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Vannessa Dorantes, LMSW
Commissioner
Department of Children and Families
Sent Electronically

Re: PUBLIC FINDINGS LETTER
OCA Review of Critical Incidents Involving Children, including the Death of Kaylee S.
OCA Recommendations for Fatality Prevention, Transparency, and Accountability

Dear Commissioner Dorantes:

This final Findings Letter follows OCA's review of certain fatalities and near fatalities of children involved with the Department of Children and Families (DCF), including Kaylee S., a baby who died from fentanyl intoxication in February 2022 and whose death was recently reported by several media outlets. With the legislative session underway, policymakers will be considering needed investments and system reform for children. In fulfillment of our statutory responsibilities to evaluate publicly funded services to vulnerable children and to report regarding the rates and causes of child deaths in the state, OCA is issuing this Findings Letter which contains:

1) An outline of the responsibilities and child death reviews conducted by the OCA;
2) A summary of DCF and OCA critical incident reviews, including findings regarding the death of baby Kaylee;
3) OCA's findings regarding DCF's Safety Practice in open cases; and,
4) OCA's recommendations for child fatality prevention and progress monitoring of our child welfare system.

OCA provided a draft of this Public Findings Letter to DCF on February 6th and met with DCF administration on two occasions to review and discuss contents. Discussions were substantive. No written response was provided for inclusion in this final public document.

Multiple critical incident reviews from 2021 to the present, including the death of Kaylee S. (outlined below), raised concerns for OCA regarding the lack of consistency in DCF's assessment and management of family risk and child safety concerns, including timely connection of caregivers to appropriate services. Given these observations, OCA requested information from DCF regarding its case reviews and the quality assurance measures it has in place to assess and improve the agency's "safety practice."

DCF has since taken steps to clarify and strengthen practice expectations for staff, including distribution of memos and trainings on Safety Planning and fentanyl. DCF recently met with its contracted providers to also discuss its safety practice model and expectations for service providers. Acknowledging these efforts, however, DCF has not yet demonstrated adequate quality assurance to determine whether identified deficiencies regarding safety planning and service delivery are being remedied. Additionally, there remains no framework for routine public reporting by the agency and no articulated plan for transparency and accountability by the agency: namely, how DCF will report on its critical incident reviews, service gaps, safety practices, or many other core practices and agency findings—critically important as DCF completed class-action driven federal court oversight almost one year ago. OCA recommends several reforms to support child injury prevention, examine services for high need caregivers, and create transparency and accountability for the state's child welfare system.

OCA agrees that children should remain in their homes with family whenever possible, necessitating effective management of child protection concerns, including the timely provision of supports and treatment interventions to caregivers. Cases like baby Kaylee's that involve findings of parental abuse or neglect of a very young child, and elevated risk or safety factors, are some of the most challenging that DCF manages. Inconsistencies in practice or lack of access to needed services increase the risk for poor, or even catastrophic outcomes, including preventable injuries, or unnecessary and traumatic removals of children into foster care. Keeping young children safely home with their parents requires vigilant attention to assessments, effective safety planning, and timely service delivery to these high-need families.

OCA Oversight and Child Fatality Responsibilities

Pursuant to Conn. Gen. Stat. § 46a-13*l* et seq., OCA is directed to "evaluate the delivery of services to children by state agencies … review complaints of persons concerning the actions of any state or municipal agency providing services to children … investigate those where the Child Advocate determines that a child or family may be in need of assistance … or that a systemic issue in the state's provision of services to children is raised by the complaint, [and] … Upon request of two-thirds of the members of the [state's Child Fatality Review] panel and within available appropriations, the Governor, the General Assembly or at the Child Advocate's discretion, the Child Advocate shall conduct an in-depth investigation and review and issue a report with recommendations on the death or critical incident of a child." OCA is also directed to "recommend changes in state policies concerning children including changes in the system of providing juvenile justice, childcare, foster care and treatment."

OCA is also obligated, in consultation with the state's Child Fatality Review Panel, to study "the causes and rates of child fatalities in the state," and issue an annual report to the legislature.[1] To that end, OCA receives notice of every sudden and unexpected child death that comes under the jurisdiction of the Medical Examiner. These deaths are typically found by the Medical Examiner to result from preventable causes: Accident, Homicide, Suicide, and Undetermined.[2] OCA reviews the cause and manner of each death as these findings are made by the Medical Examiner, and the circumstances leading to these deaths. OCA shares this information with the state's Child Fatality Review Panel[3] and outside stakeholder groups, and OCA issues an annual public report on rates and manner of preventable child deaths. Where directed or where resources permit, and in accordance with state law, OCA publishes public health alerts and individual investigative reports regarding circumstances leading to the death of a child in state custody or under state supervision.[4]

OCA is Reviewing the Preventable Deaths of Infants and Toddlers over a Recent Three-Year Period—24 Percent of Families Had Recent or Active DCF Involvement

The OCA is conducting an in-depth review of unexpected and preventable infant and toddler fatalities during a recent three-year period, including 8 deaths of young children from fentanyl intoxication. The OCA is reviewing data from across child and family serving state agencies to learn more about the needs of children who died from preventable causes, and to develop systemic recommendations for child fatality prevention. The infant-toddler death review will be completed later in the Spring of 2023.

