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

EXECUTIVE SUMMARY

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. This Addendum includes information regarding a baby who suffered a near-fatal ingestion of Fentanyl in 2024 and was saved by the administration of Naloxone by a first responder. This information is included as the case raises substantially similar findings to Liam and Marcello's cases.

Findings Related to DCF

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[1] cases, DCF made critical decisions based on the information that they had available at the time. In all three cases, however, because policies were not followed, critical decisions were made with incomplete or inaccurate information.[2] In all three cases, 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.

DCF quality improvement data shows concerns in certain practice areas, with several key areas in ongoing services cases rated as not meeting expectations. These include:

[1] John is a pseudonym.

[2] A DCF staff person involved in Liam's case was referred to the Office of Labor Relations for potential discipline. OCA identified concerns with the OLR process, including a lack of clarity in the respective roles of DCF and OLR. In addition, the DCF assigned subject matter expert who was in the direct chain of command of the person for whom discipline was being considered, did not provide questions or issues to the investigators, and did not provide information regarding any applicable DCF rules or regulations. OLR did not find just cause for formal discipline. Where OLR does not find just cause for discipline, the agency retains authority to provide counseling and other supportive/corrective measures for agency staff.

- **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.
- **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.
- **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.
- **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.
- **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.
- **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 reported efforts to improve systemic level quality assurance including:

- 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.
- 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.

OCA Recommendations Regarding 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.

Findings Related to JB-CSSD

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. 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 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 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 has created a centralized policy audit unit in its administrative subdivision to audit policy across all JB-CSSD's subdivisions. 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.

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. 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.

Recommendations Related to 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.

Findings Related to OCPD

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 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.

Recommendations Related to 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.