Office of the Child Advocate

Excerpted Special Public Report
Findings and Recommendations
Fatality Review of Baby Michael

May 2010

Forward by the Office of the Child Advocate

On May 19, 2008 Michael B. sustained a severe head injury and died at hospital hours later. The seven-month-old was fatally injured in his second foster home placement of just one week in the custody of the Department of Children and Families (DCF). The Office of the Child Advocate (OCA) was notified of Michael's death and, according to routine practice, immediately began reviewing the circumstances of Michaels' life, specifically his and his family's involvement with the DCF. Two days after his death the state Child Fatality Review Panel[1] met and heard preliminary information about Michael's death and the DCF case. The Panel planned to discuss the death further once additional information was available. The following month the Panel passed a motion for the OCA to investigate Michael's death with the CWLA and reserved the right to issue an addendum to the CWLA report. Approximately two months after Michael B.'s death his foster mother was arrested and charged with manslaughter in the first degree. On March 29, 2010, the foster mother was found *not guilty* of both charges.

A child's death, Baby Emily's in 1995, was the catalyzing event for the establishment of the OCA in 1996. Subsequently, child death review is an integral component of the OCA enabling statute and a particular focus of the work of the Office. Despite limited resources and a broad mandate to oversee the care and protection of children, the OCA has diligently monitored and reported on child death trends in Connecticut and undertaken comprehensive child death reviews of individual child fatalities that inform methods of child death prevention and safety. Through its accomplishments the OCA has established itself as a national model in child death review and a leader in the activities of the National Center for Child Death Review.

While the OCA statute mandates a review of all unexpected or unexplained deaths of children, the DCF has historically conducted self-studies of case management for children who happen to die in DCF-care. There have been occasions when both the DCF and the OCA have each conducted fatality reviews of the same child death, with the OCA including DCF internal reports in their review. In 2004, the DCF contracted with the Child Welfare League of America (CWLA) to conduct internal fatality reviews of children who die while the DCF has an open case or when a case has been closed within six months of a child's death. The contract with the CWLA brought an objective and systematic approach to review of agency function. The OCA has participated to varying degrees in many of the CWLA child fatality reviews, chiefly as monitor of the process and as a means to economize on investigative discovery. However, the contract with the CWLA to conduct independent reviews of fatalities and critical incidents of children in DCF care ended in November 2009.

[1] Child Fatality Review Panel Membership: Child Advocate, Chief State's Attorney, Chief Medical Examiner, Law enforcement representative, Dept. of Children and Families Commissioner, Dept. of Public Health Commissioner, Pediatrician, Public child welfare practitioner, Community service representation, Physician, Domestic violence expert, Injury prevention expert, Psychologist

The Michael B. fatality review was unique in that the OCA participated as an integral member of a Special Review Team (SRT) made up of the CWLA, the OCA and representation from the DCF. Participants in the joint venture had parallel purposes to examine system functions and identify opportunities for improvements in child welfare practices that may prevent deaths. Special Review reports are provided to all DCF staff on the DCF-Intranet; incorporated within the interdisciplinary curriculum at the DCF Training Academy; and ideally integrated in daily practice at DCF Area Offices, Bureaus, Divisions and Facilities as a source of information, organizational learning and professional development. The goal of all Special Reviews is to conduct investigations in a respectful manner that encourages open dialogue, with an emphasis on an effective transfer of learning to practice in the field.

The OCA holds additional obligations to the General Assembly and the public that require disclosure of findings and recommendations regarding public systems that are determined to be "in the general public interest." The expectation of public disclosure is based upon the expectation of transparency in government and accountability in government performance. Therefore the report that follows makes public major parts of the DCF internal report with the purpose of informing the public and facilitating a means for follow-up of recommendations. Some information contained in this excerpted report may typically be considered confidential in nature. The OCA has deep respect for the laws and practice of confidentiality but pursuant to Conn. Gen. Stat. Sec. 46a-13k et seq., has the authority to disclose confidential information where the interest of a child or the public is affected. The OCA has determined that it is in the public's interest to acknowledge the strengths and weaknesses of the child welfare system and promote its improvements with a clear picture of the scope of the findings and recommendations of the comprehensive fatality review.

According to the National MCH Center for Child Death Review a child's death is a community responsibility and a sentinel event to identify other children at risk to prevent further deaths. Preventing further deaths requires system improvements. The SRT made comprehensive recommendations for system improvements to address failures identified in the Michael B. investigation. The OCA applauds the interdisciplinary work of the DCF in examining Michael's death and recognizing the opportunities for improvements. But we agree with the National Center in the fact of shared responsibility. We believe the DCF may not have the full capacity to make the improvements without the support and heightened expectations of state leaders and the general public through knowledge of system weaknesses and sharing of recommendations.

DCF Commissioner's Press Conference: Immediate Action Steps

On July 17, 2008, the DCF Commissioner held a press conference, during which she reviewed the facts of the case, as she knew them, acknowledged her responsibility for responding appropriately to the death of Michael, and indicated that she had personally reviewed the case and had identified practices of concern. She outlined steps that had been taken already to address procedural

and performance issues in the case, and reiterated her commitment to follow up on recommendations coming from this comprehensive, independent Special Review.

The immediate action steps taken by the Commissioner included disciplinary action against several staff. An immediate directive was given to begin entering all future employee investigations, substantiated or not, into LINK, and to cease the decade-old practice of maintaining these records in hard-copy only. In addition, the Commissioner immediately required that all prior unsubstantiated employee investigations be entered into LINK unless those investigations would have since been expunged under state law and policy.

The Commissioner also directed that the Central Registry and the log of unsubstantiated employee investigations be reviewed for all employees who were already licensed as foster parents to ensure that all relevant information was available at the time of licensure and that any corrective action be taken as needed. In her statement to the press, the Commissioner indicated her concern about the quality and thoroughness of investigations into allegations concerning the DCF employee's care of her son, stated that the employee had been placed on administrative leave and that termination of her employment would be sought.

In the pages that follow, the Special Review Team presents specific findings and recommendations that address both the facts known at the time of the Commissioner's press conference on July 17, 2008, and issues and concerns that have resulted from the work of the Special Review Team during this thorough and lengthy Review.

Best Practices and Efforts

The Special Review Team (SRT) acknowledges and applauds best practices and best efforts evident in the work on this case:

- Staff interviews indicated the pressure staff experienced as a result of the intense media scrutiny in this case in the days following the death of Michael and again upon the arrest of the DCF employee/foster parent. The presence of reporters presented significant challenges to DCF staff attempting to complete their responsibilities. Designated media relations personnel communicated effectively with media representatives and helped to moderate the sensationalism surrounding the case.
- The Interdisciplinary Review Team (IDRT) was developed following a tragedy that resulted in a mandatory Statewide Review of all children involved with CPS services whose parent had a previous Termination of Parental Rights (TPR). The Area Office continued the practice and added high risk cases as well, in an effort to provide consultative support to the social work process with these families. The IDRT model ensures the use of interdisciplinary resources for conferencing high-risk cases. An IDRT conference was held on Michael's family in October 2007.
- Area Office staff routinely discuss Shaken Baby Syndrome with families; Shaken Baby prevention was discussed with Michael's parents.

- The Area Office has fully implemented Multiple Report Reviews to examine risks and decision-making for a child or family that has had three or more reports of abuse or neglect. The Area Office's decision not to substantiate abuse or neglect regarding the first investigation after Michael was born, but nevertheless transfer the case to a treatment unit demonstrates family-centered and integrated child welfare work at its finest.
- Area Office leadership recognized the secondary trauma experienced by staff, and afforded them support and assistance as needed; personnel were gathered to discuss and process the case with internal and external resources. The Area Office has developed an effective Worker Support Team that provided excellent guidance and support at the Area Office level. The Area Director promptly convened a staff debriefing to provide support and share information. Inclusion of Michael's first foster parent in that process was exemplary. This same foster parent later made a generous donation to the Area Office staff for prospective foster families willing to care for infants and young children, illustrating the respectful relationship she holds with staff.
- The Special Review Team appreciates the openness and cooperation of participants in the Review process. The Review Team welcomed the contributions of all staff, and received comprehensive and well-coordinated feedback from Area Office staff at the Exit Meeting.
- In the immediate aftermath of Michael's death, front-line staff, supervisors and administrators from the DCF Hotline coordinated their assessments and interventions in an exemplary fashion. The Hotline staff was responsible for internal and external communication, collaboration with multiple investigators and hospital personnel, timely documentation of these interactions, interviews of family members in significant crises, and death notification to Michael's biological parents. All of these transactions were conducted as a cohesive team with sensitivity, skill and appreciation for the increasing complexity of the case. Hotline leadership and supervisors coordinated appropriate and immediate debriefing with staff and used external resources to facilitate a meeting with all primary investigators four days after Michael's death.

Findings and Recommendations

As was stated in the introduction to the Special Review Report, the identification of opportunities for learning from Michael's death is among the most important purposes of this Special Review process. The 14 sections that follow address specific findings of the Special Review Team and ensuing recommendations highlighting significant areas for organizational learning, staff development and improvement of DCF systems, policies and practices. The findings and recommendations synthesize information obtained through extensive interviews and document review as well as from review of relevant research and literature. Special Review participants were afforded multiple opportunities to provide feedback to preliminary drafts and to contribute to shaping findings and recommendations.