Relevant to this Findings Letter, the OCA determined that in the case of the 99 infants and toddlers whose deaths were reviewed by the Office of the Chief Medical Examiner and the Child Fatality Review Panel during the three-year period, 24 percent of the children's families had an open case with DCF at the time of the child's death or within the previous 12 months. This is relevant to child fatality and injury prevention work because widely cited research found that children "with a prior allegation of maltreatment died from intentional injuries at a rate that was 5.9 times greater than unreported children and died from unintentional injuries at twice the rate of unreported children. A prior allegation to [Child Protective Services] proved to be the strongest independent risk factor for injury mortality before the age of 5."[5]

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[1] Conn. Gen. Stat. 46a-13s.

[2] "Undetermined" is a manner of death found by the Medical Examiner when there is no clear medical cause or injury, and the death is not from natural causes. Undetermined deaths are most frequently associated with an unsafe sleep environment for infants under 6 months of age (e.g., bed sharing, sleeping prone, sleeping with pillows and blankets, couch sleeping).

[3] Conn. Gen. Stat. 46a-13l provides that "c) The panel shall review the circumstances of the death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state."

[4] Fatality reports issued by the Office of the Child Advocate can be found on the state website. https://portal.ct.gov/OCA/Reports-and-Investigations/Fatality-Investigations/OCA-Fatality-Reports. OCA is not currently directed to issue individual reports regarding every fatality or near fatality of a child due to child abuse or neglect.

[5] Putnam-Hornstein, E. (2011). Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study. *Child Maltreatment*, *16*(3), 163–174. https://doi.org/10.1177/1077559511411179. This research

DCF's Framework for "Safety Practice" with Young Children

Given the paramount role that DCF plays in ensuring the safety[6] and wellbeing of children who have been abused and neglected, the OCA has specifically examined "critical incidents," including fatalities, involving young children whose families were under active or recent DCF supervision at the time of the child's death. The OCA reviewed DCF practices regarding "safety planning" for children.

DCF Safety Planning and Case Planning—Agency Policies

Pursuant to DCF Policy,[7] where a safety factor is identified, such as a non-accidental injury to a child by a caregiver, or parental substance abuse that impairs the ability of the caregiver to safely meet the needs of a child, DCF staff must work with the family and providers to "identify strategies and interventions that can be implemented immediately to safeguard the children and mitigate the safety factor(s). The interventions shall be documented in the DCF-2180, 'Safety Plan.'" DCF policy further requires that the Plan be reviewed with a Social Work Supervisor, and "when appropriate," the Program Manager, prior to Plan approval. Policy states that where "no interventions are available that can provide appropriate protection for the children, removal shall be actively pursued."

DCF Policy states that "all Safety Plans shall be reviewed and monitored closely to ensure that the planned interventions are effective in mitigating the safety factors and that the parties are following through and cooperating. Interventions may be modified as necessary to ensure the child's continued safety. Modifications require the development of a new Safety Plan. If the Safety Plan is not effective in mitigating the safety factors, the child shall be considered 'unsafe' and removed from the home."

DCF Policy 23-2 (revised/effective Jan. 2, 2019) provides that "family case plans may be developed for all families with an open case in ongoing services." The plan contains the reasons for DCF's involvement, the needs of the children and caregivers, and the services that will be provided to the family to address those needs. Policy further provides that "[w]hen a parent is not in compliance with Case Plan requirements, the Ongoing Social Work Supervisor shall consult with Ongoing Program Supervisor, the Area Office Attorney or Assistant Attorney General and [Regional Resource Group]

examined both general maltreatment allegations as a risk factor and physical maltreatment to a particular child as a risk factor for future maltreatment-related fatality, with prior physical maltreatment presenting the highest risk factor for a subsequent fatality to a young child.

