

STATE OF CONNECTICUT  
OFFICE OF THE CHILD ADVOCATE  
165 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106

- FATALITY INVESTIGATION FINDINGS & RECOMMENDATIONS LETTER-



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March 7, 2022

**VIA E-MAIL DELIVERY**

Commissioner Vannessa Dorantes, Department of Children and Families  
Commissioner Jordan Scheff, Department of Developmental Services

**RE: OCA Fatality Investigation Findings & Recommendations Letter regarding the Death of 17 year old Alex Medina**

Dear Commissioner Dorantes and Commissioner Scheff:

The Office of the Child Advocate (“OCA”) is an independent government agency that is statutorily authorized to “conduct an in-depth investigation and review and issue a report with recommendations on the death or critical incident of a child. The report shall be submitted to the Governor, the General Assembly and the commissioner of any state agency cited in the report and shall be made available to the general public.”<sup>1</sup> The OCA is further required to “[e]valuate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state.”<sup>2</sup>

The OCA is issuing this Fatality Investigation Findings & Recommendations Letter (“Findings Letter”) to the Department of Children and Families (DCF) and the Department of Developmental Services (DDS) in response to the unexpected and preventable death of Alexander Medina (Alex), a 17-year-old boy who was committed to DCF custody at the time of his death. Alex died from severe injuries sustained as a result of a motor vehicle crash allegedly caused by his foster father, Mr. James Bailey, a licensed DCF foster care provider and a previous licensed DDS provider. Mr. Bailey was allegedly intoxicated at the scene of the motor vehicle crash and has been criminally charged with multiple offenses. OCA learned that both DDS and DCF developed or investigated concerns about

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<sup>1</sup> Conn. Gen. Stat. Sec. 46a-13/. Further, “Any state agency cited in a report issued by the Office of the Child Advocate, pursuant to the Child Advocate’s responsibilities under this section, shall submit a written response to the report and recommendations made in the report to the Governor and the General Assembly not later than ninety days after receipt of such report and recommendations. The General Assembly shall submit a copy of such response to the Office of the Child Advocate immediately upon receipt.” Id.

<sup>2</sup> Id.

Mr. Bailey's drinking during his tenure as a state-licensed provider. OCA's review sought to further examine Mr. Bailey's licensing history and the state's framework for approving, monitoring, and sharing information regarding approved providers. OCA also examined certain legal safeguards for children in foster care, including the federally required case plan review process, the role of legal counsel for children in care, and the statutorily required provision of material information about children to the Superior Court for Juvenile Matters. We appreciate the cooperation of your agencies with OCA's investigation.

Pursuant to this investigation, OCA reviewed or undertook the following:

1. State agency records pertaining to the licensing, investigation, monitoring, compensation or provision of services to or by Sherron and James Bailey.
2. All correspondence between DDS and DCF regarding Sherron and/or James Bailey.
3. All agency policies regarding the investigation of licensed/contracted custodial care providers and documentation and reporting of concerns regarding the provision of such care.
4. All agency policies governing how information is exchanged between DCF, DDS, and OEC regarding licensed/contracted custodial care providers.
5. Applicable to DCF:
  - a. A list of all children and dates of birth who were placed in the home of Sherron and James Bailey between 2012 and 2019.
  - b. All DCF policies regarding the licensing and monitoring of therapeutic foster homes.
6. OCA reviewed information from the DCF-contracted foster care agencies, the Connection, Inc. and Wheeler Clinic regarding their assessment, licensing, and monitoring of the Bailey foster home.
7. OCA conducted interviews with administrators from DDS, DCF, the Office of the Chief Public Defender, The Connection and Wheeler Clinic.
8. OCA reviewed DCF's internal Special Qualitative Review of the circumstances leading to Alex's death, and OCA's Findings Letter references and concurs with several internal recommendations contained in that Review.

### **SUMMARY OF FINDINGS**

Mr. James Bailey and his wife, Sherron Bailey, were licensed foster parents for DCF from 2013 until 2019, when they were substantiated for abuse and neglect of Alex Medina. Prior to their tenure with DCF, from 2008 until 2013 the Baileys were licensed by DDS as a community training home/foster care provider for individuals with intellectual disabilities. DDS email records revealed that while Mr. Bailey was a licensed provider, DDS developed serious concerns about his drinking, the Baileys' honesty about Mr. Bailey's alcohol use, and the Baileys' reporting of the needs and behaviors of the young adult DDS client living in their home. In addition to DDS staff's own observations, DDS emails noted the young adult client's allegation as he was moving out of the Bailey home that DDS should not place anyone else with the Baileys since Mr. Bailey drank heavily and would drink and drive. DDS emails documented that due to the agency's accumulating concerns about the Baileys, it would no longer approve any clients for placement in the Bailey home. DDS did not make a formal record of these concerns or determinations in the Baileys' licensing file. DDS did not report or investigate the young man's allegations regarding Mr. Bailey's excessive drinking and driving while impaired, as

required by state mandated reporting law (C.G.S. 46a-11a and b), and DDS closed out the Bailey's file in good standing after the Baileys submitted a letter in December 2012 relinquishing their license.

Weeks after relinquishing their license with DDS, the Baileys sought licensure from DCF to become foster parents for children. Specifically, the Baileys sought to become licensed through a DCF-contracted community provider as "therapeutic" foster parents, a license that would enable them to care for children with physical, developmental, and psychiatric disabilities. Notably, while criminal and child welfare background checks are required by state law, there is no requirement that DCF conduct a regulatory check with other state agencies prior to issuing a foster care license to a prospective applicant.

Despite the lack of explicit statutory requirements for record-sharing between licensing agencies, some communication regarding the Baileys did occur between DDS, DCF, and DCF's contracted child-placing agency, The Connection, Inc. A DDS foster care manager shared a verbal warning with The Connection that they should "think twice" about approving the Baileys as DDS had had concerns about Mr. Bailey's drinking. DDS did not however have any formal records to share regarding its concerns, be they regulatory violations, investigations, or assessments. Pursuant to its contract with DCF, The Connection conducted a licensing assessment, and based in part on the formal record of the Bailey's positive DDS licensing history, Mr. Bailey and his wife were recommended for licensure as therapeutic foster parents. DDS did not share any verbal or written concerns with DCF.

Between 2013 and 2019, DCF and provider records indicate that several children with varying disabilities were placed in the Bailey home. The Baileys were noted as doing well with some of these children and struggling with others. During this time, the Baileys requested that at least two children be removed from their home due to the children's needs or behaviors. DCF reports indicate that while both Mr. and Mrs. Bailey provided care and support for the children, Mrs. Bailey was the primary parent in the household.

In 2015, two years into their tenure as DCF foster parents, concerns were again raised about Mr. Bailey's drinking, with a visiting nurse from The Connection reporting that during her morning visit to the home, Mr. Bailey appeared significantly impaired and intoxicated. Separately a DCF worker noted multiple empty beer and liquor bottles in the house. While a DCF investigation into excessive alcohol use was unsubstantiated, DCF and The Connection asked the Baileys to sign successive "safety agreements" documenting that alcohol would be responsibly consumed, and that Mr. Bailey would never drink and drive. At no time did The Connection or DCF seek information from DDS, despite Mr. Bailey volunteering that DDS had had a prior concern about his drinking.

In early 2017, due to the placement and support needs of another child, the Baileys transferred their license to Wheeler Clinic, another community-based mental health/child placing agency that re-licensed the Baileys as DCF foster care providers for very high need youth. Wheeler did not receive information from The Connection or DCF about the prior safety agreements with the Baileys regarding alcohol, and Wheeler received only a brief summary of the unsubstantiated investigation from 2015. DCF policy does not require contracted foster care agencies to review or request all available records regarding the prospective or transferring foster parents.

