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April 30, 2026

Susan Hamilton, JD
Commissioner of the Department of Children and Families
505 Hudson Street
Hartford, CT 06106
Via electronic delivery

Re: Public Letter of Findings and Recommendations – Ongoing Deficits in the Quality of Case Practice at DCF

Dear Commissioner Hamilton:

Last week, the Office of the Child Advocate (OCA) received notification that a child with an open investigation with the Department died by apparent suicide. Based on our preliminary investigative review, this apparent self-harm occurred within one hour of the Department of Children and Families (DCF) staff visiting the family. According to DCF's records, during that visit the child told the DCF caseworker that the child did not feel safe and asked to come into foster care. The family had a lengthy DCF history in Connecticut, did not have stable housing, had moved in and out of Connecticut over many years, and none of the children were enrolled in school. Despite these facts and all of the information available to DCF, DCF made a decision to leave the child with the parent, indicating that coming into care was not an option. OCA has opened an investigation to conduct a full review of the circumstances of this case. While it is too early to reach conclusions, our preliminary review of this case leaves us alarmed. In fact, OCA has grown increasingly alarmed at the quality of case practice observed through our reviews of critical incidents and child fatalities, some of which have garnered significant public attention and some of which have not. It is this increasing alarm, coupled with ongoing deficits in the quality of case practice, which DCF has been unable to address, that compels OCA to issue this Letter of Findings and Recommendations. DCF Executive Leadership must ensure that caseworkers have the support needed to meet expectations, ensure that services are available to children and families, hold all staff accountable to expectations, and publish its internal quality assurance data. Quality assurance data must be reviewed by policy makers on a regular basis and used to drive decisions about funding and policy.

OCA is charged with evaluating the delivery of publicly funded services to children, including services provided by DCF. This Letter of Findings and Recommendations is being issued to the Commissioner of DCF, state policymakers, and the public consistent with our obligation to recommend changes in state policies concerning children, including in the system of providing foster care and treatment.

Over the last several years, OCA has advocated for DCF to share its internal quality assurance data to ensure that the public and policy makers have information upon which to make both funding and policy decisions. Quality assurance data provides information on case practice across the agency. To date, while DCF has shared information that is required under federal reporting

requirements, such as the Child and Family Services Reviews, it has not shared the information gathered through its internal quality assurance measures with the State Advisory Council (SAC) or the legislature. Since 2023, OCA has engaged in conversations with, and provided recommendations to, DCF regarding the urgent need to improve case practice. In March, OCA received DCF's most recent internal quality assurance data and evaluated that data as part of its investigation of the quality of DCF case practice. Despite expression of shared concern by DCF Executive Leadership, OCA finds that DCF has been unable to demonstrate improvements and the currently identified action steps are not adequate.

Every day, the deficits in case practice have consequences for children. OCA learns about some of these consequences when a new report comes in, when there is a critical incident, or when a child dies. Other children live with those consequences in silence, when they don't receive the help they need. The deficits in the quality of case practice must be urgently remedied. There is not one statutory change that can address these issues. Rather, doing so will require concerted effort by DCF Executive Leadership; commitment to caseworkers, both by DCF Executive Leadership and the legislature, to ensure they have the support they need to meet expectations; and ongoing external oversight and accountability.

Background

In March 2022, the state exited the Juan F. consent decree, ending 30 years of oversight by a federal court monitor. Throughout those 30 years, the Juan F. Court Monitor's office conducted qualitative case reviews aligned to outcome measures identified under the consent decree. When the court monitor's office closed, the state lost external oversight of the quality of case practice at DCF. Following the exit of the consent decree, DCF continued to utilize the tool that was used by the Juan F. Court Monitor to assess the quality of work in investigations and family assessment reviews (FAR). At that time, DCF did not have any tools in place to assess the quality of work in in-home cases.

In February 2023, OCA issued a [*Public Findings Letter*](#) regarding OCA's review of critical incidents involving children, including Kaylee S., who died in February 2022 from Fentanyl intoxication. At that time, OCA recommended that DCF "implement ongoing quality assurance regarding safety planning practice for children under DCF supervision. Quality assurance should include information regarding the timely availability and utilization of services necessary to mitigate child safety concerns in the home." In addition, OCA recommended that DCF regularly publish its findings regarding safety practice and child fatalities. In April 2023, DCF implemented a new quality assurance tool for reviewing in-home cases and began sharing data from these reviews with OCA in the summer of 2023.