[6] Safety v Risk Safety and risk are not interchangeable terms. Safety applies to the need for action based on an immediate threat of harm (i.e., serious or impending danger) to the child. Risk refers to the likelihood of future maltreatment, even when immediate safety threats are not present, and is presented on a continuum from low to high. Safety assessment differs from risk assessment in that the safety assessment assesses the imminent danger of serious harm to the child and the interventions needed to protect the child. In contrast, risk assessment looks at the likelihood of any future CPS involvement related to abuse or neglect concerns. The risk assessment is based on research of abuse/neglect cases that examined the relationships between family characteristics and the outcomes of subsequent substantiations of abuse and neglect. The assessment does not predict recurrence; it simply assesses whether a family is more or less likely to have another abuse/neglect incident without CPS intervention. The risk assessment is composed of items that demonstrate a strong statistical relationship with future child abuse or neglect. DCF Safety Memo, August 2022.

[7] DCF Policy 22-2-2 (revised Feb. 2021).

members as appropriate, to determine if a neglect petition should be filed in Superior Court for Juvenile Matters."[8]

DCF Internal Review of Safety Practice Identifies Case Practice

Relevant to the practice deficiencies later identified in baby Kaylee's case, in March 2022, DCF conducted a sampling review of cases that involved Safety Plans. DCF's review identified several case practice concerns including:

- Inadequate safety plans for children;
- Inadequate documentation regarding safety plans in the case record; and
- Inadequate or lack of documentation regarding supervision/monitoring of safety planning.

DCF reported to OCA in June 2022 that it would conduct ongoing structured case reviews to monitor improvements in this core practice area. Completion of this work and development or publication of DCF findings is delayed.

Child Death and Critical Incident Reviews, Including Baby Kaylee's, Identified Case Practice and System Concerns

OCA and DCF both examine child fatalities and near fatalities of DCF-involved children. DCF's practice is to conduct internal child death reviews following the death or critical injury of certain children whose cases were actively supervised by DCF at the time of death, or whose case with DCF was recently closed. DCF's "Special Qualitative Reviews" (SQR) outline what happened in a case prior to a child's death, deviations from policy, Case Practice Concerns, Areas for Improvement, and Systems Recommendations. Per DCF's letter to OCA, January 2023:

> Themes from the reviews are provided to the SQR governance; a body of staff from the area offices and various divisions, in order to prioritize any systemic gaps or areas needing improvement. Since this process has been implemented 12 SQRs have been completed (plus the Alex [Medina] report) and summary report sent to the OCA. SQRs will continue to be sent as completed.[10]

[8] Id. The Regional Resource Group is comprised of DCF employees with various subject matter expertise across substance use, interpersonal violence, behavioral health, nursing, and education. They are utilized to support safety and case planning as needed or as required by agency policy.

[10] Letter from Commissioner Vannessa Dorantes to OCA, January 9, 2023. DCF adopted a more structured child death review format in the last few years based on guidance from the National Partnership on Child Safety. The National Partnership for Child Safety promotes the value of "information-sharing, education, and communication approaches with key community partners related to child protection services and critical incidents, including child maltreatment fatalities." https://nationalpartnershipchildsafety.org; Letter from Commissioner Vannessa Dorantes to the OCA, January 10, 2023, on file with OCA. DCF recently reported that after receiving OCA's requests for completed SQRS, it reviewed its database and "realized the need for standardization and coordination with the information produced for the National Partnership on Child Safety."

Multiple DCF SQRs conducted over the last year outlined DCF reviewers' concerns with risk assessment, safety planning and/or safety monitoring, including DCF's review of the death of baby Kaylee S. from fentanyl intoxication in February 2022. It is important to state that because OCA or DCF reviewers identify case practice deficiencies does not mean that these concerns are a proximate cause of the child's subsequent injury or death but rather an indication of areas that the agency needs to focus attention on going forward.

Near Fatality of Baby B., a 1-year-old child, from fentanyl intoxication. B's case was open with DCF at the time of the overdose. B had received no prenatal care and had been exposed prenatally to heroin and fentanyl. B went to live with a relative under a DCF safety plan/family arrangement. The safety plan included expectations that B's mother would not be alone with the baby and that B's father could not visit the home. Baby B. reportedly overdosed on fentanyl while visiting with his mother at the relative's home. DCF internally identified concerns regarding the prolonged duration of the Safety Plan, and the lack of adequate monitoring of the Plan which remained in place for 7 ½ months with no reviews. DCF reviewers identified concerns regarding adequacy of support for family caregivers and availability of intensive in-home treatment services for families with substance use disorder.