In May 2017, a child in the Bailey foster home accused Mr. Bailey of "drinking 24-7, amongst other allegations." These allegations were properly reported to DCF, investigated and unsubstantiated. Mr.

and Mrs. Bailey again denied that excessive drinking went on in the home, the child recanted much of what he alleged, and Wheeler staff did not report any concerns about substance abuse.

In September 2017, after eight different placements while in DCF care, fifteen-year-old Alex Medina was placed in the Baileys' home. Alex's DCF social work team was not aware of prior investigated concerns about the Baileys or the previous safety agreements about drinking. There is no DCF policy that requires a child's social work team to review or be made aware of prior regulatory concerns or investigative findings regarding a child's prospective licensed placement.

On the morning of September 30, 2019, Alex called Mr. Bailey from Maloney High School in Meriden and requested a ride home from school as he was not feeling well. Mr. Bailey responded to the call and drove to school to pick Alex up. Alex was never seen by a school nurse or administrator. He left school on his own and Mr. Bailey met up with Alex outside. On the drive home, Mr. Bailey crashed the vehicle, and Alex was hospitalized with critical injuries. He passed away several days later. Mr. Bailey was found by police to be intoxicated at the time of the crash and he was criminally charged.

## **BACKGROUND AND APPLICABLE LAW/REGULATION**

### **Community training home licensing at DDS**

DDS licenses what are referred to in statute and regulation as "community training homes,"<sup>3</sup> which are essentially foster homes for individuals receiving services from DDS. According to DDS regulations, "[f]or adults, the CTH provides a nurturing home environment where adults can share responsibilities, develop mutual relationships, be independent and make their own choices."<sup>4</sup> Licensing regulations require that the "licensee shall demonstrate the capacity to maintain a health and safe living environment for individuals."<sup>5</sup> DDS re-licenses each home annually per state regulation.

### **Reporting and investigation of suspected abuse/neglect in DDS-licensed homes and facilities**

Connecticut law requires a variety of individuals, including DDS staff, to report suspected abuse or neglect of a person with an intellectual disability to DDS for further action and investigation. "Abuse" and "neglect" are defined by statute as (respectively) "the wilful infliction of physical pain or injury or the wilful deprivation by a caregiver of services which are necessary to the person's health or safety;" and "where a person with intellectual disability either is living alone and is not able to obtain the services which are necessary to maintain such person's physical and mental health or is not receiving such necessary services from the caregiver."<sup>6</sup>

### **Foster home licensing at DCF**

State statutes and regulations confer on DCF the legal authority and responsibility to provide safeguards for those children who must be removed from their own homes and placed in another family home to protect them or to provide them with specialized care. State law provides that "[n]o child in the custody of DCF shall be placed with any person, unless such person is licensed or

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<sup>3</sup> Now referred to by the agency as Community Companion Homes.

<sup>4</sup> Regulations of Connecticut State Agencies. 17a-227-23

<sup>5</sup> 17a-227-29 Initial standards

<sup>6</sup> Conn. Gen. Stat. Section 46a-11a and 11b.

approved for that purpose.”<sup>7</sup> DCF may use foster homes approved by private child placing agencies (CPA) in accordance with state regulations.

State law also requires DCF to conduct a child protective service and criminal records check on the applicant for licensure and each household member 16 years of age and older. State law *does not require* that DCF conduct formal check/review with other agencies, in state or out of state, regarding any previous licensing history of an applicant.

A foster care license is effective for two years with assessment completed by a designated staff member every two years to determine if his or her foster care license should be renewed. If DCF determines that the health, safety, or welfare of a foster child requires emergency action, DCF may summarily suspend a foster care license and immediately remove any foster child residing in that foster home. The summary suspension shall remain in effect pending the completion of the administrative hearing or until further order of the Commissioner or designee.

### **Therapeutic Foster Care**

DCF contracts for a therapeutic foster care (TFC) system for children with complex medical, mental health and developmental treatment needs. TFC foster parents are expected to be especially skilled. The contracted TFC provider agency is required to ensure the integration of behavioral, mental health, recreational, cultural and psychological interventions for the child and support the child’s success in the community using a wraparound services approach. DCF contracts with over a dozen private child placing agencies across the state for the provision of TFC services. The core of the contract is the same for each agency with some variations including the number of children and regions served. TFC level programs provide a higher level of training and support to foster families including respite care, support groups, 24/7 on call service, and frequent visitation from agency staff. TFC foster care includes a stipend for the foster parents of \$55.55 per day (current rate).

### **Family and Community Ties Foster Care**

Family and Community Ties (FCT) is the highest level of therapeutic foster care that DCF contracts for. The purpose of the FCT program is to integrate children into a home setting using a wraparound approach and providing intensive home and community-based clinical treatment. The children approved for FCT have often spent a great deal of time in residential and/or other congregate care settings. FCT is a model of foster care which trains families to professionally care for these children on a long-term basis by offering intensive support systems both at their home and in the community. FCT offers additional hours of individual and family therapy, other enhanced supports to the foster family, and an increased stipend to the foster parents of at least \$82 per day (current rate).

### **Responsibilities of court-appointed attorneys for children in foster care**

State law requires that children in the care and custody of DCF and/or for whom a petition of neglect is filed in the Juvenile Court are “represented by counsel knowledgeable about representing such children.”<sup>8</sup> Counsel are appointed by the Public Defender’s Office, which is also statutorily responsible to “establish training, practice and caseload standards for the representation of children and youths.”<sup>9</sup>

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<sup>7</sup> Conn. Gen. Stat. §17a-114(b)(1).

<sup>8</sup> Conn. Gen. Stat. 46b-129a.

<sup>9</sup> Conn. Gen. Stat. 51-296.

Federal law requires that representatives for children obtain a clear and “first hand” understanding of the needs of the child.<sup>10</sup>

The Public Defender’s Office has Performance Guidelines for appointed lawyers representing children, which Guidelines provide that lawyers should “visit with the client in person at least four times a year and whenever the placement is changed.” Counsel is also advised to “interview the caregiver and other family members or staff in any placement,” “independently consult with service providers to assess the child’s progress and well-being and to determine if additional services are needed,” and regularly “obtain records from the child’s medical, educational, and childcare providers to assess the development and well-being of the child client.”<sup>11</sup> The Public Defender’s Office monitors lawyers’ adherence to these Guidelines in part through an internal review of billing codes. Lawyers are paid a combination of flat fee (\$500 per case) and hourly billing (\$50 per hour) for a limited number of activities such as visits with the child client, participation in children’s treatment plan meetings, and trial time.

### **Mandated reporting and investigation of suspected abuse/neglect in DCF-licensed homes and facilities**

State law requires that mandated reporters, which includes many licensed and unlicensed professionals and employees who interact with children, promptly report to DCF or law enforcement if they have “reasonable cause to suspect or believe that any child under the age of eighteen years (A) has been abused or neglected, (B) has had nonaccidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (C) is placed at imminent risk of serious harm.”<sup>12</sup>

## **CASE FINDINGS**

### **I. Alex’s Death from Injuries Sustained in a Motor Vehicle Crash Allegedly Caused by Mr. Bailey’s Impaired Driving**

On October 3, 2019, Alexander (Alex) Medina, a seventeen (17) year old boy, died from injuries sustained due to a motor vehicle crash that occurred on September 30, 2019. Alex had been on life support for three days. Alex was an unbelted passenger in the back seat of a vehicle driven by his foster father, James Bailey. Mr. Bailey was arrested on September 30, 2019 and charged with multiple offenses related to the crash including Manslaughter in the 2<sup>nd</sup> degree, Reckless Endangerment, Reckless Driving, and Illegal Operation of a Motor Vehicle While under the Influence. DCF investigated the circumstances leading to Alex’s death and substantiated Mr. Bailey for abuse and neglect of Alex, and emotional neglect of another foster child in the home, and he was placed on the Central Registry. Mrs. Bailey was substantiated for physical neglect of Alex. DCF also removed another foster child from the home and placed him in another licensed setting. DCF undertook a thorough internal child death review examining the agency’s practices with regard to Alex’s placements and the licensing and monitoring of the Bailey foster home. DCF’s findings and recommendations, shared with OCA during this investigation, will be referenced in this Letter. DDS reported to OCA