In October 2023, OCA issued [*Fatality Investigation Findings and Recommendations*](#) regarding Liam Rivera. OCA's report discussed the urgent need to address deficiencies in case practice and recommended increased transparency, accountability, and external oversight of DCF. In February 2024, OCA issued [*Child Fatality Investigation Findings & Recommendations*](#), regarding the death of Marcello P. OCA published DCF's internal quality assurance data regarding investigations and family assessment reviews, and recommended that DCF utilize frequent and reliable quality assurance protocols pertaining to safety planning and service delivery; that DCF assess the impact

of telework and workforce trends on DCF case practice, staff retention, and supervision; and that the state develop a framework for oversight of DCF. Subsequently, DCF created a new position, the Director of Child Safety Practice and Performance to bring heightened attention to safety practice across the agency and established the Quality Improvement Leadership Team as a governing body to review data and determine recommendations and further strategy development for statewide implementation. DCF reported to OCA in late 2024 that this group would review the results of data and focus on actionable strategies to improve practice and review of the implementation and efficiency of those strategies. DCF also indicated at that time that it was developing a new safety practice supervisory tool to be used during supervision sessions to emphasize review of child safety, quality visitation, and needed action steps. DCF indicated that certain trainings relevant to these issues would be mandatory for all social work supervisors and program supervisors in the child welfare bureau. Lastly, DCF indicated that it was creating a child welfare “Scorecard” to bring together key indicators of performance on behalf of children and families. In our [*Addendum To Fatality Investigation Findings & Recommendations Regarding The Deaths Of Liam Rivera/Marcello Meadows-- Follow Up On Individual And System Improvement Efforts*](#), issued in December 2024, OCA reported its concerns about the quality of in-home case practice based on the data from reviews conducted through April 2024 and DCF’s above-described efforts to address the concerns. OCA recommended that DCF provide the SAC a current and comprehensive review of all existing data sources to ensure that the SAC could review data in accordance with Public Act 24-126, enacted in response to Liam’s death.

Since that time, OCA has monitored DCF’s data and communicated with DCF leadership regarding our concerns with case practice, informed both by the data and by OCA’s reviews of critical incidents and child fatalities. Starting in October 2025, because the way in which the data was reported to OCA had changed over time, OCA requested to receive raw data along with reports. In December 2025, OCA received DCF’s summary review of the DRS data, with the raw data. In March 2026, OCA received DCF’s summary review of the in-home data, with the raw data. With the receipt of this data, OCA had one year of data, since DCF identified actions steps in December 2024, to assess the agency’s progress with improving adherence to policy.

Methodology

For purposes of this investigatory review, OCA examined:

- DCF documents reporting the results of internal quality assurance for the Differential Response System (DRS), which is based on randomly sampled cases selected from all investigations and family assessment reviews;
- DCF documents reporting the results of internal quality assurance for in-home cases (In-Home Case Reviews), which is based on randomly sampled cases selected from all in-home cases;
- DCF raw data for DRS and In-Home Case Reviews; and
- Review of Critical Incidents and DCF case records regarding a recent child fatality reported to OCA.

This Letter of Findings and Recommendations is also informed by OCA’s ongoing review of DCF critical incidents and child fatalities.

OCA Data Review

In reviewing DCF's data, OCA finds that the quality of case practice, for both DRS and in-home cases is not demonstrating a trend of improvement over time. Rather, the data demonstrates ongoing challenges with adherence to agency policy. DRS data demonstrates a rather precipitous decline in most areas since 2022 and In-Home Case Review data demonstrates consistent lack of adherence to policy in key areas. While DCF has indicated some changes in the DRS tool, and OCA acknowledges those changes, none of those changes are sufficient to explain the decline in case practice.