Death of Baby P. P is an infant who died due to complications from an infection while in the custody of his parent shortly after DCF closed his family's case. DCF had opened an investigation after a community provider reported a concern that the father arrived at the program while on his way to drive a young child to school; and that father presented as under the influence and belligerent and admitted to using fentanyl and marijuana prior to his arrival with his four-year-old son. Despite documenting substantial concerns regarding ongoing parental substance use, impaired parental judgment, and child safety, DCF closed the case at the end of the investigation, with no documented improvement in the family's situation, and with a safety plan directed to the family that father, who lives with mother[9], would not be unsupervised with the children. DCF reviewers, as well as the OCA, found that the concerns identified by DCF staff were "not mitigated prior to closing the case," no legal consult was sought, no DCF clinical consult, and no evaluations conducted. There was no documented consideration of the father's relevant criminal history, including recent charges for assault, reckless endangerment, and driving under the influence. DCF reviewers concluded that staff are "challenged with developing plans that mitigate safety concerns" absent clear safety planning policies. DCF and OCA reviewers also identified concerns regarding the availability and/or utilization of intensive in-home services for this family and other families with substance use disorder, with DCF reviewers noting that "[drug] testing for fentanyl is not always

[9] At the time, there was a court-ordered partial protective order in place.

widely available," thereby presenting additional challenges. P's death was subsequently determined to be the result of heart inflammation, secondary to infection. DCF did substantiate physical neglect due to unsafe environment and placed both parents on the central registry.

The Death of Baby Kaylee S., 2022 (OCA Review)

On February 8, 2022, baby Kaylee, 1 year old, died while under the care and supervision of her family. The Office of the Chief Medical Examiner later determined that Kaylee died from ingestion of fentanyl, a synthetic opiate, and xylazine, an animal tranquilizer. Her family's case had been open with DCF since August 2021 due to reported concerns of physical neglect, when father was found to have left Kaylee and two other children (age 8 and 2) unattended in a vehicle in a public parking lot. Upon response from the police, father was found to be in possession of 20 bags of fentanyl. At that time, DCF opened an investigation into concerns of abuse and neglect of the children.

On August 18, 2021, DCF created a Safety Plan for the family. The Safety Plan for baby Kaylee and her young sibling required the following:

- Kaylee's father would not be in a sole caregiving role for the children;
- Father would not be unsupervised with the children in the home;
- Father will locate a MAT (Medication Assisted Treatment) or Suboxone provider;
- Father will not use substances in the home;
- Father will not be under the influence of substances in the home.

The DCF Case Plan stated that Kaylee's mother and another relative were the "identified parties to supervise father with the children." The parents lived together. DCF substantiated allegations of Physical Neglect by father, and the case was transferred from DCF's Investigations Unit to Ongoing Treatment. No petitions were filed with the Juvenile Court and no internal legal review was sought.

The DCF Case Plan from November 2021 stated that Kaylee's father was expected to engage with out-patient community substance abuse treatment and drug screens. The Case Plan also stated that "mother has agreed to [an] additional plan to stay with her mother and the children if father continues to use substances." A DCF record in December 2021, stated that if Kaylee's father was not actively engaged in treatment, "[DCF staff is] going to have a legal consult," though no legal consult was pursued prior to Kaylee's death despite DCF's record documenting repeated concerns about father's lack of compliance with the case plan and concerns that he continued to misuse substances, including fentanyl. (DCF Policy requires that case plans *may be* developed, and that where a parent is not in compliance with the plan, a consultation shall be had with the Program Supervisor, an agency attorney or the Assistant Attorney General "as appropriate," to determine if a neglect petition should be filed.)

DCF's last in-person home visit to see the family was December 15, 2021, eight weeks prior to Kaylee's death. On January 5, 2022, DCF staff conferenced the case to "triage" whether risk and safety concerns required in-person visitation, and a determination was made to conduct all subsequent contacts with the family virtually due to concerns about rising COVID-19 infection rates. A note in

the record states that "should any safety factors be identified," the case would be triaged for in person visits immediately.

DCF records in December and January documented persistent concerns about father's compliance with the Case Plan. On January 26th, DCF documented that during its virtual meeting with the parents, father presented as "dysregulated, overly talkative, sweaty, and was unable to maintain conversation on specific topics. Father presented to be under the influence." During this virtual contact, DCF documented that Kaylee's mother communicated "that she thinks father has been using but tries to stay out of it as to not stress him out and so that she does not get him in trouble." A drug screen taken by the father on January 25th was positive for fentanyl.[10]

DCF scheduled another virtual contact for one week later, on February 2. The parents did not show for this meeting. DCF scheduled an announced in person visit for another week later on February 9. Kaylee died on February 8. At no time in December, January, or February did DCF conduct an unannounced visit to the family to monitor the safety plan, assess the capacity of either parent, determine the condition of the home, or assess the safety of the young children in the home. (DCF Policy requires that Safety Plans "be reviewed and monitored closely to ensure that the planned interventions are effective in mitigating the safety factors and that the parties are following through and cooperating. Interventions may be modified as necessary to ensure the child's continued safety." There is no current DCF policy regarding announced versus unannounced visits, though newer staff guidance provides additional direction.)