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<sup>10</sup> 42 U.S.C. § 5106a(b)(2)(B)(xiii)

<sup>11</sup> [https://portal.ct.gov/-/media/OCPD/Forms/Assigned-](https://portal.ct.gov/-/media/OCPD/Forms/Assigned-Counsel/CT_Performance_Standards_For_Counsel_In_Child_Protection_Matters_-Rev_1-2017.pdf)

Counsel/CT\_Performance\_Standards\_For\_Counsel\_In\_Child\_Protection\_Matters\_-Rev\_1-2017.pdf

<sup>12</sup> Conn. Gen. Stat. 17a-101a.

that it conducted an “informal review” of its involvement with the Baileys. The agency did not indicate to OCA that it had made findings or recommendations about its practice.

## **DDS Licensing of the Bailey Family**

### **2008 the Baileys are Licensed by DDS**

In 2008, the Baileys were licensed by DDS as Community Training Home (CTH) to serve individuals with intellectual and co-occurring developmental disabilities. A DDS-contracted agency provided support services to the family and any individual clients served in the home. During this time period, the Baileys provided care for a young adult male (“Jonah”)<sup>13</sup> with Intellectual Disability and behavioral support needs.

### **June 2011, Allegations Were Made Regarding Mr. Bailey’s Drinking and Abusive Behavior**

DDS records document that on June 3, 2011 a report of alleged verbal abuse of Jonah by Mr. Bailey was received at the Office of Protection and Advocacy (OPA).<sup>14</sup> The report, made by Jonah’s DDS case manager pursuant to her responsibilities as a mandated reporter, included the following information: “[Jonah] reported to his DDS Case Manager that while he was speaking to [Mr. Bailey’s wife], ... Mr. James Bailey told [Jonah] to ‘shut the fuck up’.” The Case Manager indicated in her report that Jonah’s Conservator contacted her on June 2, 2011, to report that Jonah’s Aunt called her the day before to report this alleged verbal abuse.

On June 8, 2011, the assigned DDS Investigator met with the Conservator who shared that on June 1, 2011 Jonah’s aunt called her at 9:15 pm to express her concern that Jonah had called her to request that he be picked up right away because “he was frightened”, and that Mr. Bailey said “shut the fuck up” after he disobeyed a request that he not tell Mrs. Bailey about the family’s car needing to be fixed. The Conservator told the Investigator that Jonah’s Aunt reported that Mr. Bailey “drinks too much, gets drunk and doesn’t let Jonah see his family”. (The Conservator clarified to the Investigator that overnight visits with family had been discontinued as Jonah reportedly didn’t take his medications consistently while on overnight visits with family.)

The Conservator reported to the DDS Investigator that she went to discuss the concerns with the Baileys on the same evening of the incident. The Baileys denied the allegations, though the Conservator “felt [Mr. Bailey] had been drinking” and that he “appeared defensive.” **Mr. Bailey asked that the Conservator not report the incident.** The Conservator also conveyed concerns from Jonah’s family that “Mr. Bailey takes Jonah to the casino, sometimes Mr. Bailey is drunk and on occasion Mr. Bailey abuses Mrs. Bailey”.

On June 14, 2011, the Investigator met with Jonah at his school. During this interview, Jonah reported that at the time of the incident Mr. Bailey said “shut the *heck* up” [emphasis added]. He further reported to the Investigator that Mr. Bailey had said to him “if he leaves the house, he will lose his benefits”. Notably, the investigation record does not document that Jonah was asked any questions about Mr. Bailey’s drinking. The investigation concluded “based on the preponderance of evidence collected

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<sup>13</sup> Jonah is a pseudonym.

<sup>14</sup> OPA was then statutorily authorized to conduct abuse/neglect investigations involving adults with intellectual disabilities. Due to subsequent changes in federal and state law, the Office of Protection and Advocacy was dissolved and reorganized as a private non-profit called Disability Rights Connecticut. OPA’s abuse investigation responsibilities were absorbed by DDS.



through direct witness interview and review of the medical and behavioral history of (Jonah) the allegation of verbal abuse is NOT Substantiated.” The DDS investigative report revealed no further development and investigative activities related to the allegations of Mr. Bailey’s excessive drinking or possible spousal abuse. Neither the DDS-contracted agency supporting the foster home nor Jonah’s Aunt were contacted by the Investigator.

Concurrent to the June 2011 DDS investigation, there were emails between DDS staff and its contracted foster care support agency. There is no documentation that the investigator was privy to these detailed emails regarding the direct account by the Conservator that Mr. Bailey was observed drinking and by the private agency supervisor indicating that Mr. Bailey smelled of alcohol on June 2nd and 3rd respectively. On June 3, 2011, the DDS manager sent an email to the private agency administrator to hold off increasing the Baileys’ licensing capacity from 1 to 2 (with no reason noted). Administrators reported to OCA that there is no agency requirement that emails, even communications documenting substantive activity or concerns, become part of the formal DDS record regarding a client or licensed provider.

The DDS investigation did make the following recommendations:

The interdisciplinary team to continue to monitor relationships between Jonah and caregivers [with noted risk of collaboration in witness statements by Baileys]; periodic unannounced visits by the case manager or DDS designee; continue to look for placements for Jonah closer to his family; and a review of the current license to insure it met requirements identifying Mrs. Bailey as a caregiver.

### **June 2011 Concerns Documented About Mr. Bailey’s Drinking in DDS Emails**

With the investigation into the verbal abuse of Jonah pending, on June 6, 2011, Jonah’s DDS case manager emailed the DDS Foster Care Manager:

I just spoke with [private foster care support agency] about [Mr. Bailey] and [administrator] said that [Mr. Bailey] is no longer allowed to drive another licensee’s client to and from [their] day program, because of the possible drinking. Should I inform [Mr. Bailey] that he is also not allowed to drive Jonah anywhere? He transports him to and from school.

No responsive email was produced by DDS for OCA.

### **February 2012, the Baileys’ DDS License was Renewed by DDS**

A Summary Application of Renewal for the Bailey home was completed and signed on February 10, 2012. On question #2 of the Application: *Have there been any allegations of abuse or neglect or other concerns regarding this licensee or the occupants of this CTH in the past year?* The response indicates “Verbal abuse, not substantiated, no recommendations.” No mention was made of concerns about drinking, taking Jonah to the casino, spousal abuse, or the recommendation for unannounced visits.

### **August 2012, Jonah Moved out of the Bailey home and DDS Told Its Contracted Foster Care Agency-Don’t Place Anyone Else with the Baileys**

On August 8, 2012, the DDS Foster Care Manager sent an email to the foster care agency Director noting concerns with the Bailey home.



“[Mr. Bailey] has been witnessed on a number of occasions drinking to the point of intoxication. A couple of weeks ago...the case manager for Jonah had to pick up ID cards from the Bailey home. James was severely intoxicated on the couch and did not recognize (the case manager) at any time during her visit.” In addition, it was reported that the case manager had a conversation with Jonah on that day and Jonah reported that it would not be a good idea to place another individual there because “James drinks heavily and drives while drinking.”