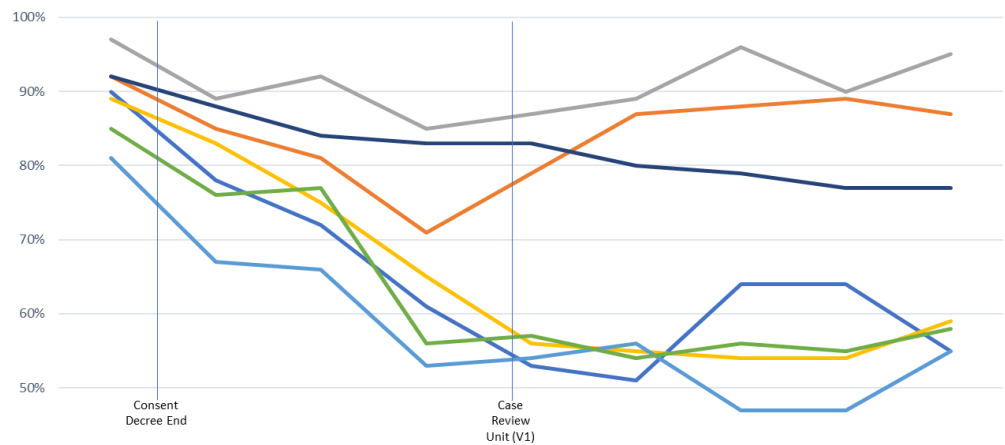
OCA is particularly concerned about adherence to policies that are foundational aspects of the work: quantity and quality of visitation, collateral contacts, and supervision. DCF policies are designed to ensure the safety and well-being of children. Without adherence to policies regarding visitation and collateral contacts, decisions will continue to be made with information that is not current, reliable, or accurate. Without consistent high quality supervision, lack of adherence to policy cannot be identified and rectified in a timely way.

It is important to note that DCF converted from LINK to CT-KIND for all of its case-management and case practice data requirements on August 7, 2025. It appears that this conversion happened prematurely as the conversion has resulted in significant challenges in access to and recording of case information. Reports previously available under LINK, which assisted supervisors with identifying cases in which expectations are not met, are not currently available, leaving supervisors to create independent ad hoc systems to manage their responsibilities. In addition, reviewing case histories is cumbersome and very time consuming, creating considerable risk that histories are not adequately reviewed when new reports are received. Entering notes related to ongoing casework is delayed, with reports of 30% to 50% more time being required to enter information. The data described below pre-dates the change from LINK to CT-KIND and it is likely that data for the period after August 2025 will show further declines in case practice due, at least in part, to challenges with documentation. While any change in technology at this scale would result in immediate short-term challenges, the change occurred 8 months ago and these issues remain ongoing.

DRS Data

The table below demonstrates the decline in essential areas of case practice from Q1 2022 through Q1/2 (June) 2025, which is the most recent data available.

**Differential Response
QA Trend Data**



	Q1 22 Avg	Q2 22 Avg	Q3 22	Q1 23	Q2 23	Q3 23	Q1/2 24	Q3/4 24	Q1/2 25
Supervisory Support, Oversight and Guidance Rating	90%	78%	72%	61%	53%	51%	64%	64%	55%
Information Collected and Documented in the Protocol Rating	92%	85%	81%	71%	79%	87%	88%	89%	87%
Services to Family to Protect Children & Prevent Removal Rating	97%	89%	92%	85%	87%	89%	96%	90%	95%
Risk and Safety Assessment and Management Rating	89%	83%	75%	65%	56%	55%	54%	54%	59%
Contact with Adult Participants Rating	81%	67%	66%	53%	54%	56%	47%	47%	55%
Contact with Children Rating	85%	76%	77%	56%	57%	54%	56%	55%	58%
Timeliness of Commencement	92%	88%	84%	83%	83%	80%	79%	77%	77%

We note that Q1 2022 through Q1 2023 reviews were completed using the Pre-certification Review Instrument created and utilized by the Court Monitor’s Office and that this tool was refined by DCF in May 2023. In our prior discussions with DCF, DCF indicated that the Court Monitor’s tool included a component that allowed for verbal input and response from staff. Our understanding is that verbal input was gathered by the Court Monitor’s office in a small percentage of the cases. Moreover, the Court Monitor’s office closed in March 2022, and OCA presumes that the completion and analysis of Q1 2022 was not done by the Court Monitor’s staff. In any event, if that was the reason for the decline, one would expect that change to be observable at the time of that change and then level off, which is not what the data shows. Instead, the data shows a precipitous decline in the most meaningful elements of DRS case practice from 2022 through 2023 and then leveling off at an unacceptably low rate that continues through June 2025, the most recent date for which data is available.