I. Foster Care Issues

The ability of a child welfare organization to provide quality foster care to children in need of placement is essential to its ability to fulfill its mission and statutory responsibilities. Integral to meeting goals to ensure children's safety, permanency and well-being, foster care functions require specialized skill,

excellent communication and commitment to consideration of each child's individual needs.

The Special Review Team recognizes that a new Director of Foster Care has been appointed since interviews with FASU staff were conducted, and that some changes to personnel responsibilities and supervision have been implemented within FASU. This report necessarily reflects the facts of this case and the resultant findings. While some changes to case practice are reportedly in process, the Special Review Team has included herein only those changes for which documentation been provided.

II. Foster Parent Training

Since 1998, DCF has utilized *Parent Resources for Information, Development, and Education (PRIDE)*[2] – CWLA's model for developing and supporting foster families and adoptive families. Integral to PRIDE is the belief that "protecting and nurturing children at risk and strengthening all their families (birth, foster, or adoptive) requires teamwork among individuals with diverse knowledge and skills, all working from a shared vision and toward a common goal." Foster and adoptive parents are essential members of the professional team.

The PRIDE model is designed to teach knowledge and skills in five essential competency categories for foster parents and adoptive parents:

- Protecting and nurturing children;
- Meeting children's developmental needs, and addressing developmental delays;
- Supporting relationships between children and their families;
- Connecting children to safe, nurturing relationships intended to last a lifetime; and,
- Working as a member of a professional team.

The group training process involving at least two trainers, one of whom should be a foster parent, and the sequence, timing and content of personal home visits and interviews are essential to the success of the PRIDE model. The information presented and discussed in each module and in each meeting and interview builds upon the content of previous interviews and classes. Also essential to the success of the model is the forging of relationships between staff and trainees.

The PRIDE Group attended by the employee/foster parent was conducted by one FASU trainer without a foster parent trainer/co-facilitator. Interviewed staff stated that there is not always a foster parent available for a planned group. When that is the case, the class proceeds without a foster parent trainer, although a foster parent may attend one or two of the group sessions. The absence of a foster parent trainer in any class is a serious departure from the PRIDE model, which compromises the curriculum.

In the "Additional Required Home Study Assessment Information" section of the Connecticut Family Assessment, which documents the PRIDE process, dates

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[2] http://www.cwla.org/programs/trieschman/pride.htm

are not identified for Inquiry, Personal interview, or Post-training interviews for the employee/foster parent. Each of these interviews/meetings is intended to explore specific topics at the particular point in the foster parent training process. FASU staff interviews indicated that the employee/foster parent had only one interview rather than the usual three, combining the content of these three interviews. Again, this departure from the PRIDE model compromises the efficacy of the process by failing to allow adequate discussion of the required topics.

Recommendations:

- In order to ensure the efficacy of the evidence-based PRIDE model, DCF should ensure that CT FASU staff implement the curriculum and home study process as developed, and should adhere to the interview protocols as designed.
- DCF FASU PRIDE trainers should ensure that each training group is staffed appropriately by staff and foster parent PRIDE trainers.
- DCF should include information about preventing Shaken Baby Syndrome in the information presented to foster parents.
- DCF should review the principles of PRIDE with FASU personnel, CPS investigators, social workers and supervisors to ensure that DCF personnel interacting with foster parents have a thorough understanding of the expected role and professionalism of foster parents.

III. Home Study

Although it was known that the DCF employee/foster mother had adopted her son from Russia, a copy of the home study completed for the adoption was not requested as a part of the foster care licensing process. Subpoenaed by the OCA during the Special Review, the intercountry adoption home study indicates some clinical issues and some family history that would have been worthy of further exploration during the foster care licensing process. Of note is the emphasis in the intercountry home study on her close relationship with her father as compared with her relative silence about that relationship in her DCF home study. Similarly, comparison of the information provided concerning her relationship with a sister, her marital history and financial difficulties would have informed the foster care home study process and provided important material for further discussion and exploration. Also of note is the use of three different references for the DCF home study than she had used for the intercountry adoption process. Discussion of her reasons for these changes might have provided valuable insight into the DCF employee/foster mother's support network, her relationships with family members as well as her ability to have enduring friendships, all of which are important considerations for foster parent home studies and powerful indicators of successful foster parenting.

During Special Review discussions, FASU staff indicated that in retrospect they could identify pieces that would have made the foster care home study process more thorough. They agreed that in future cases, more probing questions should be asked about history of domestic violence, CPS history, absences from work, previous experiences with counseling, support network and experience as an adoptive parent, as well as expectations concerning adding another child to the household. In addition, other relevant documentation should be sought, including

a record of police calls to the home, physician's records for any child in the home, and Birth to Three records.

Review of records obtained from the intercountry home study agency indicated that a post-adoption visit was conducted during the few days that Michael was placed with the foster parent. Neither DCF nor the home study agency explored sufficiently the information that could have been shared.

Recommendations:

- During every home study process, DCF should require the provision of any previous home study for foster care or adoption, whether completed by DCF or another agency.
- When a child in the home is fostered or was adopted through another agency, DCF should request a release for all records and should review them. In addition, DCF should obtain releases for sharing information with any adoption provider still providing post-placement or post-adoption supervision.
- FASU staff should receive competency-based training to ensure that their questions during interviews elicit the information required to complete a thorough home study.
- FASU workers should receive competency-based training concerning how to glean important information from foster parent applicants who have difficulty sharing personal information about themselves or their families.
- DCF should review required qualifications for FASU positions to ensure that FASU workers have the skills, experience, and education to assess, license, re-license and support foster and adoptive parents. CWLA Standards suggest that minimum qualifications for foster care staff should include a Masters degree in social work or a related field.[3]

IV. Placement of Infants and Young Children

The December 2008 issue of *Permanency Today* summarizes important research findings concerning infants in foster care:

> Once in foster care, infants and toddlers are more likely than older children to stay in foster care longer than a year and to experience multiple placements. If they are reunified, they are more likely than older children to re-enter foster care (Dicker and Gordon, 2004). These disruptions are often linked to problems with attachment and bonding (Schwartz, Ortega, Guo, & Fishman, 1994) and adverse outcomes are particularly acute among babies who enter foster care in the first three months of life (Wulczyn and Hislop, University of Chicago, 2002). More than 50% of infants and toddlers in foster care are at high risk for neurological and cognitive development impairments and nearly half of all foster children have behavioral or emotional problems (Vandivere, Chalk, & Moore, 2003).[4]

In spite of these statistics, matching of infants with foster homes in the United States is often done for expediency and not with consideration for the best fit.

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[3] CWLA Standards for Excellence in Foster Care Services, CWLA, 1995

[4] Options Counseling, Permanency Planning Today, December 2008, National Resource Center for Family Centered Practice and Permanency Planning

This case raises important questions about the Department's capacity to meet the need of infants and young children, given the lack of available foster homes appropriate to serve them. FASU, investigative and treatment staff were unanimous in their opinion that DCF does not have a sufficient number of foster parents willing and able to take placements of young children. Several staff stated that some of the foster parents willing to take infants and young children are among DCF's least satisfactory foster parents, and are unable to provide the stimulating environment and care that infants and toddlers need to facilitate their healthy brain development and recovery from abuse and neglect.[5] In addition, several staff stated that many foster homes willing to take young children do not have necessary equipment (car seats, cribs, high chairs, etc.), and are, therefore, unable to accept infants seamlessly and afford them a smooth transition. Feedback from DCF administrators indicated that when necessary, the Department is able to provide the supports which are needed to assist and ease the placement process.

Interviewed staff indicated that since they are aware that there is a statewide shortage of infant foster homes, it is not routine practice to seek to "borrow" a home from another office or from a contracted provider when an Area Office infant home is not available. Infants are sometimes placed in any foster homes with openings. Following Michael's removal from his parents' home in May 2008 he was placed with a DCF licensed foster parent who was unable to provide care for longer than a weekend due to her work schedule and lack of childcare resources. CPS workers were not aware of this limitation at the time of placement. As a result, Michael was moved to another foster home.

As was the case with Michael, placement in the first available home can result in multiple moves for a child, which is contrary to best practice and is known to contribute to attachment difficulties.[6] Likewise, the child who as an adopted child from Russia had already experienced institutional care and multiple placements in his young life, was placed in a foster home that had planned an out-of state vacation, necessitating additional moves to a respite provider and back to the foster home. It is a primary goal of child welfare practice to limit the number of placements, ideally to a single out-of-home placement. DCF did not accomplish that goal for either child in this case.

Record reviews and staff interviews indicated that sufficient information about Michael was not available to either of his foster parents. Although the first foster parent did provide a summary of her experience with Michael during the weekend to pass on to the next foster parent, the information, based on two days of care, could not provide a complete enough picture of his sleeping, eating and toileting habits, as well as his likes and dislikes, and his relationships with his caretakers. Following Michael's death, this same foster parent generously donated several relevant items for prospective foster parents that included journals, essential items for young children and carrying bags to support healthy

[5] Stamm, Jill, *Wired for Success,* Infant Brain Development, Arizona State, 2009
[6] Perry, Bruce D., *Bonding And Attachment In Maltreated Children*, Child Trauma Academy, 2001

transitions and communication about the unique qualities of the children entering care.