No in-home treatment supports or parenting supports were in place for the parents and mother's support needs were not well assessed. DCF had not visited the children in person in almost two months. Police investigating the scene after Kaylee's death documented "deplorable" conditions: drug paraphernalia, including needles, small baggies, and pills, and a Naloxone cartridge under Kaylee's pack n play. On November 3 and December 28, 2022, Kaylee's mother and father were arrested and charged with crimes related to her death.

DCF Internally Reviewed It's Work with Kaylee's Family, Finding Numerous Case Practice Concerns

Shortly after Kaylee's death and pursuant to a customary practice initiated by DCF, OCA staff met with the DCF Commissioner and Deputy Commissioner to review the available information regarding the circumstances leading to Kaylee's death. During that meeting, preliminary concerns were discussed by OCA regarding the lack of unannounced or in-person home visits and the lack of a timely response to assess any safety concerns presented by Kaylee's father's ongoing substance use and the home environment. DCF initiated an internal Special Qualitative Review (SQR) to examine the agency's case practice with the family prior to Kaylee's death and identify internal and external system concerns.

[10] Documented in the DCF case record as well as police reports and warrants.

DCF's SQR of Kaylee's death and its work with the family identified a number of what DCF reviewers categorized as "**case practice concerns**," and "**improvement opportunities**,"[11] including a lack of documentation that the Program Supervisor approved or even reviewed the family's Safety Plan, that the Safety Plan was not reviewed with all household members despite DCF requirements for "contact with household members;" the Safety Plan was not reexamined when "father continued to struggle with his use," a legal consult "was not held until following the [death,]" and visitation with the family was "always announced." Reviewers also expressed concern that Kaylee's mother's treatment and support needs were "not fully assessed," and that a prior report to DCF from 2020 alleging substance use and physical neglect of Kaylee was not "attached" to the family's case and was never discussed with the family.

"**Improvement opportunities**" identified internally by DCF included that "Parenting services and the impact of substance use on parenting was not part of [DCF's] service delivery, and [therefore] parent needs went unmet." Reviewers also noted that case record documentation did not reflect that DCF supervisors reviewed or reassessed the safety plan over time or identified "concrete steps to move the case forward." Reviewers also found that the father's "substance use provider was not included in ongoing safety planning" for the children.

DCF's review identified system issues such as the need for a clear, stand-alone "safety planning policy," and greater agency clarity as to "what constitutes a family arrangement," more staff "guidance" regarding the "dangers of poisoning when substances are utilized in the home," and a better "tickler system" to help supervisors track safety plans over time. Finally, also on a systemic level, reviewers concluded that families must have access to timely and effective in-home substance use treatment services.

DCF Public Disclosure Regarding It's Child Fatality Review Findings

In response to inquiries from the media regarding the agency's role with Kaylee's family, DCF confirmed its involvement with the family, providing a written statement:

> The death of this young child places direct focus on the lethality of fentanyl - and other substances intended for adult use - when children are exposed to them.
>
> The Connecticut Department of Children and Families adheres to state law regarding the disclosure of case-specific information as outlined in Conn. Gen. Stat. 17a-28.
>
> What we can share is that this child came to the Agency's attention in August 2021. Since that time, the family received supports from DCF, and community providers, were visible to Agency personnel and household members were

[11] DCF Reviewers also noted multiple practice "strengths," including clear documentation regarding home visits and collateral contacts; ongoing attempts to engage with the father's providers; efforts to reach the older child's father; and consistent supervision.

> engaged in a plan to ensure the safety of both children in the home. Our last contact with the family was less than a week prior to the child's death.
>
> DCF has jointly investigated this incident with Law Enforcement and additional information has been learned about the conditions in the home - not previously known or brought to our attention - until after the fatality.
>
> Over the past 10 months, the Agency has reviewed all aspects of our case practice about this family, conducted two learning forums, and Department leaders have engaged with experts in the substance use field - including sister state agencies- leading to guidance being issued for multidisciplinary Agency personnel on best case practices when fentanyl use is suspected or known in a home where children are present.

DCF's statement did not specifically address the "**case practice concerns**" or "**improvement opportunities**" documented in its internal review of Kaylee's death. DCF's internal reports are not publicly available and there is no requirement or other mechanism in state law or agency practice for disclosing critical incident review findings to the public or policymakers. Similar to DCF, OCA received several requests for information regarding the circumstances leading to Kaylee's death, with individuals seeking more details regarding the supervision and support provided to the family.