The DDS Manager also wrote in the email exchange that she had “personally witnessed” Mr. Bailey under the influence when she stopped by to discuss concerns with him and “in the mid-afternoon he reeked of alcohol just driving home. I think his drinking has become much worse than just occasional social drinking.” The DDS manager cautioned that contracted foster care agency should not license Mrs. Bailey either “considering the environment over there and the poor judgment of the Baileys.” The DDS manager referenced previous “episodes” between the Baileys and Jonah that had been attributed to Jonah’s behavior, and she “questioned if [Mr. Bailey] becomes belligerent during his binges.” The manager concluded that “I am sure there is much more that went on over there than we are aware,” and asked that the agency administrator give her a call to discuss further.

There is no DDS record of what transpired thereafter and no DDS documentation of a phone call with the contracted agency administrator.<sup>15</sup>

The contracted agency Director inquired with DDS via email about any actions taken to notify the Office of Protection and Advocacy about the Baileys and Jonah’s allegations. On August 9, 2012, the DDS Manager responded: “*Jonah was out of the home already, so it was not a [reportable] issue.*” No steps were taken to formally report or investigate Jonah’s concerns or determine whether there were regulatory violations that warranted a formal corrective action or revocation of James Bailey’s DDS license.

Upon inquiry by OCA, DDS acknowledged that its earlier investigation in 2011 may not have been as complete as it could have, that Jonah’s 2012 allegations likely should have been more fully developed and possibly reported and investigated, and that ongoing examination should be made of its abuse/neglect definitions that guide reporting and investigation. DDS acknowledged potential limitations in its investigative division, which is largely staffed, per DDS, “by retired police officers.”

In response to OCA’s questions about the lack of formal records of the DDS home visits and field observations, DDS administrators acknowledged that there is no electronic information management system for recording/maintaining visitation records, field observations or substantive emails regarding licensed homes, and no requirement that staff copy or store email communications. DDS administrators told OCA that because the final visits to the Bailey home took place after Jonah’s departure, no further action was taken. DDS voiced to OCA that it is not “illegal to drink,” and it is difficult to prove someone drinks to excess, and that a disparaging record or finding from DDS might open up the agency to legal action, including libel, and harm the former license-holder’s ability to seek

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<sup>15</sup> For purposes of this portion of the review, OCA sought DDS records only.

approval from another agency. DDS also stated that while Mr. Bailey may have been intoxicated on a few occasions in the home, that Mrs. Bailey was also present and capable of providing competent care.

OCA concludes that DDS was statutorily obligated to report concerns about Mr. Bailey's drinking and driving as possible abuse and neglect of Jonah pursuant to state statute, and that DDS was obligated to assess whether Mr. Bailey's behavior constituted a violation of the agency's licensing requirements, including the requirement that the "licensee demonstrate the capacity to maintain a healthy and safe living environment for individuals," and that the "licensee shall not mistreat, abuse, or neglect an individual." The fact that the young man moved out of the Bailey's home did not negate these obligations. OCA also disagrees with DDS's assertion that the presence of a sober caregiver negates or neutralizes the impact on a dependent individual living with someone who is actively abusing drugs or alcohol.

### **DCF Licensing of the Bailey Family**

#### **December 2012, the Baileys Seek Licensure as DCF Foster Parents**

Immediately upon relinquishing their DDS foster care license, in December 2012 the Baileys applied for licensure as DCF foster parents through one of DCF's contracted agencies, The Connection, Inc.

Applicable statute, regulation and DCF contracts do not require that prospective licensees be subject to a multi-agency review to determine whether the applicant had a regulatory history with another licensing agency (such as DDS or Office of Early Childhood).<sup>16</sup>

Despite the lack of formal DCF practice or requirement for inter-agency license checks on prospective foster parents, it appears that DDS and DCF do communicate regarding such matters. In December of 2012, the DDS foster care manager emailed the DCF Foster Care Manager that if the Baileys sought licensure from DCF (it is not apparent how DDS knew that the Baileys were seeking a DCF foster care license) that the community agency processing the request should pursue a release of information so that DDS could share information regarding the Baileys.

The Connection secured a standard Release of Information for DDS, requesting delivery of the Bailey's full licensing record. However, because the release did not explicitly seek information about drugs or alcohol, DDS internally concluded that its concerns about Mr. Bailey's drinking *could not be disclosed*. DDS did not delineate for OCA regarding what federal or state law prohibited it from sharing its observations about the Baileys with another licensing agency.

After Alex's death, both DCF and OCA determined that despite DDS's internal decision that it could not convey concerns about Mr. Bailey's drinking, the DDS manager gave "off the record" information via a telephone call to The Connection's foster care manager outlining some concerns. In an interview with OCA, The Connection acknowledged the phone call, which it characterized as highly unusual, and recounted that the DDS manager conveyed some concerns about Mr. Bailey's drinking, cautioning that the Connection "should think twice about licensing the Baileys."

The Connection stated that they asked the DDS foster care manager for any records or investigations regarding the alcohol use concerns but DDS did not provide anything in writing and did not indicate

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<sup>16</sup> DDS agency protocols do require an inter-agency check and DDS licenses are now available for search on the state's E-License data base.

that the release they obtained was not sufficient for a complete release of information. According to The Connection, they asked about the nature of the concerns, and the DDS manager stated only that a support agency staff member saw him on the couch one afternoon and he appeared to be inebriated.. The Connection reported to OCA that in the absence of any records, investigative findings or regulatory concerns specifically addressing substance misuse by the Baileys, it had nothing tangible to apply to an assessment of the Baileys as prospective foster parents for DCF-involved children. During The Connection's home study, the Baileys denied any problems with substances, including alcohol, and referenced their years of experience with DDS as an asset. The Connection records, including the home study of the Baileys, do not reference the telephone call from DDS or whether and how DDS's specific concerns about drinking were directly explored with the Baileys.

The DDS licensing record provided to The Connection did not reflect that there had been an allegation of abuse or neglect made against the Baileys by a young adult in 2011, though it did include information about regulatory violations and corrective actions regarding missed medical appointments for Jonah and inadequate documentation regarding Jonah's benefits. The Connection record does not indicate that these prior regulatory concerns were further explored as part of the home study for DCF, and The Connection record states that Jonah "disrupted" from the Bailey home, a term often used in child welfare records when a child's behavior becomes difficult for a foster parent to manage. The Connection home study notes that both foster parents were unemployed due to disability and that they collected disability benefits. There was minimal documentation in the foster care record regarding the impact of their disabilities on the ability of the Baileys to care for children with complex needs or how they managed their disabilities on a day-to-day basis. The Baileys did produce, per DCF policy, a medical statement of their physical fitness to be foster parents by their primary care physician.

The Connection approved the family and recommended them for licensure.

It is this worker's assessment that the Baileys are sensitive and caring people who have raised children together in their blended family. This worker believes that they would be devoted to raising a special needs youth.

### **2013 the Baileys were Approved as DCF Foster Parents and Two Children with Disabilities were Placed with Them**

The Connection placed two children with the Baileys right away, including a non-verbal child with medical complexity and intellectual disability. The latter child stayed in the Bailey home for two and a half years. Per The Connection's account and DCF records, this child thrived in the Bailey's home and the Baileys were very bonded to him.

According to DCF policy, children in foster care must be visited by their DCF social worker at least monthly and, where warranted, more often. The Connection was required to conduct monthly "walk throughs," and the forms for the walk-throughs include a DCF-checklist of items that staff must observe and verify each month in the foster home. These checklists did not include any specific reference to alcohol or use of other substances.

### **January 2015, Concerns Arise About Alcohol Use in Bailey Home**

In January 2015, the DCF assigned social worker for one of the children in the home visited and observed many empty beer cans and other alcohol containers in the home. This observation was

documented in the DCF case record and discussed with both The Connection, Inc. and the DCF child protective services team.