Recommendations:

- DCF should examine its capacity to serve infants and young children in foster homes by examining the number of children placed into DCF homes in the last 12 months who were under two years of age at the time of placement. For each child, DCF should review the age range for which the home was licensed at the time, the availability of appropriate supplies and furnishings in the home at the time of placement and the skills and interest of the foster parent(s) to care for infants.
- DCF should recruit and cultivate relationships with prospective foster parents who have the special skills and knowledge to care for infants and young children, whose homes can accommodate young children, who are not working outside the home, and who have the interest and capacity for caring for infants and young children.
- DCF should develop protocol for the removal of infants from their homes that includes attempts to obtain specific information that should include, at minimum, basic information about the child's schedule, care, (including such things as sleep position, current and past formula issues, etc), health, preferences and relationships with current and former caretakers.
- DCF should develop protocols for the placement of infants in foster homes and the decisions that may and may not be made by foster parents independently.
- DCF should consult *Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals*[7] for an excellent foundation for considerations that should be made when making placement decisions for infants.
- The DCF Training Academy offers a range of appropriate pre-service and in-service training with regard to infant and child development that should be reinforced in the field by supervisors, local leadership and ARG staff.

V. Employees as Foster Parents

There is not universal agreement concerning whether or not a child welfare organization should allow its employees to become foster parents. CWLA Best Practice Standards state that organizations should not allow employees to be foster parents[8]. ***DCF Policy 7-4-3.7 Department Employees as Foster Parents***, effective October 15, 2000 establishes a process for ensuring that there is not a conflict of interest that includes a review of the application by the Bureau Chief of Child Welfare Services. Staff interviewed had no recollection concerning the use of this process for this employee foster parent applicant and the foster parent's file does not include documentation of review by the Bureau Chief of Child Welfare Services.

Some child welfare professionals in favor of allowing employees to become foster parents argue:

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[7] Sheryl Dicker and Elysa Gordon, Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals, Zero to Three Policy Center, January 2004 retrieved online from: http://www.courts.state.ny.us/ip/justiceforchildren/PDF/Infant%20Booklet.pdf

[8] CWLA Standards for Excellence in Foster Care Services, CWLA, 1995, 3.21

- The child welfare profession has been working to promote mentoring and lifelong relationships as an antidote to some of the ill effects of multiple placements. In some cases the mentor and longest-term relationship may be the social worker. To deny the possibility of growing a parent-child relationship from a mentoring or worker-child relationship would be contrary to best practices in promoting lifelong connections.
- Adoption of children from the child welfare system is most successful when prospective adopters are thoroughly informed about the child's history, needs and challenges. Especially for older children in the system, the social worker may the person who is most knowledgeable about the child. When a worker who really understands the child wants to foster or adopt him/her, it is sometimes a perfect match.
- Workers are likely to have a solid understanding of the child's behaviors and the interventions most likely to succeed.
- Children who have attachment issues are often more able to connect to trusted professionals in their lives than to other prospective adoptive or foster parents.

On the other hand, there are strong arguments against employees as foster parents that include:

- There is the potential for preferential treatment of workers if they are allowed to adopt from the system.
- Co-workers may not be able to do objective home studies and make unbiased placement decisions.
- There may the appearance of a conflict of interest, even if there is not an actual conflict.

DCF has decided to continue to allow its employees to be licensed foster parents. In an effort to address any real or perceived conflict of interest, the Commissioner made the decision to outsource the licensing of all DCF employees seeking to become foster parents to a private agency effective October 1, 2008. On January 27, 2009, the DCF Commissioner sent a notice to staff, stating:

> Please be advised that, as of October 2008, the licensing of DCF employees as DCF foster or adoptive parents is being conducted by a group of contracted private Child Placing Agencies. Any DCF employees who started the licensing process with DCF prior to 10/1/08 will continue to be licensed by DCF. Any employee interested in becoming a DCF foster or adoptive parent, who has not yet started the process, will be assigned to a private Child Placing Agency for initial licensure.

DCF policy and state law dictates that all prospective foster parents should be held to the same standards with regard to licensure, training and supervision. While the 2002 Child and Family Service Review (CFSR) noted that the licensing and training process of DCF foster parents had improved, efforts to enhance these processes needs to continue.

Recommendations:

- DCF should strengthen its current policy to ensure that employees who are interested in becoming foster or adoptive parents can do so in a manner that avoids conflicts of interest while safeguarding the best interest of children. Policy should address the initial application and licensure of foster parents who are DCF employees, as well as periodic reviews, relicensing, ongoing supervision and support of the foster or adoptive home. Policy should ensure that home studies are never conducted by co-workers.
- Policy should establish clear expectations concerning the qualifications of all foster and adoptive parents. A waiver or variance of qualifications should not be considered for an employee unless it would also be considered for any other foster or adoptive parent applicant. Children should always be consulted, and their opinions and preferences should weigh heavily in decisions about permanency.
- Before finalizing policy on this important subject, DCF should explore the policies and procedures of other jurisdictions, the North American Council on Adoptable Children (NACAC)[9] and the National Center for Family Centered Practice and Permanency[10].

VI. Family-Centered Assessment and Practices

While experts agree that comprehensive family assessment is crucial to good child welfare practice, there are many approaches to completing family assessment and a myriad of tools available for doing so. Comprehensive family assessment in the context of child welfare has been defined as the process of identifying, gathering and weighing information to understand the significant factors affecting a child's safety, permanency, and well-being, parental protective capacities, and the family's ability to assure the safety of their children.[11]

Comprehensive Family Assessment Guidelines For Child Welfare published by the National Resource Center for Family-Centered Practice and Permanency, a service of the Children's Bureau Children's Bureau of the U.S. Department of Health and Human Services, recently released guidelines for comprehensive family assessment.[12] The guidelines identify key points in the life of a case for comprehensive family assessment, beginning with the initial contact with the family and continuing through several decision making stages, including placement, reunification, termination of parental rights, and case closure. Other assessment points include decisions to change service plan or case goals, independent living decisions, formal progress reviews, as well as, anytime there is a significant change in the family constellation or the behavior of a family member.

Although there are elements of family assessment included in DCF investigation protocols, there is not a Department approach to gathering and documenting such history consistently, nor does DCF conduct a comprehensive assessment during which such family information is considered. A family treatment plan guide developed in October 2007 addresses some, but not all, of the recommended elements of a comprehensive family assessment.

[9] www.nacac.org
[10] http://www.hunter.cuny.edu/socwork/nrcfcpp
[11] Family Assessment in Child Welfare Services: Instrument Comparisons, Bay Area Social Services Consortium, 2006
[12] Retrieved online at http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/family_assessment.pdf

As part of the CFSR and Program Improvement Plan (PIP) process, the Department is presently developing a family-centered practice model to guide staff interactions in the field. Family-centered principles and practices bring together relevant aspects of the client's past, present and future potential into a cohesive developmental whole, focus on the family's strengths, consider an array of biological, educational, legal, and psychosocial factors, and empower family members to participate in decision-making processes. Family-centered practice is emphasized in DCF's policies and procedures, within the orientation and training programs of the Training Academy and is a core value of the Department. The Department's development of a practice model and integrated treatment plan is intended to serve as the basis for improving policy and procedures for conducting comprehensive family assessment.

In this case, an earlier and more thorough assessment of the family would have revealed a multi-generational pattern of behavioral, mental health and substance abuse issues that could certainly have influenced assessment of parents' strengths and needs, as well as their ability to make decisions. Limited social history was obtained on behalf of Michael's father. For example, father was referred to ABH for a substance abuse evaluation and drug screen. During this evaluation, father reported that he had not used any drugs or alcohol since he was a young man. Father's self disclosure of a history of substance use/abuse and family history of substance abuse was never further explored by the ABH evaluator or assigned DCF staff. Parents were not helped to explore their own relationship, nor was there discussion of the effects of mother's substance abuse and mental health history on the relationship or on the family. There was little assessment done regarding the reasons for mother's older son's returning to live with the family. Michael's mother's history with DCF began in 1998. A significant history of domestic violence, severe mental health disturbances, chronic substance abuse, and a chaotic family structure are revealed in record reviews and interviews. Michael's birth activated a referral, an unsubstantiation and an appropriate referral to on-going services in October of 2007; however, a comprehensive family assessment was not completed.

At the time of closing, when she was sober and stable, mother appeared to be meeting Michael's needs. This was confirmed by the in home provider. At that point, it had been approximately two weeks since mother was permitted to engage with Michael without supervision. At the time of the case closing, it appeared that more of an emphasis was placed on urine screens and hair tests for mother than on assessment of the parent-child interaction and her ability to parent effectively. Although father was assessed to have appropriate parental skills in his own right, observations over time of his co-parenting with mother could have offered another view of the spousal and parental subsystems. The in-home program, which was assessing parenting, was discontinued at the time of the case closing in accord with the terms of the contract between DCF and the community provider.

Case closing process would have been enhanced by additional observation and feedback about the mother-son interactions, mother's tolerance for frustration and threshold for managing the new demands of parenting without supervision, and her bonding with Michael. In addition, work with parents before case closing could have helped them to anticipate mother's ongoing challenge to maintain mental health and sobriety (avoiding substance abuse relapse), and could have formulated a safety plan with both parents and significant others to reduce potential risk if mother regressed or relapsed.