In discussion with OCA about the findings in this Letter, and in response to OCA's concerns regarding the material information omitted from DCF's public statements, DCF stated that its public comments on the agency's work with Kaylee and her family were adequate and consistent with the agency's commitment to transparency. Regarding DCF's internal child death review process, in several meetings DCF leaders have told OCA they think an internal review process is essential for fostering a "Safety Culture" which allows for candid discussion with staff. However, given the critical public function that DCF provides, a candid *public* discussion is equally necessary, which requires disclosure and discussion of the agency's general conclusions and recommendations for internal and external system improvement. DCF's demonstration of this capacity and accompanying transparency would support public confidence in the agency's willingness to rigorously review its work and course correct as needed. In discussion regarding this Findings Letter, OCA asserted that a "safety culture" for staff is not incongruous with a commitment to rigorous public disclosure, and DCF principally stated that it is committed to the same goal. A transparent framework for establishing priorities, reviewing performance, and demonstrating sustained improvement over time will serve both the public and the agency. Moreover, the information contained in critical incident and quality assurance reviews is publicly needed to help inform policymakers' priorities and investments in service systems that support vulnerable children and caregivers.[12] A clear plan and state requirement for such transparency is needed.

[12] Nothing in federal or state law precludes disclosure by child welfare agencies about the effectiveness of their own work and resulting recommendations for system improvement. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires state CAPTA plans include assurances that the state "has in effect and is operating a statewide program that includes provisions for the public disclosure of findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality." 42 USC § 5106a(b). HHS ACF Guidance provides that states "develop procedures for the release of information [regarding cases

DCF Actions Following SQR and Other Case Review Findings

DCF has taken certain steps to address concerns identified in Kaylee's SQR and other case reviews: DCF issued a staff memo and conducted trainings and meetings with staff and providers to discuss working with families where fentanyl use is a concern. In August 2022, DCF disseminated new Safety Planning Practice Guidance, stating in a staff-wide memo:

> Child safety is the foundation of our work. It is critical we complete comprehensive assessments and ensure consistency in practice statewide when working with families. As we move forward with implementation of our Child Safety Practice Model, it becomes imperative that we refine and enhance our safety planning practice. In light of several case reviews, it is important we address practice issues that have emerged.

The eleven-page Guidance outlines the purpose of the Safety Assessment, which "assesses the *imminent* danger of serious harm to the child and the interventions needed to protect the child." DCF's Guidance provides detailed direction to staff regarding what must go into a Safety Plan—immediate and actionable supports and interventions—and what should *not* go into a Safety Plan – it "should not include interventions that are promissory in nature (e.g., remain sober, always supervise, stop threatening…) Safety interventions should never rely on parental promises but rather provide an alternate action or a protective third party to assist." (Guidance at 2.) The Safety Plan must specify the "tasks and responsibilities of all persons (parent/caretaker, household/family members, social worker, or other service providers) who have a role in protecting children." The Guidance also outlines the purpose of Family Arrangements to support safety planning, outlines expectations regarding the duration of Safety Plans (generally 30 days), supervisory review, and ongoing monitoring by staff and supervisors, including consideration of both announced and unannounced visits.

Notably, the August Guidance detailed DCF's Quality Assurance Plan (QA Plan) for Safety Planning and Family Arrangements. The QA Plan included requirements regarding logging and "real time tracking" of Safety Plans to "ensure compliance with policy," and the implementation of "Safety Plan Reviews." The latter effort would include a sampling methodology to assess safety planning practice

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of abuse or neglect that result in child fatalities or near fatalities] including, but not limited to: the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; the result of any such investigations; and the services provided by and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality or near fatality." The guidance is clear that states are "not required to provide information to the public unless requested. However, once a request has been made, the State must provide the information." https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=68; Connecticut General Statutes 17a-28(h)(15) permits DCF to disclose information in its records "when the information concerns an incident of abuse or neglect that resulted in a child or youth fatality or near fatality of a child or youth, provided disclosure of such information is in general terms and does not jeopardize a pending investigation." DCF receives approximately one million dollars per year of CAPTA funding that goes to a variety of measures and interventions also required by the federal legislation. https://portal.ct.gov/-/media/DCF/DataConnect/Federal/APSR-2022-Amended-92921.pdf

and fidelity to case practice expectations, culminating in a monthly statewide report so all staff would be aware of the results.