While OCA acknowledges ratings for Services to Family to Protect Children and Prevent Removal and Information Collected and Documented in the Protocol have largely remained steady and above 85%, both measures can be rated as adequate based on the information gathered, even if the information itself is not adequate. For example, if contact with children, contact with collaterals, and/or supervision did not meet expectations, but the investigation protocol documents the information that was collected and decisions about services were appropriate based on the information that was collected, the case could receive adequate ratings for information collected and documented and services to the family. Because sound decisions cannot be made without complete, current, reliable, and accurate information, OCA finds that measures related to contact with children, contact with parents, contact with collaterals, and supervision are the most meaningful measures and comprise the foundational aspects of keeping children safe.

These foundational aspects of the work have persistently remained unacceptably low since May 2023. Scores for contact with children, contact with adult participants, and risk and safety assessment persistently remain below 60%. Scores for supervisory support did climb above 60% for several months but has again dropped below 60%. This creates significant risk that DCF is frequently making decisions without current, complete, reliable, and accurate information. This leaves children at risk.

When viewed collectively, DCF’s DRS data is even more alarming, as these key components are all rated as a strength in only one-quarter of the cases.

DRS Review Period	Score contact w/ children	Score contact w/ adults and collaterals	Score Risk and Safety	Score Supervision	Percentage Strength all 4 Components
7/24-12/24	55.8%	46.9%	53.8%	52.0%	22.7%
1/25-6/25	57.9%	54.9%	59.1%	55.3%	25.4%

In February 2026, the Department reported to OCA that it identified three action steps to address some of the deficits identified by the DRS quality assurance tool, including:

- Hartford Pilot to implement a touch point on Fridays, as timeliness is most often related to 72-hour cases reported on Fridays;
- Willimantic/Waterbury Pilot assessment and engagement tool, to be utilized in coaching sessions following observation of home visits by caseworkers; and
- Working with program leads and data scientists to understand utilization and need, specifically for safety related services for substance misuse and Intimate Partner Violence. This will include AIM tool enhancements and statewide education and communication.

While the Willimantic/Waterbury pilot targets the quality of home visits, we see little evidence of identified action steps to address the ongoing lack of adherence to policy in each of the foundational aspects identified across the agency. OCA finds that these action steps are not adequate to address the deficits.

In-Home Case Review Data

We must note at the outset that in-home cases inherently carry a high level of risk, as these are cases in which the Department has determined that a child has been abused and/or neglected, that ongoing agency involvement is required, and a decision has been made to leave the child in the home where the abuse and/or neglect occurred. These cases are often assigned to social work trainees.

While DCF has modified the tools and the way in which it aggregates and reports the data, making review of progress over time somewhat challenging, past and current data reveal persistent underperformance in key areas. In-Home Case Reviews conducted in **November 2023 through April 2024** revealed the following concerning findings, as reported in OCA’s [Addendum To](#)

Fatality Investigation Findings & Recommendations Regarding The Deaths Of Liam Rivera/Marcello Meadows-- Follow Up On Individual And System Improvement Efforts:

1. **Case Supervision.** Reviewers identified concerns with incorporating provider input into the case record, tracking progress on case directives, and documenting supervision of the Safety Plan.
2. **Safety Assessment.** For the cases in which a Safety Plan was in place, reviewers found that visitation was not conducted per practice guide in 35% of the cases.
3. **Quantity of Visitation.** For the cases reviewed that were recently transferred from investigations, 44% met the expectation that the social worker visit once per week for the first 30 days.
4. **Quality of Visitation.** In 43% of the cases, documentation of face-to-face visits with the children did not demonstrate that a quality assessment was developed specific to addressing the reason for involvement.
5. **Provision of Services.** Reviewers found that while DCF case plans typically identified appropriate services needed by the family (90%), only 49% of cases included documentation that the identified service was actually delivered to the family during the review period.
6. **Contact with Providers.** Fewer than a third (28%) of cases included quality documentation of monthly contact with the parents' providers to review their progress with treatment goals.