Recommendations:

- Initial assessment should be conducted during investigation (or at intake in voluntary cases), addressing biological, psychological and social current and historical factors. In developing policy and procedures for the conducting of comprehensive assessments, DCF should refer to the US HHS Family Guidelines cited above[13], as well as to standards developed by CWLA[14] and to Council on Accreditation's Assessment Matrix[15], which delineates the biopsychosocial factors that should be assessed in each case.
- Family assessments should be revised and amended as new information becomes available throughout the life of the case.
- Supervisors should ensure appropriate use of a family's history in intake and planning, particularly in those cases where multiple reports have been made.
- Parent-child interactions and assessment of both the parental and spousal subsystems should be a central aspect of case closing considerations.
- DCF should continue to encourage the use of family conferences to maximize resources and promote collaboration with families as partners in treatment planning and interventions. Additional support for family conferences should be accompanied by family-centered training to DCF staff at all levels.

*VII. Risk and Safety Assessment and Decision Makin*g

Essential to a child welfare organization's efforts to ensure the safety, permanency and well-being of children is its ability to make sound decisions concerning the risk and safety status of children and their families.

Since 2006, CT has embraced the Structured Decision Making® (SDM) system, developed by National Council on Crime and Delinquency (NCCD) and the Children's Research Center (CRC). SDM®'s goals are to reduce subsequent maltreatment to children and families and to expedite permanency for children.[16] SDM® provides "workers with simple, objective, and reliable tools with which to make the best possible decisions for individual cases, and to provide managers with information for improved planning, evaluation, and resource allocation."[17]
The principle behind the SDM® system is that child welfare decisions can be improved by:

[13] ibid
[14] Child Welfare Leagues of America Standards to Strengthen and Preserve Families With Children, 1.24 – 1.30
[15] Council on Accreditation, 8th Edition Standards, Assessment Matrix, COA, 2006
[16] CT Structured Decision Making Policy and Procedures Manual, CRC, 2007
[17] http://www.nccd-crc.org/crc/c_sdm_about.html

- Clearly defined and consistently applied decision-making criteria.
- Readily measurable practice standards, with expectations of staff clearly identified and reinforced.
- Assessment results directly affecting case and agency decision-making.

SDM® risk assessment tools are developed and validated for each jurisdiction in which they are used. When a jurisdiction uses tools validated in another jurisdiction, CRC recommends that they be validated in the current jurisdiction within three years of implementation. In addition, CRC states:

> *Differences in agency practice and families served can affect a risk assessment's ability to accurately classify families by the likelihood of maltreatment. An adopted assessment should be validated with a sample of local families within approximately three years of implementation. In addition, an agency should conduct a validation study after substantial policy or program changes like implementing an alternative response program, restructuring intake procedures, expanding services to families with unsubstantiated allegations, or increasing the intensity of services to families; or when the client population served by the agency changes significantly as a result of demographic, economic, or other changes.*[18]

The SDM® tools used by DCF will be subject to a full validation study in CT within the prescribed CRC timeframes.

This case presented several opportunities for DCF staff to assess risk and safety and make decisions on the direction of the case. The case disposition in 1999, before implementation of SDM® in CT, demonstrates the Department's evolution and improvement in the decision-making process. (Please refer to page 8.) Another example of improved practice was evident when the 10/07 investigation was unsubstantiated; the SDM® tool indicated low risk, but there was a discretionary override, and the case was transferred for ongoing protective services. The decision to do so was based upon the past history of mother's mental illness, her significant history of substance abuse, and the limited parenting experience of Michael's father.

There is not evidence in the case record indicating use of the SDM® screening tool for the two non-accepted reports concerning the care of Michael. One report alleged mother's substance abuse while the other report alleged mother's substance abuse and absence. Mother's substance abuse could have been considered "general neglect" according to the SDM® screening tool. Although the information contained in the two non-accepted Hotline Reports (the first coming seven days after the case closing on 3/13/08) was determined to not meet the criteria for neglect, use of the SDM® screening tool would have changed that determination and therefore provided a basis for the report to have been screened in.

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[18] What Is a Risk Assessment Validation Study and Why Is It Important?, SDM® News, December 2008, Issue 18

Recommendations:

- DCF should review the current SDM® tools to ensure that they capture adequately the risk factors demonstrated in this case. For example, the fact that Michael's mother is alleged to have relapsed within one week of case closing with an assessment of minimal risk raises questions about the risk factors considered, and suggests that other predictors of relapse should be considered in such cases. The tools and/or guidance regarding overrides should be modified if necessary.
- CT should plan for a validation study of the SDM® tools currently in use in CT.
- The Special Review Team recommends that "Connect the Dots" training be offered to Area Office and Hotline Supervisors to help them to integrate and synthesize salient information and reach well-informed conclusions when making and or overriding risk and safety decisions.

VIII. Substance Abuse

All members of a family system are affected when one member of the family abuses substances. The co-occurrence of substance abuse and mental health disorders represents a particular and growing challenge to child welfare agencies, which requires that both partners needs help.[19]

This case involves issues regarding substance abuse, mental illness, and impaired parenting. Michael's mother had a significant history of mental illness and had diagnoses including, but not limited to, Cocaine Dependence, Alcohol Dependence, Major Depressive Disorder-Severe with Psychotic Features, Post Traumatic Stress Disorder-Chronic, and Borderline Personality Disorder with Histrionic Traits. Mother had been psychiatrically hospitalized approximately ten times dating back to 1998 due to her significant substance abuse and mental health issues. On 5/9/08, Michael, Jr. was removed from the home via a 96-hour hold. On 5/13/08, an OTC was filed and granted on behalf of Michael. Father appeared to lack insight into the seriousness of mother's substance abuse and mental health issues and it was unclear if he himself had a history of use and dependency issues.

Throughout the case history, mother's substance abuse had been identified. DCF Workers made attempts to engage mother in treatment and to support her in recovery. The case record documents discussions with father and other family members concerning mother's substance abuse and mother's passing a hair test just before case closing was an indicator of non-use at that time. Insufficient attention was paid, however to mother's potential for relapse, especially as she had just assumed an unsupervised caretaking role with Michael. Emphasis was placed on mother's being "clean" but not on the effects of her substance abuse on Michael; the fact that mother had not been a primary caregiver for Michael did not diminish the potential for significant impact on his development. Research indicates that the effects of parental substance abuse, even when the parent is not a primary caregiver, are significant.

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[19] Substance Abuse Treatment and Family Therapy, *Impact of Substance Abuse on Families,* US Dept of Health and Human Services, Tip #39, www.samhsa.org

Recommendations:

- The SAMHSA publication "Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers"[20] should be provided to Workers and Supervisors to increase their awareness of substance abuse and to enhance their understanding of the significant impact of parental and caretaker substance abuse on the development of children.
- CWLA's Fact Sheet Alcohol *and Other Drugs Abuse: A Critical Child Welfare Issue*[21] may be another valuable training tool for assisting workers to understand the correlation between alcohol and other drug use and risks to children.
- To improve the efficacy of ABH evaluations and substance abuse consultation, DCF should explore options for alternate models. The Special Review Team recommends consideration of replication of the current DV consultation model.
- The National Center for Substance Abuse and Child Welfare (NCSACW) offers resources for staff training and development as well as consultation models. The Team recommends that DCF consult with Dr. Nancy Young at NCSACW at it has in the past.
- When ABH evaluations have been requested in a case, the Special Review Team recommends DCF's requiring completion of evaluations and obtaining test results a pre-requisite to case closing, especially when children are too young to express their needs and there are not other professional eyes on the family.
- Consultation with a substance abuse ARG prior to case closing is also recommended when a case involves allegations of substance abuse, especially when there are young children in the family.

IX. Policy on Mental Health Services

Interviews and case record entries document numerous instances of unstable, erratic and concerning behavior by mother and clear statements of her mental health history and on-going functional challenges. Mother was engaged with community providers, but as indicated in the previous finding, at case closing, emphasis was placed on her passing a hair test, rather than on her mental health, her ability to handle the stresses of parenting and assurance of her continued participation in appropriate mental health services.

Although the importance of ensuring access to appropriate services for children and families is embedded in other related sections of the policy manual, a review of DCF Policy indicates that there is not currently a separate section containing policy relative to mental health services for children and families who are receiving services from the Department. ***DCF Policy 44-2 Healthcare Introduction*** states, "The mission of administration of health care in the regions is to assure optimal health care of children in the care and custody of the Department. This includes the medical, mental health and substance abuse

[20] A publication of the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration that may be reproduced or copied without permission; Electronic access at www.ncsacw.samhsa.gov. Print copies may be ordered from SAMHSA by calling 1-800-729-6686.

[21] http://www.cwla.org/programs/bhd/AODFactSheet.htm

aspects of health care." ***DCF Policy Manual Chapter 44-1 Healthcare Overview*** includes a section titled Standards regarding Health Care of Children in the Care and Custody of the Department; however the manual indicates, "This section will be developed at a later date."