DCF Quality Assurance Model for Child Safety Practice Must Be Prioritized and Transparent

OCA requested the safety planning quality assurance reports as well as data regarding DCF's "in-home visitation" efforts, which DCF had previously reported to OCA would also be reviewed on an ongoing basis to assess the efficacy of the agency's in-home engagement with children and caregivers.[13]

OCA credits the new practice model and trainings that DCF has implemented over the last several months. However, whether due to resource constraints or other limitations, DCF has not produced the safety practice or in-home visitation quality assurance updates, and no public updates or information, regarding this work.[14]

In January 2023, DCF reported to OCA that it had postponed a "focused review" of safety planning "given the strategies underway to address system improvement opportunities…. [but that it] has now been conducted and findings are being reviewed." When OCA requested the findings, DCF added that while "reviews have been conducted, data hasn't been aggregated/analyzed yet **due to resource limitations**," (emphasis added) and therefore no findings or requested reports could be provided to OCA. DCF also clarified that the review of Safety Planning was not ongoing, and that DCF was still evaluating what QA reports would be developed in 2023. DCF further stated that the agency's quality improvement work is evolving and that **"[t]he restructuring continues to be hampered a bit by managerial staff vacancies within the Bureau [of Quality Improvement] and resources available for both data analytics and visualizations**."[17]

DCF does internally generate certain quality assurance data in a format called ChildStat, which has been shared in recent months with OCA. ChildStat data is not yet public, though DCF recently informed OCA that it intends to work towards that. Notably, in the March 2022 motion to conclude class-action driven federal court oversight of DCF, the agency's new ChildStat framework was referenced as evidence of DCF's "commitment to being a data informed and data driven agency," and

[13] DCF's June presentation to OCA stated that "A sample of cases is reviewed for each [Area Office] each month (between 4-6 cases per office contingent upon the average number of [In Home] cases for the office), and the findings are collated, analyzed, and reported on in the QI statewide monthly report." This work has not been produced for the OCA.

[14] After multiple requests for this information, DCF reported to OCA in January 2023 that the safety planning practice concerns identified in last year's small sample review were "integrated into Area Office CQI meetings to enhance practice and used to inform the continued refinement of the Safety Planning Practice Model (ABCD), safety planning guidance and development of a statewide Safety Summit for agency leaders held in November 2022. [Quality Improvement Staff] continued to assess Family Arrangements and Safety Plans as part of the DRS [intake/investigation] reviews and discussed with Area Office leadership as part of the quarterly CQI data report." OCA notes that the review of safety assessment/planning referred to in the Commissioner's response does not encompass review of safety planning in cases opened with DCF for "ongoing treatment," such as Kaylee's case. It is this practice that DCF's small sample review was concerned with and this practice that OCA has pushed the Department to report out on.

[17] DCF Letter to OCA, January 2023. On file with OCA.

"essential in continued progress."[15] OCA finds that the ChildStat work is promising in concept, but will need to include qualitative review of all aspects of child welfare practice, including safety planning, assessment, case planning, and meeting children and families' needs.

It is urgent that there be consistent focused reviews of agency safety planning and support for families whose cases, like Kaylee's, remain open with DCF. Given the practice deficiencies identified in the case reviews discussed above, if resources are limiting DCF's quality assurance and public disclosure efforts, or other system improvements, then this must be addressed with policymakers and appropriators during the budget session. Given DCF's critical public function and work with families in high-risk situations, public policy should require that information regarding the agency's performance, including the work in need of improvement, be regularly produced and reviewed so that stakeholders can help define and support child welfare system priorities and goals.

State law provides for a Children's Report Card, inclusive of a steering committee, which heretofore met quarterly to review data and information from state agencies, including DCF, regarding the safety and wellbeing of children.[16] The passage of time, interruptions created by COVID 19, and lack of administrative staff to support the Repot Card, have left it dormant. OCA recommends that this Report Card structure be revived, resourced, and utilized, in part, for child welfare progress monitoring and fatality review. OCA has discussed this recommendation with legislators on the Children's Committee, and they are committed to the concept.

There Remains a Need for Intensive and Comprehensive Support Services for Families Struggling with Fentanyl Use

While child fatalities and near-fatalities result from myriad causes, the deaths of eight infants[17] and toddlers in the last few years from fentanyl intoxication demonstrate not only the paramount importance of effective safety planning by DCF (where it is involved), but also the need for a continuum of community and home-based services that can work with families struggling with opioid use disorder and fentanyl dependency. Families like Kaylee's must have access to timely support services that can assess and address the need for treatment, but that also provide parenting or peer supports, basic need assistance including housing and childcare, and care coordination. Gaps in this service system must be identified and swiftly addressed, not just by agencies themselves, but in partnership with policymakers and legislators.

Multiple community-based providers and family advocates have reported to OCA the inadequacy of services or supports to serve high need (and sometimes high risk) caregivers struggling with substance

[15] *Juan F. v. Lamont*, Case 2:89-cv-00859-SRU, Joint Motion to Terminate Jurisdiction and End Case (Mar. 14 2014) motion, at 44.