DCF's In-Home Case Review data for **the period of November 2024 to October 2025** continues to raise concerns with respect to quantity of face-to-face visits with the child, visits with the primary caregiver, and supervision:

53. Did all children in the home have two documented face to face visits per month in the PUR?	11/24-4/25	5/25-10/25
Yes-All	59.0%	55.8%
No-Some	36.2%	35.6%
No-None	4.9%	8.7%
54. Was there documentation of in-person visits with the primary caregiver twice per month (or at frequency as per SWS directive) during the PUR?		
Yes-All	69.9%	59.9%
No-Some	25.8%	34.0%
No-None	4.3%	6.1%
92. Is there a monthly supervisory conference documented for each month of the PUR?		
Yes-All	67.2%	70.1%
No-Some	31.0%	26.0%
No-None	1.8%	3.2%

OCA is particularly concerned about the fact that there are cases with no documented face-to-face visits with the child and also cases with no documented visits with the primary caregiver during the PUR.¹

OCA recently reviewed DCF’s raw data. When OCA looked collectively at four measures of quality that OCA believes are foundational to sound decision making, these measures are all rated as a strength in only 7% of the cases during the PUR, suggesting that few cases consistently meet expectations regarding visits, service provision/collateral contacts, and supervision.

IH Review Period	Quality Visits w/ Children Rating	Quality Visits w/ Caregiver Rating	Quality of Service Provision Rating	Quality of Supervision	Percentage Strength all 4 Components
11/24-4/25	41.3%	66.9%	17.2%	14.0%	7.0%
5/25-10/25	37.4%	65.9%	25.6%	19.6%	7.4%

When OCA raised concerns to DCF in October 2025, regarding the data for the period between November 2024 and April 2025,² DCF identified using the ABCD Practice Profiles to track and address skill competency. DCF also indicated that it would be creating a supervision pilot, using the Practice Profiles to make improvements. To our knowledge, neither of these identified action steps have occurred as of the date of this letter.

Discussion

OCA recognizes that many factors contribute to the lack of adherence to policy and that DCF faces many challenges in its efforts to improve case practice. We acknowledge that DCF, like many employers, experienced workforce shortages following the pandemic. Many seasoned DCF workers retired in 2022, leaving DCF with a less experienced workforce. DCF lost a significant number of foster families when it transitioned from therapeutic foster care to FFT-FC in 2022 and has not been able to recruit and retain sufficient numbers of foster parents since that time. The work is challenging, and DCF is struggling to recruit and retain workers, with approximately 50% of new workers leaving in the first two years. That said, the work of DCF has always been among the most challenging and critical work in state government.

Since 2023, OCA has raised concerns with the quality assurance data and, in response, DCF has identified action steps. Unfortunately, the identified action steps have not resulted in improvements to date. Anecdotally, workers express that they are overwhelmed and can’t complete the amount of work that is expected. OCA’s review of caseloads notes an increase over the last six months, but caseloads during the periods of review for the data described above remained consistent with caseloads during the Juan F. Consent decree. While the agency modified caseload expectations in August, when it transitioned to CT-KIND, reducing caseload, alone, is not sufficient. DCF must also recognize the lack of service array as a driver of the sense of overwhelm being experienced by caseworkers, and shared by many providers. The state’s current lack of sufficient foster homes,

¹ The period under review is six months, though some cases in the review may be opened or closed within that time period and thus not open for the full six-month period.

² This data was provided to OCA in July 2025.

sufficiently supported foster homes, and lack of a continuum of treatment options fuels placement instability. According to the Child and Family Service Reviews, the placement instability rate has been trending in the wrong direction. Workers and children are in a near constant state of crisis: caseworkers can't find placements for children, and need to rely on emergency placements; children have significant behavioral health needs that go untreated, and foster parents can't meet their needs without supports that are currently not available; children are placed in STTAR homes for many months with no real exit plan, lose hope, and engage in challenging behaviors. This constant state of crisis leaves workers feeling unsupported and burnt out.

There is a critical need for DCF Executive Leadership to take swift and bold action to ensure that workers are adequately supported to meet policy expectations and to hold staff accountable to those expectations. There is no statutory change that can quickly remedy lack of adherence to policy. However, ongoing external oversight, identified outcome measures, and public transparency are integral to holding the agency accountable.