Development of specific policy regarding family-centered mental health services is essential to best practice service delivery to children and families with mental health issues, and would align with the Department's *Mission, Guiding Principles and Practices.*

Several other Special Review Reports have highlighted the need for an updated policy to enhance understanding and delivery of family-centered, culturally competent, community-based and trauma-informed behavioral health services to guide all DCF staff.

Recommendation:

- DCF should develop and promulgate policy concerning delivery of mental health services to children and families, including at minimum, evaluation and assessment, counseling, therapy, hospitalization, and medication management.

X. Forensic Interviewing of Children

The validity and reliability of children's testimony is the subject of great debate. Some experts argue that young children cannot be considered reliable sources of information, especially when the topics of questioning are connected with traumatic events.

There is agreement that the foster mother's own son was present at the time of Michael's injury; during her interviews with DCF workers, she indicated that her son "saw Michael fall." DCF record reviews and interviews indicate that while was being transitioned to a foster home by two SIU staff, he made references to his experience on the night of Michael's death. A forensic interview of was scheduled for the fourth day after Michael's injury. Within several hours, the SIU ISW was first notified that the interview would occur, then that it could not occur, then that it could proceed. By that time it was too late in the day. A senior DCF official, a State's Prosecutor and the State Police were involved in discussion about whether the forensic interview could occur. The forensic interview was re-scheduled for the 8th day after the critical event.

The SIU ISW was able to observe the interview via video camera. She observed that although his demeanor changed during the interview, he did not disclose specific information about the incident. It is not surprising that it would be difficult to obtain information from a 3.5 year-old child 8 days after the incident.

In the information provided to the Special Review Team, there is no indication that the State Police were aware that he had been adopted from Russia and that English is not his first language. In addition, there is no indication that State

Police were aware that he also has had multiple caretakers in his short life, that he has exhibited some behaviors that are indicators of attachment difficulties, or that within 24 hours of his placement with the foster mother he was already referring to her as "mommy," or that on the day of the forensic interview he was calling his foster mother "mommy."

Recommendations:

- DCF should clarify the circumstances under which DCF does and does not have the authority to permit the forensic interviewing of a child, and should develop policies and procedures for such interviews in conjunction with law enforcement officials.
- The DCF Training Academy and State Police should conduct joint in-service training in forensic interviewing. It is recommended that trainers from both agencies be part of an interdisciplinary team that develops policy and practices for conducting forensic interviews of children. Such training should include discussion of normal language development of children and the particular issues of language development for children whose spoken language is not their first language. [22]
- As part of on-going training, curriculum should consider use of the article *Child witness research and forensic interviews of young children: A review,* which provides an overview of literature on the subject of child forensic interviews and the factors that may influence a child's ability to recall and report traumatic incidents.

XI. Organizational Response to Critical Incidents and Fatalities

An organized, cohesive, and timely mechanism for responding to critical incidents is essential to sound management of any agency or organization, whether or not it operates within the child welfare array of services. Emphasis on critical incident management within child welfare organizations, which surged in the United States after the 1995 bombing of the Alfred P. Murrah Building in Oklahoma City, has become a primary focus of organizational preparedness in the wake of 9-11-2001, and more recently, of Katrina.

DCF Policy 31-8-3 Significant Events: Reporting Procedures and ***DCF Policy 31-8-3.1 Critical Incidents: Reporting Procedures*** address the responsibilities of Area Directors, Facility Superintendents or congregate care providers, DCF Risk Management Division, Hotline, and DCF staff for reporting critical incidents. These policies indicate the timeframes for reporting and the persons or entities to which reports must be made. These policies do not address other responsibilities known to be essential to critical incident management, especially when the incident involves the death of a child.

Case records and staff interviews indicate that there are two standard documents completed when a critical incident occurs: ***DCF-823 Critical Incident Report*** is

[22] Boris Gindis, Ph.D. is one resource for current research in this area. He is a licensed psychologist and a nationally certified bilingual (Russian/English) school psychologist. Center for Cognitive-Developmental Assessment and Remediation in Airmont, NY.

the form completed by Hotline at the time of the report. This initial form includes basic identifying information about the child and family, as well as a summary of the reported critical incident. Within 48 hours of a critical incident, Area Office or Facility staff are required to submit a comprehensive written Critical Incident Review that summarizes the reason the case has been identified as critical, case and staff identification, family constellation, DCF history, Area Office (or Facility) activity in the case, current situation, assessment, case practice issues, and next steps. Staff interviewed during this Special Review conveyed that the requirement of compiling a comprehensive critical incident report within the first 48 hours after Michael's death was very challenging, given the intensity of the situation and multiple tasks they were involved with during that period. At the same time, staff acknowledged the importance of providing timely and accurate information to senior staff at Central Office. This concern has been cited in recent Special Review Reports (*S, January 2008 & J, December 2008).* Most Area Directors interviewed as part of these Special Reviews have indicated that compilation of comprehensive critical incident information is a fruitful process, but its value could be increased if they had more time to gather information and bring their teams together.

Michael's death had profound effects on his family, community and the DCF system. Interviews with staff at all levels and across programs indicated that although each critical incident and fatality have significant affects personally and professionally, Michael's death was further complicated by extraordinarily high media attention; intensive public scrutiny and reactivity; immediate requests for information from a variety of sources; and, the involvement of a DCF staff serving as his foster parent.

Interviews with staff across programs and area of responsibility indicated that in the hours and days after Michael's death, the aforementioned requests for information from multiple sources resulted in multiple requests to multiple staff for the same information; for example, at least three individuals stated that they were asked to contact the Medical Examiner's Office for information. Other interviews indicated that individual staff received multiple requests for information from internal and external sources, sometimes with competing timeframes for response. Information and feedback from sources such as hospitals, law enforcement agencies, Medical Examiner's Office and other public officials were placed side-by-side with internal needs for information and feedback. These simultaneous, conflicting, and sometimes redundant demands came at the time that Michael's family, Area Office and DCF investigative staff were at their most vulnerable.

On another dimension, DCF professionals from across the State indicated that the implication of a DCF employee/foster parent had a powerful effect on relationships with clients in their communities. The level of trust between child welfare staff and their clients was perceived as being compromised in some cases, and was considered a safety concern for front-line staff carrying-out legitimate removals and/or transitions of children into foster care. During interviews, staff suggested that synchronized meetings across the State would

have been helpful to clarify information; allow staff to reflect upon perceptions and emotions in a professional context; prepare for community reactions; reduce staff anxiety; and, offer consistent communication to offset rumors and inaccurate information.

The article *When a Child Welfare Client Dies: An Agency-Centered Perspective*[23] provides an overview of steps an organization can take to balance and manage the support needed by staff when there is a client fatality with the demands of managing and responding to a critical incident. This article is available for staff to read on the DCF Special Review Intranet site.

Recommendations:

- DCF should re-examine its procedures for collecting information in response to a critical incident, with special attention to the facts that must be gathered immediately. DCF should review the current Critical Case Review process, and should identify information that could be provided after several days rather than within 48 hours. The SRT recommends that Area Directors Superintendents and senior staff be involved in discussion concerning realistic timeframes for competing preliminary case assessment, as well as timeframes for completing the more thorough reflective, introspective and analytical work that should be done by staff as a component of assessing case practice.
- DCF should establish procedures for responding to critical incidents that address responsibilities and timeframes beyond internal reporting. At minimum, procedures should:
    - Establish clear lines of communication and authority that delineate critical incident responses and decisions that can ordinarily be made at the Area Office level, and the circumstances under which decision-making will be the responsibility of Central Office;
    - Identify the internal persons, programs, and departments with a need to know about critical incidents;
    - Identify mechanisms and timeframes for communicating essential information to involved staff when a critical incident occurs;
    - Describe how staff will be debriefed;
    - Encourage provision of immediate support to involved staff, with a focus on prevention and reduction of secondary trauma;
    - Identify external organizations and agencies with a need to know and identify mechanisms for managing the flow of information to and from external entities;
    - Identify circumstances for appointment of a spokesperson and/or key contacts (for example, liaison to State Police);
    - Set boundaries and expectations for communication with the media and should provide guidance to staff concerning how to deal with intensive media scrutiny;
    - Establish mechanisms for providing needed assistance and services to involved families (for example, grief counseling, assistance in arranging funeral or memorial services, and providing emergency financial assistance).

[23] Child Welfare, 2004 (4), Child Welfare League of America

- DCF should establish a protocol with the Office of the CT Medical Examiner (OCME) whereby it is the Medical Director or her designee who obtains and shares critical case information with that Office.

XII. Hotline

The Hotline is DCF's centralized system for receiving reports of suspected abuse or neglect of children. It operates twenty-four hours a day, seven days a week, 365 days a year. A report to the Hotline can be made on any child under the age of eighteen, and certain young adults through age 21 when they remain in the care of the Department after age 18.

Reports may allege suspected abuse, neglect, emotional abuse, maltreatment, medical neglect or educational neglect. Allegations made to the Hotline during regular business hours that meet the statutory criteria for suspected abuse or neglect are passed to the DCF Area Office of geographical jurisdiction for the commencement of an investigation. Calls made during non-business hours may be deferred for investigation until the next business day if it is assessed safe to do so. If the report relates an urgent matter requiring immediate action, a DCF Hotline primary investigator is dispatched to respond. In the situation involving Michael, DCF Hotline staff responded immediately to both the hospital and the family home.