A decision was made by DCF and The Connection to have the Baileys sign a Safety Agreement regarding alcohol use:

Mr. Bailey will not transport any child while under the influence of alcohol. Children in the home will not have access to alcohol. Mr. Bailey will drink alcoholic beverages in a responsible manner with the understanding that he is a role model for the foster children in his home... and must never jeopardize the safety of the children by consumption of alcohol.

The agreement did not state how the contract would be monitored. The contract was signed by The Connection's foster care manager, the same staff member that had spoken by telephone with the DDS manager in 2012 about earlier concerns regarding Mr. Bailey.

There is no indication in the DCF record that The Connection shared with the DCF Investigator its earlier telephone call with DDS regarding Mr. Bailey's drinking or the caution that The Connection should "think twice" about licensing him.

### **July 2015, Additional Concerns Regarding Mr. Bailey's Alcohol Use Were Reported and Investigated as Suspected Child Abuse or Neglect**

On July 16, 2015, a nurse consultant from The Connection made a standard monthly home visit to check on a developmentally and medically complex child (he was not home when the nurse arrived). The nurse later reported to management at The Connection that when she went to the home at 10:15 in the morning, Mr. Bailey appeared to be under the influence. She described him as being unsteady on his feet, having blood shot eyes and smelling of liquor. Although the child that the nurse was scheduled to visit was not in the home, another foster child was present. The nurse reported that she conducted another monthly visit about six months prior and that Mr. Bailey was holding a beer during the visit but was not intoxicated thus she didn't think much of it. The Connection reported the incident as required by state law to the DCF Careline as suspected child abuse/neglect.

During the ensuing DCF investigation, Mr. Bailey volunteered to DCF investigators that he had had a previous incident when he was a DDS foster care provider where he got in trouble for "having a beer." The DCF investigation did not follow up with DDS regarding Mr. Bailey's statement.<sup>17</sup>

During the investigation and concurrent heightened monitoring (including unannounced visits) of the Bailey foster home, DCF referred Mr. Bailey for a substance abuse evaluation by Rushford, a community provider. A substance abuse evaluation often consists of a screening and assessment. The screening is completed to evaluate the possible presence of a particular problem in which the outcome is a yes or no. The assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations. The assessment of Mr. Bailey, which reportedly included a breathalyzer and urine screen, concluded with no reported recommendations

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<sup>17</sup> The Connection reviewed a draft of this Letter prior to publication and informed OCA that its staff had reported DDS's earlier concerns to DCF. However no business records were produced to confirm this notification.

for treatment. OCA requested a copy of the full assessment from DCF but was told that it is DCF's policy allows for providers to summarize findings and therefore a full report was not available.<sup>18</sup>

Mr. Bailey denied drinking the morning of the report to DCF, and he denied any problems with alcohol or drugs. He stated that he may have presented as under the weather due to complications from diabetes. Another child in the home was interviewed by the investigator, and he reported that he sees Mr. Bailey drink beer occasionally. The boy stated that he spent a lot of time in his bedroom so he did not know how much his foster father drank. Mrs. Bailey also denied any substance abuse by her husband.

The allegation of possible abuse/neglect of a child due to inebriation was unsubstantiated by DCF. The Baileys were asked to sign another Safety Agreement regarding alcohol use. This Safety Agreement required Mr. Bailey to undergo the aforementioned substance abuse assessment, but otherwise contained the same language as the earlier contract.

### **2015-16, Concerns developed at DCF regarding the Baileys and the Connections' support of a child in the foster home.**

Another foster child in the home struggled with the Baileys during this same time period. The Baileys asked for this child's removal several times due to concerns that the boy smoked marijuana. This child's treatment planning documents<sup>19</sup> included concerns that the Baileys did not participate in the treatment planning process at DCF. The Connection staff acknowledged the concerns of the DCF reviewer and stated that they would address the Baileys' lack of participation in the child's treatment plan meetings. This child was later removed from the Bailey home at the foster parents' request.

### **The Connection, Inc. closed the Bailey home on October 3, 2016, due to the Baileys transferring to Wheeler Clinic to become a licensed Family and Community Ties Foster Homehe aforementioned**

In 2016, the Baileys sought to transfer support of their therapeutic foster care approval to another agency (Wheeler Clinic) in order to have a previous foster child re-placed with them. The plan was approved by DCF, and the Baileys closed their file with The Connection and were transferred and approved by Wheeler, this time as a Family and Community Ties Foster Home, the highest level of therapeutic foster care that DCF offers.

### **December 2016: Wheeler Clinic Receives Limited Information Regarding Concerns about Mr. Bailey's Drinking**

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<sup>18</sup> OCA requested more information about standard assessments from the community provider, but to date, OCA has not received a response.

<sup>19</sup> Administrative Care Reviews (ACR): The goals, plans, services and expectations for the children in DCF care are put into written documents called treatment plans. In order to review and evaluate the efforts being made to implement those treatment plans, DCF holds regular meetings called administrative case reviews. These meetings occur at least every six months and are facilitated by DCF staff who have this special role.

As part of the transfer, The Connection sent the Bailey family file to Wheeler Clinic. This file did not include a complete DCF investigation record from the 2015 report by the Connection nurse and the file did not include a copy of the safety agreements regarding Mr. Bailey's drinking.<sup>20</sup>

Foster care licensing agencies do not automatically receive the entire investigation record regarding a prospective/transferring foster family, though additional records can be requested by the receiving agency. In this case, Wheeler Clinic did not request the complete investigation record. Specifically, Wheeler received the following information:

The 2017 Intake Protocol which referenced "CPS History: On 7/15/15 emotional and physical neglect – substance abuse with an adverse emotional and physical impact was alleged towards Mr. Bailey. Mr. Bailey was observed to be unsteady on his feet and smelled of alcohol. These allegations were investigated and unsubstantiated."

Wheeler also spoke to The Connection staff as part of the Bailey's transition to their agency. Wheeler reported to DCF that it was not aware that The Connection or DDS had concerns with alcohol use by Mr. Bailey. Wheeler staff reported they were unaware a safety agreement had been put in place with the family while with The Connection. Wheeler Clinic staff did a routine license search and was aware that DDS had closed the Bailey's license in good standing.

### **2017 A Foster Youth Alleged that Mr. Bailey Abused Alcohol – limited investigation by DCF as to this issue**

On May 15, 2017, a relative of a youth placed in the Bailey home called the DCF Careline reporting that the youth said he was kicked out of the home. The youth made several allegations regarding Mr. Bailey, including that he watched the boy in the shower, threatened to cut off his hands with a machete and that Mr. Bailey "drinks 24-7." He denied being mistreated by Mrs. Bailey. The DCF investigator also spoke with Wheeler staff who, according to DCF, "reported the youth had a pattern of making allegations against the foster home to justify his [running away behavior] from the home." The youth later recanted most of the allegations further into the investigation.

Mrs. Bailey and the Wheeler clinician denied any concerns of substance use (with Mrs. Bailey offering that Mr. Bailey would have a glass of wine/beer sometimes during dinner). Mr. Bailey denied any substance abuse or family violence in the home.

DCF investigators did not substantiate the report of abuse/neglect. Although there was reference to a previous allegation of Mr. Bailey drinking, this investigation contained no significant assessment of substance abuse. The investigation record did not include a reference to the history of allegations/observations about alcohol use (e.g., the beer cans, the observations of the Connection's nurse, the safety agreements) or the possible prior concern with DDS, all of which were noted in DCF's 2015 investigative record.

### **2017: Alex Medina was placed in the Bailey Foster Home**

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<sup>20</sup> Upon review of a draft of this Findings Letter, the Connection told OCA that they did send these documents to Wheeler Clinic. OCA reviewed Wheeler Clinic's file regarding the Baileys and this file does not include the Safety Agreements or full DCF Investigation record. Wheeler Clinic also confirmed for OCA that these documents were not received during the transfer of the Baileys file from The Connection.