Recommendations

Support DCF Caseworkers to Ensure That They Can Meet Expectations

1. Provide administrative support and social work case aides.

Appropriate administrative support allows caseworkers to focus on social work – visiting homes, assessing families, communicating with collateral providers, etc. – while administrative support staff can follow up on referrals made, gathering documents, and other tasks that do not require the skills of a social worker. Similarly, case aides can assist with some transportation tasks, obtaining items on an urgent basis (such as diapers and cribs), again freeing up caseworkers to focus on higher level social work tasks. DCF Executive Leadership recently informed OCA that they were working with OPM to move forward with hiring case aides for positions that had previously gone unfilled. To provide the necessary support, administrative support staff and case aides must be in the office so that they are available to complete tasks on short notice.

2. DCF must urgently identify and develop additional models of therapeutic foster care and support foster parents.

- a. Children with significant needs can be cared for in foster homes, but those foster homes must have timely access to in-home supports, respite, on-call support, and other forms of support to enable them to meet the needs of children in their care. Functional Family Therapy-Foster Care (FFT-FC), adopted by the agency in 2022, is not adequate as the sole option for therapeutic foster care. While Functional Family Therapy (FFT) is evidence based, FFT-FC is not. It is not designed for children with significant behavioral health needs and needs for intensive family therapy while the child is in foster care. DCF may consider Treatment Foster Care Oregon, an evidence-based model for children aged 12-17 with severe emotional and behavioral disorders and juvenile justice involvement. They must also design foster care for children with a combination of two or more disabilities, intellectual disability, autism, medical complexity, and behavioral health needs.

- b. DCF must make funding for supplemental support for foster families available in a speedy fashion.
- 3. DCF must take affirmative steps to develop a continuum of mental health treatment services, including out-patient, intensive in-home services for children and families, therapeutic group homes, and residential treatment.**
 - a. DCF is statutorily responsible for developing comprehensive services for children with mental health needs.³ It must actively support the development of a robust continuum of mental health services in the state, serving as preventive services for all families, and serving as intervention and support for children involved with DCF and/or in DCF care.
 - b. While most children who are removed from their homes should be cared for by relatives, fictive kin, or foster families, some children have significant mental health needs, sometimes co-occurring with and sometimes driven by the trauma they have experienced. In an effort to reduce unnecessary congregate care, the state intentionally reduced congregate care, starting in 2011. Between 2011 and 2024, the state went from having 52 therapeutic group homes (serving up to 268 children) and 20 residential treatment centers (serving up to 330 children) to 21 therapeutic group homes (serving 81 children) and six residential treatment centers (serving up to 143 children). This drastic reduction has significant ramifications. While OCA supports keeping children in the community whenever possible, many children served by DCF have extensive trauma histories, multiple placements, and DCF has not been able to find foster homes for them. Many require significant mental health treatment and stabilization to which they currently do not have access. Girls, in particular, are not able to access the mental health treatment services they need. Girls currently wait twice as long as boys (about 80 days) for access to Psychiatric Residential Treatment Facilities (PRTF). When the state does not have the treatment programs girls need, girls in DCF care are placed in STTAR shelters. Instead of receiving treatment, they are in a temporary short-term placement for months on end, and many girls lose hope, run away and/or fall prey to human trafficking. The state must urgently address this need. DCF should consider developing Qualified Residential Treatment Program for girls with complex trauma and behavioral health needs, including those who are at risk of trafficking. If such a program is created, DCF must ensure that it provides trauma-informed, gender-responsive treatment of the highest quality, and must develop methods for quality assurance that will be in place from the outset of such program.
- 4. DCF must provide all staff with less than two years of experience enhanced supervision.**

Given the loss of a large number of very experienced staff in 2022, and the high rate of staff turnover, the DCF workforce includes many staff with little child protection

³ Conn. Gen. Stat. § 17a-3.

experience. DCF currently assigns most trainees to in-home services units, which serve DCF's highest risk cases: those on which it has been determined that children were abused and/or neglected, and a decision has been made to keep the child(ren) in-home with services. With telework, the type of learning and mentoring that naturally occurs when new staff enter a workplace to work alongside much more experienced staff can no longer be counted upon. New staff need more support and need to learn through engaging with more experienced staff. The ABCD Practice Profiles and Discussion Guide, already established through policy, could be used to support supervision.