The work of the DCF Hotline primary investigators, on-call staff, supervisors, and administrators on the evening of Michael's death was exemplary. All reports indicate that the evening volume and complexity of calls to the DCF Abuse and Neglect Hotline (the Hotline) on May 19, 2008 was high. The Hotline manager on call that night received three critical concerns regarding children. Critical concerns may include the death of a child or other serious injuries. The critical concern regarding Michael was a report describing his fatal injuries – the most serious report of the night. His death alone amounted to a critical concern, but the case included the additional factors that he was in the care of DCF and that his foster parent was a DCF employee.

A Hotline primary investigator was dispatched to the hospital to begin evaluating the circumstances of Michael's injuries and death. A second Hotline primary investigator and an on-call worker were sent to the home of Michael's biological parents to inform them of his death and provide necessary support. The Hotline investigator and on-call worker transported Michael's parents to the hospital. Unfortunately, when they arrived at the hospital they were not able to see their son. Police on the scene were already treating the circumstances of Michael's death as suspicious; consequently, they were not allowing anyone to see him. The investigator later described Michael's family as devastated at not being able to see him. On the following day, the DCF Hotline investigator transported them to the Office of the Chief Medical Examiner where they were finally able to view Michael's body.

The Hotline investigator assigned to the hospital began to work closely with the police to gain a better understanding of the circumstances of Michael's death.

That investigator also needed to assess the needs and safety of the foster mother's three-year-old adopted son to determine whether the DCF should pursue emergency custody of this child. Ultimately, DCF determined that they did not have grounds to take custody of the DCF employee/foster mother own child until approximately 72 hours later, after an OTC was granted based on the findings of the Medical Examiner.

The morning after Michael's death, the case was transferred to the Special Investigations Unit (SIU) because the allegation of abuse involved a DCF licensed foster parent who was also a DCF employee. SIU is responsible for investigating all DCF employee and foster home reports. The Area Office that originally removed Michael from his biological parents was advised by DCF Central Office administration to discontinue their investigation on Michael's family concerning the report that resulted in his removal from the home. Although the Area Office SW and the SIU ISW had contact, the sudden instructions for Area Office staff to cease contact with Michael's family was a source of confusion and stress, especially among staff that knew the biological family and felt they should be offering support and understanding at a time the family was most vulnerable. The Area Office was, for example, involved in communication with Michael's family regarding assistance with funeral expenses.

DCF Hotline Reports

During the 2008 fiscal year in which Michael died, DCF investigated 68,089 allegations of abuse/neglect, 17,437 were substantiated and 50,652 were unsubstantiated, a substantiation rate of 26%. The Accepted Hotline Reports table below depicts the breakdown of allegations.

Number of Accepted Reports and Allegations to DCF[24]
Statewide
State Fiscal Year: 2008

Allegations	Total	Substantiated	Substantiation Rate
Physical Abuse	7,426	613	8%
Educational Neglect	1,551	767	49%
Emotional Neglect	13,182	3,443	26%
High Risk Newborn	-	-	-
Medical Neglect	1,548	457	30%
At Risk	-	-	-
Physical Neglect	39,124	11,126	28%
Sexual Abuse	1,980	536	27%
Total Allegations	**68,089**	**17,437**	**26%**

Children Substantiated as Abuse/Neglect/Uncared For: 8,544

Additionally, during FY'08, DCF received 15,892 Hotline calls that did meet the statutory threshold and were not accepted for investigation. Non-accept reports are currently linked to individual persons in LINK and can only be accessed by

[24] DCF Abuse Neglect Reports, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2008.pdf

LINK/IT staff; DCF workers do not have access to these reports from the regular LINK system.

There were five hotline reports made involving Michael's short seven months of life. There were also two Hotline reports made regarding the DCF employee/foster mother in her capacity as an adoptive mother, and one report alleging abuse of Michael at the time of his death.

The first allegation against the DCF employee/foster mother concerning her care of her adopted son was made just three months after she returned from Russia. The second allegation against was seven months after the first report. The third allegation against was made after Michael sustained injuries while in her care. The Special Investigations Unit (SIU), which investigates allegations made against DCF employees, investigated both allegations regarding her son. Both allegations were unsubstantiated. The allegation of abuse of Michael was substantiated by DCF.

The first report regarding Michael's care by his parents was made at the time of his birth. That report was accepted for investigation by the Hotline and the report was transferred to the appropriate Area Office for investigation. After completion of the investigation, although the allegation of neglect was not substantiated, the Area Office appropriately opened the case for services. As outlined in DCF policy Michael was considered to be a high risk newborn primarily due to indicators of his mother's substance abuse and psychiatric history.

Michael's case remained open for services for approximately five months. His family cooperated with DCF supports and services and subsequently the case was closed. However, just seven days after the case was closed the second Hotline report was made alleging similar concerns related to maternal substance abuse. Hotline staff determined that the allegation did not meet the statutory criteria for abuse or neglect and it was coded as a non-accepted report. Although there is a process for sharing non-accepted reports on an open case with Area Offices, under existing law, DCF believes that there is no legal authority to re-open a closed case unless it is determined that a new allegation meets the statutory definition of abuse or neglect. Because of this legality, no DCF staff previously involved with Michael's family was made aware that a new report had been received.

A third Hotline report on Michael included allegations similar to the previous reports alleging parental substance use. This Hotline report was also not accepted for investigation because a determination was made that the report did not meet the threshold criteria for abuse or neglect. According to the Hotline record, the case was not accepted for investigation primarily because the reporter noted that Michael's father was providing him with adequate care even though his mother may have been unable to do so. No further action was taken on this unaccepted report. This report occurred just one week prior to the fourth report.

The fourth report was made to the Hotline regarding Michael on May 12, 2008, alleging similar concerns related to Michael's mother's substance abuse. However, this time, it was reported that Michael's father and mother had not returned home from the previous evening when they went to dinner. This call was accepted for investigation and coded for an immediate response. The anonymous caller indicated that the police had been dispatched to Michael's home to ensure his well-being. This report was the impetus for Michael's removal from his biological home.

On May 19th, just seven months after his birth, a fifth and final Hotline report was made on Michael. The fifth call was the report by his foster mother concerning the injuries that resulted in his death.

Recommendations:

- DCF should initiate action to gain legal authority for the re-opening of a case after the case has been closed if a new allegation is received within a designated period (10-30 days), in order to ensure that Area Office personnel familiar with the case have an opportunity to assess the allegations. The Department would benefit from consultation with other jurisdictions to bring together legal safeguards and best practice standards.
- DCF should explore linking non-accept reports to cases rather than to individual persons to ensure that staff has access to all relevant CPS history. Although these reports will eventually be expunged, non-accepted reports in the short-term are indicative of patterns of behavior that would inform staff of increasing risk.
- Hotline staff should be retrained concerning the CT SDM® Child Abuse and Neglect Screening Criteria. Supervisors should ensure that the tool is completed properly on each case and that screening decisions to not accept are reviewed as required in the CT SDM® policy and procedure manual.[25]

XIII. Special Investigations Unit (SIU)

The Special Investigations Unit (SIU) was initially created in 1996 to investigate allegations of abuse and neglect involving DCF employees. Such investigations might include DCF employees in their capacity as caseworkers, as staff in DCF programs, or as parents or caretakers involving their own families. Originally attached to the Hotline, at some point it was made independent of the Hotline becoming a stand-alone entity. The SIU also assumed the responsibility of investigations of all DCF- licensed residential programs, and DCF owned and operated programs. Currently, DCF operates four of its own facilities (RVH, HM, CCP, and CJTS), for which SIU has the responsibility to investigate allegations of abuse or neglect against employees. SIU is also responsible for investigations of allegations of abuse or neglect within DCF licensed congregate care programs in CT.

Further, in 2006 the SIU assumed the responsibility for the investigations of allegations of abuse or neglect related to all licensed foster care homes. During the course of the Special Review it was learned that the purpose of having the

[25] Structured Decision Making® Policy and Procedures Manual, Children's Research Center, Madison, WI September, 2007

SIU conduct foster home investigations was to separate oversight responsibilities from consumer needs. Area Offices license, support, and rely upon foster homes for the placement of children. Responsibility for investigating them could risk, or be seen as at risk of, influencing investigational outcomes. While no complaints had been made regarding the objectivity of investigations, DCF sought transparency and minimization of conflict of interest.

In the SIU, there were approximately nine investigator FTEs assigned to cover the entire state. It was reported during the Special Review, that the staffing constellation was rarely, if ever, at full compliment due to maternity leaves, vacations, and illness. Further, it was reported that the scope and breadth of the multiple mandates (congregate care providers, DCF employees, and foster care) lead to an intense caseload and, at times, an unmanageable workload. However, senior DCF administrative personnel interviewed disagreed; they believed the caseload and workload responsibilities were in line with the Area Offices.

On the night that Michael died, the after-hours Hotline primary investigator worked the case though the night gathering as much relevant information as possible about what happened to Michael. In the morning, the investigator passed the case to the SIU for the continuation of the investigation. An SIU investigator (SIU ISW) was assigned to the case. The SIU ISW was familiar with Michael's foster mother, having been assigned to one of the two previous investigations completed regarding the DCF employee/foster parents care of her adopted son.