In September 2017, Alex M. was approved by DCF and Wheeler Clinic to be placed in the Bailey foster home after several meetings with Alex, his treatment team and the Bailey family. A DCF case plan review (ACR) for Alex held in December 2017 notes the placement is a “Strength.”

Youth moved from [group home] setting to [Family and Community Ties home] in the town of origin. [Wheeler Clinician] stated she is not required to do monthly reports,<sup>21</sup> but [DCF social worker] asked for a monthly update anyways and she agreed to do this. The family is a two-parent family who appears very loving and welcoming of youth in their home. He reportedly wants to stay in this home. Since the placement is somewhat new, continued supports are needed and the family feels supported by DCF and [Wheeler]. Clinician reported youth is always respectful to foster parents.

As the Case Plan for Alex would be focused, per policy, on him and his adaptation to the placement, and given the lapse of time (more than 6 months) from the last investigation of the Bailey foster home, the DCF case plan (ACR) document does not contain a reference to the 2015 or 2017 allegations regarding drinking or the prior safety agreements regarding drinking. In addition, Alex’s DCF social work team was reportedly *not aware* of this history.

Wheeler staff that visited the home at least weekly did not observe or document any concerns about substance use. OCA notes that the agency staff turned over multiple times during Alex’s tenure in the home. However, despite the turnover in direct clinical staff, the Wheeler Clinical Supervisor remained consistent and was not made aware of any historical concerns/observations about Mr. Bailey’s drinking. During discussions with OCA, DCF noted that Mrs. Bailey provided most of the parental care in the home, and that based on their experience, it is not uncommon for professionals assigned to support or monitor a foster home to gravitate and engage more with the primary parent, often the mother.

**September 30, 2019, Alex Medina was Critically Injured in a Car Crash: Mr. Bailey, the driver of the car was allegedly intoxicated at the time of the crash.**

According to a DCF Special Investigations Unit Report, Mr. Bailey stated that Alex called him from school asking to be picked up approximately two hours after he arrived at school by bus because he wasn’t feeling well. Mr. Bailey reportedly told his wife that he was leaving, and their family friend went along for the ride. Mr. Bailey noticed that Alex was walking down the street about a half mile away from school, so he picked him up and turned around to drive back home. Mr. Bailey was reported to have driven the car off the road, hitting a telephone pole. Alex was ejected from the vehicle and hit a second telephone pole. Alex was transported to Hartford Hospital via Life Star helicopter in critical condition. He was placed on life support for three days and died from a brain injury on October 3, 2019. Mr. Bailey was reported to be driving under the influence and was charged with Assault 2<sup>nd</sup> with a motor vehicle, reckless endangerment and reckless driving.

A second youth, “Nathan,” had been placed in the Bailey home a few months before the car crash. During the DCF investigation regarding Alex’s death, Nathan disclosed that Mr. Bailey drank and often slept and drank on the sun porch. He said the Baileys went to the casino often (he and Alex would play video games in the lobby) and the day before Alex’s death they went to the casino. Mrs. Bailey had to wake Mr. Bailey up to go the casino because he was so drunk and was “acting crazy.”

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<sup>21</sup> Wheeler clinician is referring to requirements in DCF’s “Scope of Service” (contract) with the agency.



Nathan reported that the foster parents got into an argument because of this. Nathan reported that this type of incident had happened a few times since he had been at the home (about two and a half months). Nathan, who was identified in DCF records as having Borderline Intellectual Functioning, was unsure of the difference between hard alcohol and beer and was also unsure if someone could get drunk off beer alone.

**While Alex’s State-Appointed Lawyer/s Had Phone Contact with Him, State Records Do Not Reflect That Alex Was Visited In-Person During 2019 or that Lawyer/s Participated in His Treatment Plan Meetings.**

All children for whom a neglect petition is filed have a statutory right to counsel to advocate for them. Pursuant to state law, counsel is obligated to provide client-directed representation in accordance with the Rules for Professional Conduct for attorneys,<sup>22</sup> and Public Defender performance guidelines for lawyers representing children require that lawyers visit their child client at least quarterly, and whenever a child’s placement changes. While lawyers are paid only a flat fee (\$500) for the life of a child protection case which may extend for years, they are permitted to bill hourly for a limited number of activities conducted on behalf of their child client, including participation in treatment plan meetings and visits with the client, including visits to the foster home.

OCA sought billing records from the Public Defender’s Office corresponding to foster home visits and treatment plan meeting participation for Alex Medina between 2017 and Alex’s death in 2019. Alex had two lawyers while living with the Baileys as his first lawyer retired and was replaced in 2018. The Public Defender’s Office reported to OCA that there was one billing entry for a visit with Alex on August 24, 2018, almost a year after he moved into the Bailey home. There were no billing entries for visits with Alex in 2019. There were no billing entries by either lawyer for participation in Alex’s treatment plan meetings.<sup>23</sup> OCA confirmed with DCF that Alex’s newly appointed lawyer in 2019 did not receive notification of Alex’s treatment plan meeting in the Spring of 2019 as the DCF record still had the former lawyer listed for notification purposes.<sup>24</sup>

Upon further inquiry by OCA with the Public Defender’s Office about counsel’s contact with Alex, the following additional information was provided:

[Alex’s attorney] reported that he spoke with Alex shortly after he was appointed [to represent him] on 1/18/19 and [he] reviewed all the DCF records, etc. Alex expressed his desire to remain in the foster home (without an adoption) and to continue maintaining contact with his biological family. Alex expressed no concerns in the foster home. [Alex’s lawyer] also spoke with Alex again in advance of his permanency hearing, and Alex confirmed again that he still wished to remain in the foster home with no issues or concerns reported. Alex’s plan was to stay in DCF care post-18 so they could assist him with independent living and transitional services. Given that [Alex’s lawyer] was unaware of any prior concerns about the foster father, and Alex

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<sup>22</sup> Conn. Gen. Stat. Sec. 46b-129a.

<sup>23</sup> Billing records do not necessarily reflect all contact between a lawyer and client.

<sup>24</sup> According to DCF Legal, it is the child’s assigned social worker’s role to update the contact information in the child’s record, and that this record is used by the agency for treatment plan notifications.

consistently reported no concerns, his meetings with him were via phone versus in-person.

While it is not uncommon for lawyers to engage child clients, particularly older children, by phone, Public Defender Performance Guidelines require that lawyers for child “visit with the client in person at least four times a year and whenever the placement is changed.” Counsel is also advised to “interview the caregiver and other family members or staff in any placement.”

### **About Alex**

Alex was a seventeen-year-old Hispanic/Caucasian male, and the second child born to his parents of a sibling group of three. Alex did not have a consistent relationship with his father but maintained some contact with his mother. Alex identified his maternal aunt and older brother as strong systems of support and maintained regular contact with them. Alex entered the DCF foster care system after the death of his maternal grandmother and maternal grandfather (2013 and 2014 respectively). Alex’s parents’ rights were terminated in August 2015.

With an extensive history of loss, grief and disrupted attachments, Alex was adamant that he did not want to be adopted but wanted to remain in his last foster home. Alex resided in three non-relative foster homes from 2013-2016, a specialized residential program in 2016 and then a therapeutic group home from until his placement with the Baileys in September 2017.

According to DCF records, “In the summer of 2018, Alexander was accepted into the UCONN STARS program which provides academic and college readiness programs to high school students in foster care. Alexander’s brother, [ ], had enjoyed the program when he was in DCF care which encouraged Alexander to participate.” Although Alex had trouble adjusting to the program, according to DCF, the Baileys actively supported him, calling him regularly and encouraging him. Alex attended the UCONN STARS program again in the summer of 2019, winning an award for improved study skills. After completing the program, Alex returned to high school in the fall where he considered trying out for the basketball team.

