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Commissioner

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For Immediate Release
May 6, 2009

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Joint Special Review Fatality Report
on 2008 death of Michael B.

Hartford- Commissioner Susan I. Hamilton and State Child Advocate Jeanne Milstein, chairperson of the State 's Child Fatality Review Panel, announce the completion of a thorough and exhaustive collaborative review of the tragic death last May of Michael B., a 7-month-old infant in state foster care. The report notes several important reforms already implemented by the DCF in response to early review findings and outlines multiple other recommendations for policy and practice reforms.

Both Commissioner Hamilton and Ms. Milstein recognized the expertise of the Child Welfare League of America (CWLA), and their leadership in this unprecedented joint review process. The Special Review, which included more than 70 interviews, extensive record reviews and a thorough review of national child welfare best practice research, culminated in an 80 page report. "The death of Michael badly shook the Department and me personally," Commissioner Hamilton said. "While several notable reforms have been implemented, I am determined that we learn everything we can so we can continue to improve the safety and well-being of children in foster care."

State's Child Advocate Jeanne Milstein stated "the tragedy of baby Michael's death, as with the untimely death of any child, must result in both a strong commitment to thoroughly examining every action or inaction taken by those

responsible for ensuring his safety *and* taking any and all action necessary to ensure the prevention of future tragedy. "

The DCF Commissioner also ordered disciplinary actions that resulted in the termination of the employee/foster mother, as well as the termination of an investigator and suspensions of two managers who were involved in earlier investigations concerning the employee/foster mother's adopted child, which were found to be unacceptable.

In addition, Commissioner Hamilton placed the specialized unit that conducted the investigations under new management and directed a complete overhaul of that unit including the re-training of the entire staff. Further, in order to avoid even an appearance of a conflict-of-interest, the Department began outsourcing the licensing of any DCF employees seeking to become foster parents to a private agency effective October 1, 2008. Finally, the Department's review of this case identified a decade-old practice of recording reports and investigations of DCF employees in a paper record only rather than in the Department's electronic database. This practice immediately ceased, and now all reports and investigations involving DCF employees are entered into the Department's electronic data base. This change became fully effective in June 2008 for new reports, and all old paper records were entered into the electronic database by early August 2008.

The report identifies other areas in need of improvement and offers additional recommendations for the department, including:

- Implement improvements in the recruitment, training, support and assessment of foster parents and clarify procedures involving DCF employees who are foster parents;
- Enhance family-centered practice, particularly relating to families involved with substance abuse and mental health issues and improve comprehensive family assessments at all stages of involvement with the Department; and
- Improve communication and the definition of clear roles in cases involving multiple Department divisions, offices, and units.

An Executive Summary of the key findings and recommendations is attached. The Department and the OCA appreciate the thoroughness of this report and its recommendations and agree that all necessary steps must be taken to help prevent such tragedies from occurring in the future and to ensure the safety and well-being of the children and families served by Connecticut's child welfare system.

Executive Summary
Michael B. Special Review Report

On May 19, 2008 seven-month old Michael B. sustained a traumatic injury to his head and died while in foster care. Approximately two months after his death, Michael's former foster parent, an employee of the Department of Children and Families (DCF), was arrested and charged with manslaughter in the first degree. At the request of the DCF Commissioner and Connecticut Child Fatality Review Panel, facilitated by the Office of the Child Advocate (OCA), the Child Welfare League of America (CWLA) was called upon to: (a) coordinate an independent Special Review of the circumstances of Michael's death; (b) assess the Department's case practice and provide an analysis of the findings; (c) offer recommendations to improve systems and organizational competence; and, (d) cultivate a context for learning and professional support.

Since 2004, the Department of Children and Families has partnered with CWLA to develop a quality improvement model for reviewing critical incidents and child fatalities. The resulting Special Review process represents an unprecedented collaboration of inquiry and transparency of government that is regarded as a national model for child fatality reviews.

The Special Review of Michael's death included interviews with approximately 70 DCF personnel between July and December, 2008. Concurrently, the Special Review Team (representing DCF, CWLA and the OCA) reviewed the family's case record, the foster parent record, relevant DCF Policies and other related documents, data and records. Literature, federal regulation and best practice journals were reviewed to enhance findings and recommendations. Participants were afforded the opportunity to contribute to findings and recommendations, and to share learning with their colleagues. The Special Review Report was completed on April 19, 2009.

The full 80-page Special Review Report summarizes DCF's involvement with Michael and his family, outlines the details of Michael's life and relationships, and highlights the critical interdependencies and transactions among communities and professionals that are necessary to adequately educate, protect and support vulnerable children and their families involved with the child welfare system. Michael's life story is painfully familiar to child welfare professionals and those that encounter the impact of multigenerational abuse and neglect on a daily basis. These prominent factors include: domestic violence; impaired parenting; severe mental health disturbances; abject poverty; chronic substance abuse; and, complex trauma associated with these compelling biological and psychosocial conditions. Among the several factors that make Michael's life and death so unique is the context in which he died.