The two previous SIU investigations were reviewed by several DCF senior staff, all of whom had concerns about the content and thoroughness of the investigations. DCF administrators determined that the first investigator did not adequately conduct necessary collateral contacts. The second investigation report was nearly identical to the first. A Senior DCF official then completed review of eight additional investigations that had been completed on DCF employees; none was considered to be adequate.

SIU continued the investigation of Michael's death in the foster home until June 4, 2008. Records indicate that on that date, the SIU ISW was instructed to "complete all narratives and get case ready for transfer to another worker who will complete the investigation as soon as possible. This worker is not to seek further contact with collaterals, however will continue to document any collateral narratives when this worker is contacted as such." However, the case was not actually transferred until 6/23/08, 19 days after the principle investigator was told to take no further action on the case. The investigative portion of the case was closed within two weeks of the case transfer by a second Area Office team. The determination was that there was sufficient evidence to substantiate abuse, and to place the DCF employee/foster mother on the DCF Central Registry. The case was transferred to ongoing services so that DCF could continue to monitor the out of home placement of her adoptive son.

As a result of the concern about the quality of the two previous investigations of the DCF employee, DCF senior staff mandated that all SIU personnel go through retraining on investigations techniques and protocols. Records made available to the SRT by the Training Academy indicate that training was scheduled for SIU staff from 7-24-08 through 9-3-08 and that training attendance was documented. Topics included Best Practices, Interviewing, SDM®, Decision making, Sexual Abuse, and Assessment Tools. Staff interviewed during the Review reported that the re-training was basic in nature and less than relevant to the investigations the SIU staff typically conduct. Several staff interviewed believed if retraining were determined to be necessary, the type of training should have consisted of higher-level investigative training given the scope of their mandate and responsibilities. The Training Academy also provided to the SRT evidence that training by the Residential Child Care Project of Cornell University, "Investigating the Maltreatment of Children in Out of Home Care," was presented to SIU and other investigations staff in March, 2008.

DCF staff reported to the Special Review Team that orientation and training for new SIU investigators has been analogous to "trial by fire." New SIU investigators have not been not provided specific training for conducting facility investigations, which are most often allegations associated with restraints and injuries resulting from restraints. They have not been provided training on understanding the management of difficult children who might require restraint, nor have they been provided with training on various positive behavioral support interventions that should be utilized by facilities to avoid restraints. (It is important to note that these topics were a focus of the March, 2008 Cornell Training.) Additionally, it was reported that when SIU was given the responsibility of investigating foster care, no additional training was provided on how to conduct an investigation into a foster home. Some of those interviewed indicated that a foster home investigation was no different from a regular home; others disagreed, and believed that foster parents needed to be held to a higher standard compared with a "regular family," because foster parents are paid to care for children removed from their family.

The chain of command in the SIU was a qualitatively different structure than is typical in all other DCF programs. There are typically five investigators to each supervisor. In the SIU, there were 9 investigators to one supervisor. The Program Supervisor essentially served as a direct supervisor to manage the case flow, which is not a structure in any other facet of DCF. Another concern about structure was related to support personnel. In the Area Office model, staff has access to clinical consultation (nursing, substance abuse, and mental health clinicians), legal consultation and domestic violence consultant; the same was not true for the SIU. SIU staff may consult Area Office ARG staff when they are already familiar with or involved with a child's case. Central Office consultation is available at other times.

Shortly after Michael's death, the SIU was restructured, supplemental resources were provided, and a new management structure was developed with additional staff. For a period of time foster care investigations went back to the Area

Offices to provide for some breathing room for the SIU to reorganize. At the time of this Report, SIU staffing includes a Program Director, two SWSs, and nine investigators in two units.

Recommendations:

- DCF should develop a comprehensive competency-based training and certification program for SIU personnel. Training should focus on: advanced investigation techniques; interviewing special populations; special considerations in conducting investigations in congregate care and foster homes; and, relevant federal and state mandates and statues that impact investigations in these settings.
- Although SDM® tools have not been developed and validated for residential settings or for foster homes, DCF should consider development of comparable risk and safety assessment tools to ensure that SIU investigators have sound decision-making tools available to them.
- Serious and deliberative consideration should be given to determine where SIU fits best within the DCF organizational structure. No real consensus emerged during the Special Review interviews about where the SIU should be located. DCF should conduct a functional assessment of the unit and consider the overall needs of DCF to determine how best to utilize the resources of the SIU personnel. Consideration could include various components of the SIU being distributed to other divisions at DCF. For example, employee investigations could be aligned with Human Resources, and facility investigations could be aligned with CQI/Licensing, and foster care investigations could be subsumed in the reorganization under FASU.
- DCF should establish clear guidelines concerning any additional expectations of SIU or its equivalent, such as the investigation of relatives of DCF employees, or high profile cases such as politicians.
- DCF should ensure that SIU personnel have priority access to the clinical resources, and substance abuse, domestic violence, nursing and mental health ARG or consulting staff when needed.

XIV. Human Resources Personnel Function

The Division of Human Resources (HR) at the DCF is accountable for administering a comprehensive, statewide, human resource management operation by supporting the Commissioner's Office, the regions, facilities, and central office through the performance of traditional personnel functions. The mission of HR is "to provide quality service in partnership with our customers that promote success, mutual respect and understanding, and enable us to support the overall mission of the Agency."[26]

DCF Policy describes the major functions performed by the HR Division for the approximately 3,800 employees as follows:

- Recruitment and hiring of qualified staff;
- Retention and upward mobility of qualified staff;
- Workers' compensation and employee safety;
- Labor relations, including grievance handling;

[26]The Department of Children and Families, Human Resources Department Mission Statement

- Administrative control of agency positions;
- Operation of a Decentralized Promotional Examination Program;
- Payroll administration and benefits operations.

The intersection of the Human Resources division functions and the Special Investigation Unit process pertaining to employees was an important question raised by the Special Review of Michael's death. Specifically, a series of questions emerged in relation to these two divisions

1. How do the two divisions collaborate when there is an allegation against a DCF employee?
2. Does the HR function integrate with SIU investigation findings?
3. Are there joint investigations?
4. How are personnel issues communicated between the two divisions?
5. If employee data are not collected in LINK, how is HR kept apprised of the investigatory outcomes?
6. If data are not collected centrally, how can personnel know about concerns arising from abuse or neglect of employees?

Interviews indicated that for the most part HR interacts with SIU on investigations related to employees in their capacity as DCF employees, but not in their capacity as parents. The newly established off duty conduct policy, ***DCF Policy 7-4-3.5 Employee Conduct Staff/Child/Family Relationships***, will likely lead to more interaction between the two divisions in the future. The interaction between the SIU and HR is most often a transfer of an investigation. Interviews indicated that there has been very little direct communication about findings and outcomes.

When an allegation of abuse or neglect is made against an employee related to his/her job duties, HR works with the employee's supervisor to determine if the employee should be put off duty, or if limits should be placed on the employee's interaction with children. The SIU takes the lead on the investigation. When the investigation has been completed, a copy of the investigation is sent to personnel. Irrespective of whether or not there is substantiation of the allegation or there are other concerns that require a personnel action, the HR division makes the determination. The SIU has no influence over or knowledge of personnel actions. Any personnel action determined by HR is not recorded as part of the investigation nor is it shared with SIU. The HR and SIU work completely separately. There are occasions whereby HR is making some inquiry of the SIU about a particular finding, but for the most part those interactions are limited.

The HR division keeps their own database of personnel actions related to employees. They do not use the LINK system to document any action, nor were HR personnel interviewed especially aware of how that system is utilized.

Until the recent development of the Off Duty Employee Conduct Policy, if an allegation were made but not substantiated against an employee as a parent or guardian, there was likely no disciplinary action. In fact, HR might not have even been apprised of the allegation.

There is a need for increased collaboration between SIU and HR when they are involved simultaneously in investigation of employees. Consideration could be given to joint interviews when determined that a joint interview could serve an important function. Making such a determination would then require HR and SIU to work more closely on employee investigations and have a more established level of communication.

Recommendations:

- A closer nexus should be established between the Human Resources personnel functions and SIU investigation as it pertains to employee investigations; specifically, HR and SIU should work closely with DAS on high profile complex employee investigations.
- The HR mission statement should be re-written to be reflective of disciplinary and investigative aspects of the unit.

XV. The DCF Automated Case Management System (LINK)

One of the major concerns identified after Michael's death involved the practice of documentation and information storage in the LINK system. The LINK system is the DCF comprehensive automated case management and data collection system. It is used to collect, store, and manage information about reports of abuse and neglect; investigations of abuse and neglect; and management of open neglect or abuse cases. The system is used similarly for Voluntary Services cases. The specific problem identified in Michael's case involved the documentation and storage of information regarding DCF employees about whom abuse and neglect allegations had been made, investigated, or substantiated.

According to staff interviews, at the time of Michael's death, abuse and neglect allegations against DCF employees were not regularly entered into the LINK system, as were all other reports. Allegations of abuse and neglect concerning DCF employees were not entered regardless of whether the employees were acting in their capacity as public servants, or in their capacity within their families.

There are several processes that occur with child welfare record keeping. On a single case, information may be stored in LINK to account for investigative actions and provide record of data used for determining outcomes of investigations. On a substantiated case, records may be kept of actions taken, services provided or accessed, court rulings and so forth. This primary use of LINK is a case management function.

