidance for Cases Involving Fentanyl and Substance Use".** This training covered the final fentanyl protocol, the agency's substance use practice guide, screening and testing and a refresher on substance use and misuse in general.
- Work will continue with thought partners and subject matter experts, including the Alcohol and Drug Policy Council, the Department of Mental Health and Addiction Services, the federal Substance Abuse and Mental Health Services Administration, to develop best practice in child protection when parental/caregiver substance use is present.
- Educational literature and brochures were distributed to each of the offices labeled "keeping you safe and your families safe". This was education on Fentanyl and resources to support our staff and our families in prevention and treatment.
- The Department is also initiating training for our staff on Naloxone and distributing this to all DCF offices along with reviewing and updating policy and procedures related to its use.

2. Accessing/Enhancing Fentanyl testing

- Partnerships will continue with the adult substance use community to address challenges with and developments related to Fentanyl testing.

- The state has received technical assistance from the Opioid Response Network regarding this issue, including training on the Role of Substance Use Disorders & Management in the Family Unit.

- Providers now have an FDA CLIA waived rapid screening test for Fentanyl. The goal is to have all providers begin using this in February.

- Family Based Recovery (FBR) is now testing for Fentanyl. The Department will continue to review the protocols, expectations and best practices regarding testing and revise/update FBR and other provider contracts as needed.

3. Including all providers in teaming

- DCF will continue to engage with non-contracted programs such as Methadone Programs and Probation to include them in the DCF teaming process and in meetings with other providers involved with the family. This will ensure all entities involved with a family have coordinated communication and sharing of information.

- DCF and JB-CSSD have been meeting to discuss barriers to information sharing, many statutorily set, and determine ways to ensure better communication between agencies.

4. Addressing provider staff turnover

    - Connecticut continues to experience a workforce shortage and the Department will continue to strategize with the provider community to develop solutions. Challenges existed with staffing in the FBR provider network, and turnover occurred specifically with members of the FBR team working with this family leaving those directly involved newer to their roles.

5. Engaging Fathers

    - The Department has hired a Fatherhood Engagement Coordinator to establish best case practice standards regarding fatherhood engagement and to promote more comprehensive assessments of fathers as an integral component of case planning.

The Department acknowledges the OCA's observations regarding this case and our shared focus on continuous quality improvement for all agencies and partners who comprise the child welfare system. While the Department may have a different perspective on some of the OCA's findings and conclusions, we are reviewing the recommendations and remain committed to collaborating with the OCA, our sister agencies and other system partners to support and improve the safety and well-being of the children and families we collectively serve.