Findings

- Foster parent pre-service training did not adhere to certain components of the prescribed PRIDE curriculum, compromising the efficacy of the training program.
- The foster care licensing home study process did not thoroughly assess the consistency of personal relationships, the existence of support networks or the applicant's ability to maintain enduring friendships, which are all powerful indicators for successful fostering. DCF staff did not review a previous adoption home study and did not consult with the home study agency.
- Safe foster placements of infants and children are hampered by a shortage of homes equipped to accommodate them and the absence of protocol for the collection of essential information to best inform foster parents.
- A comprehensive family assessment was not completed on Michael's family, missing the opportunity to consider relationship issues, thresholds for parenting and coping, and potential for substance abuse relapse once the case was closed.
- Structured Decision Making® was not utilized consistently in Michael's case, specifically on Hotline referrals made immediately after the family's case was closed.
- DCF does not have policy on use of forensic interviews with children, placing them at risk for re-traumatization.
- CT does not have the authority to re-open cases or re-assess circumstances when allegations are received after case closure unless those allegations meet the statutory criteria for neglect or abuse.
- Some abuse/neglect investigations of employees were found to be substandard. Substantial changes to the structure and supervision of the SIU have been implemented.
- Critical Incident reporting procedures were hampered by short timelines for conducting assessments and producing information, duplicative requests for information and conflicting assignments.
- Personnel responsible for licensing the employee foster parent were not aware of two previous unsubstantiated investigations concerning the employee's care of her child. These reports and investigations were maintained in paper files and were not entered in the LINK system. After Michael's death, the Commissioner ordered that all such records be entered into the LINK system.

This Special Review also identified positive findings, including, but not limited to:

- Establishment of Interdisciplinary Review Teams ensuring the use of all available resources to conference high risk cases;
- Shaken Baby Syndrome is now routinely discussed with families;

- Multiple Report Reviews have been implemented for risk assessment of families with multiple abuse/neglect allegations applying cumulative risk to open cases for treatment;
- Area Office leadership responded to staff secondary trauma with excellent interventions and support
- DCF Hotline staff and administrators coordinated assessments and interventions in exemplary fashion;
- There was effective communication with the media that moderated sensationalism of the case.

Recommendations

- In order to ensure the efficacy of an evidenced-based model of foster parent training, DCF must implement the full PRIDE curriculum and home study process as designed.
- DCF should examine all available sources of home study data including previously conducted home study reports. FASU staff should meet the nationally recommended professional qualifications of a Master's degree in Social Work or a related field and should receive competency-based training in the home study and licensing process.
- DCF should examine its capacity for accommodating infants and children through a statewide inventory of needs, available foster homes, and special skills and knowledge of current foster parents. Protocol should be developed for the collection and provision of child-specific caregiving information for foster parents.
- DCF should strengthen its policies regarding employees as foster or adoptive parents to avoid conflicts of interest, preclude co-workers from conducting home studies, and ensure proper qualifications of applicants.
- DCF should develop policy and procedures for conducting comprehensive family assessments early in the life of a case with updates as family circumstances change or case closure nears.
- DCF should review and validate current Structured Decision Making® tools and should ensure their full and consistent use to assess risk and safety. Hotline staff should be retrained in the use of CT SDM® Child Abuse and Neglect Screening Criteria.
- DCF should develop and augment policy on the delivery of substance abuse and mental health services to children and their families.
- DCF should develop policy and practice regarding safe forensic interviews of children in the Department's custody to avoid re-traumatization.
- 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, in order to ensure that Area Office personnel familiar with the case have an opportunity to assess the allegations.
- DCF should develop risk and safety assessment tools to be used by SIU staff in the investigation of allegations of abuse and neglect in foster care

and residential facilities. SIU investigators should also have full access to clinical and other consultation resources during investigations.

- DCF should develop policy and practice that ensures all child abuse/neglect allegations are investigated, documented and reviewed in the same manner regardless of where the alleged perpetrators are employed.
- DCF should develop protocol for responding to critical incidents that includes clear delineation of roles and responsibilities, guidance for lines of communication, mechanisms for managing flow of information internally and externally, appointing spokespersons and liaisons with the Medical Examiner, and dealing with media communication.

Conclusion

The death of any child is a tragedy. When a child dies in the care of the child welfare agency, the tragedy is heightened because the purpose of child welfare services is to protect children and families. Michael's death has had profound effects on his family, community and the DCF system. It is the hope of the Special Review Team that this Report will serve to enhance DCF's ability to ensure the safety and well-being of the children and families its serves.