The moment a report of suspected abuse or neglect is made to the DCF Hotline, a LINK record is initiated and all subsequent actions and outcomes are documented in that record. Additionally, existing LINK records are a useful source of data and history. Investigators may find a history of allegations or substantiations against an individual that will inform new investigations. LINK searches are routinely used to conduct child welfare background checks for

individuals applying for positions in child caring agencies. DCF FASU staff review the records of foster and adoptive parent applicants to determine whether they have any history of abusing or neglecting children and whether it would be appropriate and safe to place children in their care.
At the time of his death, Michael was in the care of a foster mother who was a DCF employee. Prior to her application to be a foster parent and prior to Michael's placement with her, [S] had been the subject of two investigations of alleged abuse or neglect upon her adopted child. Neither of those original reports nor investigations was documented in the LINK system. When FASU staff reviewed her records during her home study process, they did not find any evidence that allegations of abuse or neglect had been made against her or that two investigations of her care of a child had been conducted.

Interviews indicated that since the inception of LINK more than ten years ago, reports of abuse or neglect, screening decisions and investigative information about DCF employees have not been entered into the LINK database and have been maintained in hard copy only. Only a few DCF employees interviewed recalled discussions in the early stages of developing the LINK system that addressed the management of abuse/neglect reports and confidential information related to DCF employees; those interviews indicated that at the time of LINK development, decisions were made to refrain from entering these data in order to protect employees' confidential information. There was no explanation for why the practice of omitting employee records from the LINK system had continued.

Instead of entering the reports in LINK and forwarding to the Area Offices, Hotline intake workers would fax or E-mail reports of allegations to the SIU manager. The manager would then assign the investigation to an SIU investigator. While paper records were created and maintained, at no point from the time of the call to the completion of the investigation would LINK be utilized. In fact, if a LINK entry was created at the time of the allegation because it was not known that the individual was a DCF employee, the LINK entry would later be expunged. Interviews indicated that at times cases might be entered into the LINK system when there was a substantiation and subsequent termination from DCF employment; however, if the allegation against the employee was substantiated and the employee remained employed by DCF, it was less likely the information would be entered into the LINK system. There would generally not be a LINK record created at all in cases of unsubstantiated allegations. Although there was no written policy and procedure for these practices, many DCF employees, senior managers among them, were well aware of them and interviews consistently indicated that these practices were "common knowledge."

Nevertheless, DCF FASU workers interviewed for this review had not been aware of these practices at the time of [S]'s home study. In fact, the written protocol for background checks included the task of checking LINK. It did not include checking any other DCF database for DCF employees. Therefore, when FASU licensing staff screened [S]'s application to become a foster parent, they found no history of abuse or neglect allegations and concluded that the absence of a record indicated the absence of a history of concerns regarding her ability to

parent. (Please refer to the Home Study section on page 48.) While the original allegations against [S] were not substantiated, their existence was critically important information. Had FASU staff been aware that employee data was not included in LINK, they might have known to examine other sources of information to ensure that [S]'s history would be thoroughly reviewed and considered. Paradoxically, as indicated in the SIU section of the Review Report (see page 68) the thoroughness of those investigations was called into question after Michael's death.

LINK Expungement Process and Access to Confidential Cases

The LINK system is designed to manage cases, and identify and delete cases that do not meet legal standards for maintaining confidential information. For example, an allegation of abuse or neglect that was not accepted for investigation because it did not meet the legal criteria to warrant an investigation is automatically expunged from the LINK system in 60 days. Maintaining those cases for the 60-day period allows for a level of tracking in the event that another allegation is made that builds evidence of an individual's problematic pattern of behavior. If an allegation of abuse or neglect is accepted for investigation but is not substantiated, the case is expunged from the LINK system in five years per state law. The expungement process identifies and deletes unsubstantiated investigations with a completion date older than five years, as long as there are no newer substantiated or unsubstantiated investigations within the five years. According to ***DCF Policy 33-32***, "Reports of neglect and abuse that have been investigated and not substantiated shall be kept for five (5) years from the completion date of the investigation and then expunged. If the Department has received more than one report on a person, and they are all unsubstantiated, they shall be expunged five (5) years from the completion date of the most recent investigation. Unsubstantiated investigations will not be expunged if the person has been substantiated as a perpetrator in any other case."

In a similar way the LINK system also has the capacity to protect the privacy of certain individuals. As of the time of this Report, the confidential access function of the LINK system only allows the case to be coded as "confidential." There is not a current mechanism to ensure a multi-level set of security criteria for application to either cases or workers who have access to cases. In other words, currently a LINK user is allowed access to confidential cases based on job title. LINK users with a job title of Program Director or above are allowed access to confidential case information. As of this Report, more than 500 people are designated at the PD level or above and therefore have access to confidential cases.

Department's Practice Changes

On June 4, 2008, following revelations of missed records in the case of Michael's foster mother, DCF senior staff announced changes in the way abuse/neglect allegations against DCF staff would be documented going forward. A memo from Senior DCF staff directed DCF personnel to enter investigations pertaining to DCF employees, "into Link from the point of acceptance by the Hotline through the completion of the investigation by the SIU." Cases against DCF employees

would no longer, "automatically be designated as classified. This holds for employees in regard to their own children, guardian or circumstances in which they are a person entrusted. It also holds for all investigations of employees in our own families, and in instances in which our employee is working in a facility licensed by the Department."

In addition to this change in practice, in mid July 2008, the DCF administration directed a subgroup of Hotline staff to retrospectively enter allegations against employees from paper classified records into the LINK system. While apparently administrators were not certain about the exact number of employee allegations staff would be accessing, it was presumed to be a significant undertaking. There were reports of large numbers of file cabinets filled with records of investigations of DCF employees at the SIU and within Human Resources. The LINK/SACWIS program management staff created a "widget" to facilitate data entry.

As data entry proceeded, the Special Review Team requested an accounting of the data to examine the scope of the problem. Although the DCF administration had directed the data entry, they had not made a similar request for data analysis. Initially, data indicated that there had not been any substantiated allegations against DCF employees. With repeated inquiries for various data, the LINK technicians eventually produced a report of 1,141 backlogged child protection cases entered on DCF employees. There were 181 employees that had been retrospectively entered into the DCF LINK system. There were many instances of multiple allegations against the same employee.

Many questions about the backlogged cases emerged including the management of initial allegations and the quality of investigations. The noticeable lack of transparency and organizational structure may have served as an obstacle to oversight and therefore thoroughness of investigations, a phenomenon that likely transpired over several years.

Interference with Federal Mandates

In addition to interfering with access to historical records and potentially compromising the safety of children, the DCF practice of maintaining separate files for employees may have interfered with federal reporting mandates. The LINK system is Connecticut's version of the statewide-automated child welfare information system (SACWIS) that is funded by the federal government. Enabled by the Omnibus Budget Reconciliation Act (OBRA) of 1993 and regulated by the federal Administration of Children and Families (ACF), funding for SACWIS is accompanied by certain procedural expectations. It is expected that all case management information will be entered into the system, making systems like LINK the "official case record." All data reporting required by the Adoption and Foster Care Analysis Reporting System (AFCARS), and the National Child Abuse and Neglect Data System (NCANDS) would therefore be obtained from that official record. A practice of omitting data from the LINK system suggests inaccurate data reporting and a breakdown of use of SACWIS as prescribed.

In Connecticut, as with many states, there is a corrective action plan to bring the LINK system into compliance with all of the federal requirements. Currently the LINK system is undergoing a major upgrade to better capture information in compliance with Title IV eligibility and reimbursement mechanisms. Some of the other more recent LINK upgrades have included the Structured Decision Making® tools/assessments and the new investigative protocols. According to managers of LINK, the system is constantly being tweaked to meet the day-to-day demands of the system. It has been suggested that the demands on the LINK system are beginning to be more sophisticated than the system can accommodate and it has been conjectured that the system will be obsolete within the next decade.

Recommendations:

- To ensure that the current practice is maintained, DCF should develop policy to ensure that all allegations of abuse/neglect against any DCF employee are entered into the LINK system, conforming to the same standards applied to any case. The policy should include a protocol for making a case confidential.
- DCF should conduct a thorough analysis of the cases of DCF employees entered into the LINK system, including review of both "Active and "Inactive" for purposes of LINK access.
- DCF should examine the LINK data concerning current employees whose data were entered retroactively, to determine possible patterns, need for re-training or other implications.
- The Special Review Team recommends development of a Multiple Report Review process for employees (equivalent to the Multiple Report Review process for families), whereby employees with three or more reports of abuse/neglect, whether in their professional or personal capacity, be reviewed to determine whether additional attention or action is warranted. Given the concerns regarding the thoroughness of some of the SIU investigations, DCF administrators should review the original investigations concerning employees with three or more allegations as part of this review process.
- DCF should continue to improve the confidential case access function to LINK to curtail inappropriate and unauthorized access. DCF should develop a process to ensure that employees who are terminated from employment are immediately removed/prohibited from accessing the LINK system.
- DCF should conduct an analysis of the amount of staff support provided to the SACWIS/LINK program to determine if it is adequate to meet the multiple mandates and demands by DCF personnel.