Accountability to Expectations

- 5. DCF must set clear goals for increasing adherence to its policies, particularly those regarding visitation, collateral contacts, and supervision; communicate these goals to staff; and publish data to ensure transparency and accountability.**

Along with support necessary to meet expectations, DCF must send a clear message to all staff that the most important measure of success is the quality of case practice. DCF cannot make sound decisions if staff do not adhere to policies regarding visitation, collateral contacts and supervision. These policies are designed to ensure comprehensive assessments of child safety.

- 6. Adherence to agency policy for quantity/frequency of contact with children and caregivers, contact with collateral contacts, and supervision should be tracked within CT-KIND, with alerts and reminders to ensure both awareness and accountability.**

Reports previously available under LINK, which assisted supervisors with identifying cases in which expectations are not met, are not currently available. This must be remedied expeditiously. Unless/until reports are available through CT-KIND, every regional office must have alternative methods to track case activities and ensure accountability.

- 7. Telework approvals should be dependent upon meeting performance expectations.**

DCF staff are currently permitted to telework 80% of the time, with prior approval. All approvals for telework should be predicated upon adherence to agency policy for quantity and quality of contact with children and caregivers, contact with collateral contacts, and supervision. If agency goals for adherence to these expectations are not consistently met by the individual, telework should not be approved for that individual. Likewise, lack of adherence to policies regarding frequency and quality of case supervision should result in denial of telework requests for supervisors and program supervisors.

- 8. DCF must use quality assurance data to drive training, performance expectations, and accountability.**

The agency's quality assurance data should be used to identify regional offices, units, workgroups, and/or specific staff that persistently do not adhere to agency policy, and

develop targeted workplans for those individuals/workgroups, with accountability for improving adherence to policy in these key areas.

Child Safety Assessment

9. DCF must fully implement the ABCD Child Safety Practice Model, adopted by the Department in 2021, to ensure consistent practice and critical thinking.

The model consists of three components: (1) the ABCD Paradigm for assessing child safety (Adult Protective Capacities; Behaviors that are harmful; Child Vulnerabilities; and Dangerous conditions); (2) the Practice Profiles (a tool to “support consistent and effective practice and encourage skill development and critical thinking”); and (3) Discussion Guides (a reference for DCF workers to use while collecting information, seeking specialized consultation, and integrating [their] work with community; the purpose is to “foster communication, share information, and promote critical thinking between the Department and community based partners.”). DCF policy requires supervisors to utilize the Practice Profiles with new staff coming into the unit to identify areas of focus in supervision and training needs, as well as with existing staff to enhance their skills. Similarly, all staff are directed to use the Discussion Guides (dependent upon individual case circumstance) with community providers to gather pertinent information. Despite these policies, neither the Practice Profiles nor the Discussions Guides have been fully implemented. DCF has indicated that the Practice Profiles were not well understood and noted that the Continuous Quality Improvement (CQI) division has developed tools as a part of the Program Improvement Plan (PIP)⁴ to improve understanding of the components of the safety practice model. The Practice Profiles and Discussion Guides support critical thinking and communication and are necessary components of the model. OCA emphasizes the need for all caseworkers and supervisors to have a strong understanding of the ABCD Child Safety Practice Model and the ability to employ critical thinking throughout the life of the case. Given the importance of these components to meaningful implementation of the ABCD Child Safety Practice Model, OCA recommends that DCF make concerted efforts to re-train staff and ensure that supervisors are firmly grounded in the Practice Profiles and Discussion Guides.

10. DCF must develop criteria for assessing children who do not have access to mandated reporters and how these criteria may be added to the SDM and/or Child Safety Practice Guides.

The current Structured Decision Making (SDM) tool, which is an evidence-based tool, does not consider access to mandated reporters when assessing safety. As a result, while isolation from mandated reporters is an indicator of risk, it is not routinely considered in assessing risk and safety. This should be remedied expeditiously.

⁴ The Program Improvement Plan is required in response to DCF’s performance on the federal Child and Family Service Reviews.