Per DCF records, Alex’s placement with the Baileys was his longest placement since his entry into foster care and “he was cognizant about the significance of time and his desire to maintain the placement. It became apparent ... that he appeared cautious about sharing any troubling information about the family although there were multiple occasions of tension in the home.” After his death, Alex’s relative disclosed to DCF investigator/s that Alex had confided in her about Mr. Bailey’s drinking, and she talked to Alex about notifying the DCF worker but Alex told her not to.

### **SYSTEM ISSUES AND RECOMMENDATIONS**

- I. DDS Must Ensure All Information Material to The Health and Safety of Consumers Is Documented in Its Case Records and Licensing Records.

OCA found that serious concerns developed by DDS staff and a young adult client living in the Bailey home regarding Mr. Bailey’s drinking lived only in staff emails and were not made a part of the Bailey’s permanent record. OCA found that DDS does not have an electronic licensing record that stores case-worker field notes and electronic communications. Accordingly, when the Baileys subsequently applied to become a DCF foster parent, the DDS licensing record obtained by the DCF-contracted

foster care agency did not contain material information regarding the Baileys' capacity to provide safe and appropriate care.

Though DDS expressed caution to OCA about documenting concerns and observations that it could not necessarily prove, OCA finds that DDS must take steps to adequately assess and investigate concerns, and that DDS has an obligation to record its observations and findings about any licensed entity. While best practice and due process require that prior to taking a licensing action the licensee receive notice of any concern and be afforded a chance to respond, state agencies must be required to document any and all health and safety observations about a prospective or actual license holder who is caring for or seeking to care for a child or vulnerable adult.

It is alarming that a state agency determined it would never place another vulnerable client in a licensed home due to concerns about adult substance abuse, honesty, and caregiver judgment, leave that license in good standing, and witness a sister state agency license the same home to care for disabled and even non-verbal children. OCA disagrees with DDS's assertion during this review that it exhausted avenues to alert DCF to concerns about the Baileys. Moreover, DDS should have had a clear and comprehensive record that outlined staff's observations, concerns, and conclusions about the appropriateness of the foster home.

In general, the lack of a clear and shareable record of home visits, field visits, and concerns that arise through DDS's monitoring and client-related activities, hampers the ability of supervisors and staff at DDS and at other agencies to ensure the needs of vulnerable adults and children are met.

OCA recommends that DDS immediately adopt policies and protocols and an information management system that supports comprehensive electronic documentation regarding all of its activities monitoring the safety and appropriateness of their licensed providers.

## II. DDS Staff Must be Trained to Identify, Report and Investigate All Possible Areas of Consumer Abuse and Neglect

OCA found that during the Baileys' licensing tenure with DDS, concerns arose regarding not only Mr. Bailey's drinking, but his possible emotional abuse of the young adult consumer in the home, and possible spousal abuse. However, the one DDS investigation conducted of the Baileys in 2011 did not pursue the allegations of excessive drinking or spousal abuse. Despite the young adult's family's concerns about conditions in the home, the DDS investigator did not outreach to them, and the young adult was not questioned about Mr. Bailey's alcohol use. Accordingly, the investigation made no findings regarding Mr. Bailey's drinking, though the investigator did recommend that DDS conduct unannounced visits going forward.

OCA shared its concerns about the narrow scope of the Bailey investigation with DDS administrators. DDS acknowledged the need to ensure that all its investigators, largely comprised of law enforcement professionals, are fully trained about the agency's operational definitions, and corresponding guidance, including scenarios, pertaining to abuse and neglect.

OCA also reviewed with DDS its finding that the young adult's allegation that Mr. Bailey drinks and drives and therefore no one should be placed with him (a recommendation that DDS concurred with) was required to be immediately reported as suspected abuse/neglect and investigated. Ultimately, in

an interview with OCA, DDS administrators agreed that the young man's allegations should have been subject to additional review and likely reported and investigated.

Overall, OCA's discussions with DDS administrators and OCA's findings regarding record-keeping and oversight of licensed homes lead to our conclusion that more work may need to be done to ensure DDS's compliance with state laws regarding reporting and investigation of suspected abuse and neglect of vulnerable adults.

OCA incorporates by reference a 2016 report from the U.S. Health and Human Services Inspector General regarding DDS, which found:

[DDS did] not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents [involving DDS clients] because staff at DDS and group homes lacked adequate training to correctly identify and report critical incidents and reasonable suspicions of abuse and neglect, DDS staff did not always follow procedures, DDS staff lacked access to Medicaid claims data, and DDS did not establish clear definitions and examples of potential abuse or neglect.<sup>25</sup>

The HHS Inspector General report recommended:

[DSS] work with DDS to develop and provide training for staff of DDS and group homes on how to identify and report critical incidents and reasonable suspicions of abuse or neglect, ... and work with DDS to update DDS policies and procedures to clearly define and provide examples of potential abuse or neglect that must be reported."<sup>26</sup>

While DDS shared updated training manuals with OCA, OCA recommends oversight by the legislature's Public Health and Human Services Committees to ensure that the concerns articulated by the HHS Inspector General as to DDS and DSS have been thoroughly and sustainably remedied.

### III. The State Must Ensure that Agencies Request and Receive Complete Licensing Records Regarding An Applicant for a Custodial Care License.

After DDS decided to stop placing any clients in the Bailey home, the Baileys immediately sought licensure as DCF foster care providers. State law does not currently require that a prior public or private agency's licensing/monitoring record be obtained as part of the licensing application and review process either by DCF itself or one of its contracted foster care agencies. And DDS had an incomplete record to share, one that did not include material information regarding the Baileys' capacity to provide safe and appropriate care.

While OCA found that a DDS manager tried to convey via a phone call with DCF's contracted child placing agency that there had been concerns regarding Mr. Bailey, the lack of a clear and comprehensive record hampered this critical information-sharing process. Additionally, DDS erroneously predicated sharing its full concerns about Mr. Baileys' drinking on the production of a signed and comprehensive release that would have specifically authorized the release of information about alcohol and drug use, a release that neither DCF nor its contracted agency would have known

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<sup>25</sup> <https://oig.hhs.gov/oas/reports/region1/11400002.pdf>

<sup>26</sup> Id.

was needed. During this review, DDS did not provide OCA with any state or federal statutory provision that precludes the agency from sharing material information with another licensing agency.

OCA recommends that both DDS and DCF urgently review their protocols regarding record-acquisition and record-sharing and that state law be amended to ensure that all information relevant to an assessment of a licensee or prospective licensee's capacity to provide safe and appropriate care are documented and shared with other state and, where applicable, contracted licensing agencies.

#### IV. DCF Should Standardize What Contracted Foster Care Agencies are Required to Obtain and Share Regarding Prospective/Licensed Homes.

OCA and DCF (in its internal review of Alex's death) found that there is a lack of clarity regarding what information DCF-contracted foster care agencies must obtain and share regarding prospective/licensed homes.<sup>27</sup> In this case, when the Baileys moved from The Connection, Inc. to Wheeler Clinic in 2017, Wheeler stated that it did not receive copies of either Safety/Service agreement signed by the family about Mr. Bailey's drinking. Wheeler also did not receive (or request) a full copy of DCF's 2015 investigation of Mr. Bailey's alleged mid-morning intoxication during a nurse's home visit. Providers are typically given a summary of the report finding, which in this case included the information that abuse/neglect was not substantiated against Mr. Bailey. The full report would have additional information about the allegations, the agency's investigative activities, and interviews with the complainant and other collateral witnesses, all of which would have informed Wheeler regarding its licensing assessment and any targeted monitoring needed of the home.