[16] State law also provides for a DCF Statewide Advisory Council made up of consumers, individuals with lived experience, and community providers. However, while this body provides important community feedback to DCF, it is advisory, and per OCA's review of its' agendas and minutes, the SAC does not routinely receive or review data regarding the agency's performance.

[17] 2021 saw 6 infant/toddler deaths from fentanyl, with an anticipated decline in 2022 (2022 data is not yet complete at this time).

use disorder. While state agencies are working to help adults with opiate use disorder, support gaps remain. There is limited access to two-generational intensive home-based services for caregivers, and providers have shared concerns about access to the state's Family Based Recovery program for caregivers with fentanyl dependency, though FBR is one of the state's only in-home models that works with a parent and child together. Concerns have also arisen that there is no approved method for timely drug use-testing for fentanyl (not to be confused with fentanyl strips used to detect the presence of the substance in other drugs) that can be used by in-home providers to test caregivers, further complicating treatment and safety planning. The state must swiftly examine availability of two-generational supports for adults and affected children to ensure not only the safety and well-being of children but also to ensure service delivery that will prevent unnecessary removals of children into foster care.

Conclusion

OCA supports the state's child protection goals of maintaining children with their families whenever safely possible. Kaylee's case and other cases discussed herein reveal a number of system priorities: the need to strengthen and continuously monitor DCF's safety practice; improve timely access to effective in-home substance use treatment and related supports for families struggling with fentanyl use; address concerns over the lack of access to regular in-home drug testing for families receiving treatment for fentanyl use, and address the lack of an existing statutory framework for public disclosure of material information from DCF's fatality and near-fatality review. Finally, legislators should assess whether DCF has necessary resources or has allocated resources adequately to conduct sustained quality assurance activities in a transparent manner.

It is important to acknowledge the systemic gains demonstrated by DCF in recent years, including the state's exit from the *Juan F.* consent decree and a separately required federal Performance Improvement Plan. However, the exit from involuntary federal court supervision cannot mean the end of structured monitoring. DCF remains in a first-responder role with highly vulnerable children and families, and critical incident and other case reviews discussed herein demonstrate the need and value of structured, routinized, and public progress monitoring of the state's child welfare system. In this way, system needs can be timely reviewed and addressed with stakeholders, and agency improvements sustained and supported with adequate resources over time.

OCA Recommendations

1. DCF should implement ongoing quality assurance regarding safety planning practice for children under DCF supervision. Quality assurance should include information regarding the timely availability and utilization of services necessary to mitigate child safety concerns in the home.
2. DCF should regularly publish findings and recommendations regarding its safety practice and child fatalities. To that end, OCA submitted a recommendation to the Legislature's Committee on Children that it revive the Children's Report Card codified in Connecticut General Statutes

§2-53m and regularly review information from DCF regarding children's safety, permanency, and wellbeing.[20]

3. The legislature should hold an informational public hearing to review available services and supports for families when a caregiver has an opioid use disorder. The hearing should include feedback from the OCA, DCF, Department of Mental Health and Addiction Services, CT Judicial Branch Court Support Services Division, community providers, and family advocates/individuals with lived experience. The hearing can then inform needed investments and resource allocations during this important budget session.
4. The state's Opioid Settlement Committee should include members with specific expertise and lived experience supporting children, including infants and toddlers, affected by the opioid crisis.
5. OCA requests to receive a portion of the state's federal CAPTA funding to support additional and independent child fatality reporting, in consultation with the state's Child Fatality Review Panel. The work of the OCA and CFRP is not currently supported with CAPTA dollars.

OCA will have additional findings and recommendations for the public and policymakers following completion of our infant-toddler fatality review, scheduled to be completed in the Spring of 2023.

Sincerely,

Sarah H. Eagan, Esq.
Child Advocate
State of Connecticut

[20] DCF reported recently to OCA that "DCF does intend on publishing QI reports to its public site and is working to hire staff to update, redesign and maintain the agency's website. Bureau staff is currently working on inventorying the website to inform the redesign." DCF reported to OCA that after successfully exiting a federally required Performance Improvement Plan (PIP) in Spring 2021, that it "continues conducting a sample of reviews (In Home and Out of Home cases) using the [Federal Tool ("OSRI")]. An initial report, post PIP completion, was drafted (and shared with OCA) to assess outcomes. A report for CY 2022 is pending given the need for all December reviews to have been completed and finalized. For CY 2023, OSRI reporting will occur every 6 months (June and December) and this will be integrated into the reporting framework being developed for 2023. This will allow for a sufficient sample for data aggregation and identification of patterns. It should be noted that the federal tool and guidelines have changed from Round 3 so OSRI data for Round 4 cannot be compared with Round 3." DCF Letter to OCA, January 2023.