Transparency

- 11. DCF should publish a data dashboard that makes available in real-time quantitative data regarding the number of reports received, number accepted, number placed on FAR track versus investigations, number substantiated, number placed on the child abuse registry, number of children in in-home care, number of children in out-of-home care, worker caseloads, and other data that can be pulled from CT-KIND.**

This kind of data dashboard would provide important real-time data to the public and policy makers.

- 12. DCF should publish its qualitative case reviews (DRS and In-Home) and present data to the State Advisory Council and policy makers on a regular basis.**

Qualitative data is necessary to inform policy makers about the quality of DCF case practice. As described in this Letter of Findings, DCF's current qualitative case reviews indicate significant deficits in case practice. These deficits directly impact child safety and well-being and it is urgent that they be remedied. This data, however, is not published in any form by the Department. Policy makers must be provided with regular updates on performance, and the information must be presented in ways that are complete, understandable, and accurate.

- 13. DCF must comply with state law and update the SAC website.**

The [website for the State Advisory Council](#) has not been updated since July 2022. Meeting agendas, minutes, and recordings of virtual meetings are not published on the website, as required by state law. This must be expeditiously remedied.

- 14. DCF should resume conducting individualized Special Qualitative Reviews.**

Until June 2024, DCF completed individual reports on Special Qualitative Reviews (SQR). SQR assessments are completed when there is a fatality or near fatality. The SQR assessments include "interviews with DCF staff and external stakeholders in addition to the review of the case circumstances, and the areas of case review focus include: case practice concerns, system concerns, policy concerns, and strengths of the work. The SQR assessment method includes process mapping of themes to identify areas of system change."⁵ DCF no longer completes these individualized reports and instead takes information from reviews and aggregates that data to identify trends. This data is entered into a national database to inform national child welfare work, including the work in Connecticut. While OCA agrees that aggregation and identification of trends is of significant value and should occur, it is equally important that the consequences of lack of adherence to policy be visible to caseworkers, the public, and policy makers. The purpose of this visibility is to learn from tragedies, identify prevention strategies to avert similar tragedies in the future, and make changes to law, policy, and practice.

⁵ Department of Children and Families Appropriates Workgroup Meeting, Question 9 (2023).

15. DCF should affirmatively report to the public regarding child fatalities and near fatalities consistent with federal Child Abuse Prevention and Treatment (CAPTA) provisions.

CAPTA states:

States must develop procedures for the release of information including, but not limited to: the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; the result of any such investigations; and the services provided by and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality or near fatality.⁶

Several states have codified child fatality reporting obligations by child welfare agencies.

OCA believes that implementation of these recommendations will improve the quality of case practice and thereby improve the safety and well-being of children. We urge DCF and policy makers to take swift action to implement these recommendations. Pursuant to Connecticut General Statutes § 46a-131(f), OCA requests that DCF provide a written response to this Letter of Findings and Recommendations to the Governor and the General Assembly no later than 90 days from the date of this letter.

Sincerely,

Christina D. Ghio

Christina D. Ghio, JD, CWLS
Acting Child Advocate
Office of the Child Advocate

Cc: Via electronic delivery:
Governor Ned Lamont
Senator Martin Looney, Senate President Pro Tempore
Senator Bob Duff, Senate Majority Leader
Senator Stephen G. Harding, Jr., Senate Republican Leader
Senator Henri Martin, Senate Republican Leader Pro Tempore
Representative Matthew Ritter, Speaker of the House
Representative Jason Rojas, Majority Leader of the House
Representative Vincent Candelora, Minority Leader of the House
Senator Catherine Osten, Co-Chair, Appropriation Committee

⁶ Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5106a et seq.) Section 106. DCF receives the federal CAPTA funding. <https://www.cga.ct.gov/2020/rpt/pdf/2020-R-0223.pdf>

Representative Toni Walker, Co-Chair, Appropriations Committee
Senator Heather Somers, Ranking Member, Appropriations Committee
Representative Tammy Nuccio, Ranking Member, Appropriations Committee
Senator Ceci Maher, Co-Chair, Committee on Children
Representative Corey Paris, Co-Chair, Committee on Children
Senator Jason Perillo, Ranking Member, Committee on Children
Representative Anne Dauphinais, Ranking Member, Committee on Children