OCA recommends that DCF, and where applicable, DDS, ensure that their contracted community providers access complete licensing and investigation/regulatory histories from any previous licensing agencies, public or private, to inform home studies, licensing recommendations, and monitoring of licensed homes. Applicants must be specifically asked whether they have been accused of abuse/neglect in any jurisdiction that has granted them a custodial license.

#### V. Contracted Foster Care Agencies Standardized Home Visits/Walk-Throughs Must Address Matters Specific to the Licensed Home and Alcohol/Substance Storage

OCA found that the monthly walk-through forms documenting routine foster home visits conducted by The Connection did not include reference to alcohol or other substance use/storage. The standard form continued to be used even after the Safety Agreements regarding Mr. Bailey's alcohol use were signed.

OCA recommends that monthly walk-throughs be tailored to items that are individualized to that license and include specific reference to any previous issues, needs, or concerns that have been identified to ensure that they are systematically addressed. DCF may also want to consider adding to the private agencies' routine inspections, like its standard assessment of an infant's sleep environment, an assessment of the use and storage of substances in the household, particularly in the wake of the legalization of marijuana and the challenges created by various and sometimes child-friendly packaging. Certain children in therapeutic foster care have histories of substance use or misuse, and

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<sup>27</sup> DCF reported that "contracts can be made more explicit in the [Therapeutic Foster Care] procurement currently underway."

issues regarding substance/medication use in the foster home should be routinely processed with adult caregivers.

- VI. DCF Should Revise its Treatment Plan Review Protocols to Ensure That Any Concerns Raised of Suspected Abuse/Neglect and Any Safety or Service Agreements Involving a Foster Home are Documented and Reviewed.

State and federal law require that DCF conduct an Administrative Case Review (ACR) every six months for each child in foster care. The ACR, facilitated by a supervisory worker, is required to make findings regarding DCF's efforts to ensure the health, safety, permanency, and wellbeing of the child. Per agency policy, the ACR process is required to review any substantiations regarding the child's placement that occurred in the previous six months. The ACR process is not specifically required to document all concerns called into the DCF Careline about a child's caregiver, or that led to a DCF service or safety agreement with the foster care provider.

OCA found that multiple ACRs for other children placed in the Bailey home did not document the contemporaneous investigations regarding the Baileys, or the safety agreements entered into with the Baileys. The ACR process is an important safeguard, and all participants should be aware of issues that materially bear on the health and safety of the child.

OCA recommends that DCF revise its ACR protocols to ensure that any concerns raised regarding suspected abuse/neglect and any safety or service agreements within a set period involving a foster home are documented and reviewed.

- VII. DCF Should Ensure That a Child's Social Work Team Review any Prior Concerns About a Prospective Foster Parent Prior to a Child's Placement in the Home.

OCA and DCF both found that Alex's social work team at DCF was unaware of prior investigations into the Bailey home and safety agreements regarding Mr. Bailey's drinking prior to Alex's placement in the Bailey home, nor is such a review required by agency policy. DCF noted to OCA that "caseload carrying staff would have expected [the foster care licensing unit] or the therapeutic foster care agency to have assessed concerns in the record before matching Alex to this home." DCF also found that Alex may have shared observations of Mr. Bailey's drinking with a family member but that he did not want any concerns reported due to fear of being removed from the Bailey home and having to start over again in a new placement. There are many reasons that a child may be unwilling or unable to report concerns about a foster home or other licensed care provider: fear of being removed, fear of not being believed, fear of retaliation.

OCA recommends that all relevant staff at DCF and (where applicable) the contracted foster care agency be aware of concerns, previous and current, about a child's foster home. The information allows the social work staff to tailor their monitoring of the home and determine what questions they may want to ask the child during visits, where such visits need to occur, and what questions to ask other stakeholders. DCF reported to OCA that integration of information and communication between the DCF child protective services and licensing divisions has been a continual focus in recent years to incorporate multiple perspectives on safety and wellbeing.

- VIII. The Legislature Should Review the Adequacy of Resources to Support Robust Legal Representation for Indigent Parents and Children in Child Protection Proceedings

OCA found that Alex was represented by two lawyers during his time in foster care, and while he had some contact with his lawyers, he was not visited in accordance with state guidelines or contractual expectations. State agency performance guidelines for lawyers representing children, referenced in state contracts with lawyers, outline expectations of quarterly visits with clients and whenever a child's placement changes.<sup>28</sup> While Alex was living with the Baileys, state billing records indicate that he received only one in-person visit with his lawyer between September 2017 and his death in November 2019, though his lawyer had multiple phone calls with him during 2019.<sup>29</sup> Given that Alex's social work team was not aware of prior concerns about Mr. Bailey's drinking, Alex's lawyer would also not have been on notice that this was a concern s/he needed to review further.

Notwithstanding the lawyer's professional and/or contractual obligation to conduct visits, OCA still finds that the current payment and fee structure for lawyers (a flat fee of \$500 for the life of a child protection case with a brief schedule of billable activities) is not adequate to support the scope of lawyers' responsibilities on behalf of children and the need and right of children to legal representation.

OCA recommends that the legislature review the adequacy of currently allocated resources to support a system of representation for both indigent parents and all children in abuse/neglect proceedings. Lawyers are an essential and irreplaceable safeguard for children living in the care and custody of the state. While the state agency guidelines and statutory expectations for lawyers who represent children are laudable, resources must support the realization of those requirements. Resources could include federal Title IV-E revenue and/or increasing the flat and hourly rates for attorneys.

IX. DCF's Statutorily Required Reports to the Juvenile Court Should Address Concerns of Suspected Abuse/Neglect of a Child in Placement and Any Safety Agreements with Designated or Licensed Caregivers.

The Superior Court for Juvenile Matters has jurisdiction over child protection cases involving children alleged or found to be abused or neglected. The Court is statutorily authorized and directed to make a number of determinations as to the child's safety and well-being,<sup>30</sup> and The Court relies, in part, on information provided to it by DCF as well as the lawyers for the child and parent/s. Current state law, amended by Public Act 17-92, requires that if a child is placed in foster care, DCF must include in any report to the Juvenile Court information regarding "the safety and suitability of such child or youth's placement," as well as other material information about the child's health, education, and general wellbeing.<sup>31</sup> The statute also requires that DCF submit this information to the court not later than 90 days after the child is placed in out-of-home care, if the child's placement changes, and whenever DCF files a permanency plan on behalf of a child.

OCA recommends that state law specify that the information provided by DCF to the Court include any contemporaneous reports of suspected abuse or neglect of a child in placement, the resolution of

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<sup>28</sup> For very young children, visitation requirements are heightened.

<sup>29</sup> Billing records may not reflect all contact between a lawyer and a client.

<sup>30</sup> Conn. Gen. Stat. Sec. 46b-129.

<sup>31</sup> See. Conn. Gen. Stat. Sec. 46b-129(t). Public Act 17-92 was enacted following an OCA investigative report regarding the profound abuse of a young child in DCF foster care. OCA found that while DCF had escalating and accumulating concerns about the child's foster home, no information about these concerns was shared with the Court.



such concerns, any corresponding regulatory concerns or findings made regarding a child's foster home or placement, and any Safety Agreements or Service Agreements entered into with a licensed or designated provider. It is essential that the Court and the parties, including their lawyers, have all material information about the safety and wellbeing of a child subject to the Court's jurisdiction.

Please do not hesitate to contact me at any time with any questions, concerns, or comments about the findings and recommendations contained herein. If your agency has a summary of activities undertaken that are responsive to these Findings, please send them to our attention so that we may attach to this letter for final publication.

Sincerely,

Sarah Healy Eagan  
Child Advocate, State of Connecticut

**Cc:** Christine Rapillo, Chief Public Defender