

**Presentation to the Children's  
Committee Regarding Dylan C. and  
Related OCA Follow-up Activities and  
Recommendations**

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**February 14, 2017**

**Office of the Child Advocate**

## January, 2016, OCA begins investigation into critical injury to baby Dylan C. in DCF foster care

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- OCA is notified of reports to DCF alleging critical injury to a child, suspicious for abuse/neglect.
- OCA received a complaint regarding the circumstances leading to Dylan's injuries.
- OCA received a whistle-blower complaint asking for a review of Dylan's case.

# OCA investigates injuries to Dylan C.

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- Initial questions of investigation:
  - Where was child placed?
  - Was this a safe placement?
  - How was the placement monitored?
  - How were Dylan's needs/treatment assessed over time?
  - How did he sustain such significant injuries over time (inclusive of severe malnutrition) without *anyone noticing*?
  - Are there gaps in DCF practice/protocols that make the mistakes leading to Dylan's injuries more or less likely to recur?

# OCA investigation activities: Dylan C.

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- Review of DCF electronic record (LINK)
- Review of foster parent application and related documentation
- Review of all hard copy records obtained or received by DCF with regard to management of Dylan C.' care.
- Review of medical records/providers records. Interviews with providers. (Birth to Three, supervised visitation provider, director of CCMC SCAN program).
- Interview with Regional Office leadership and senior management.

# OCA investigation activities Dylan C.

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- Preliminary OCA findings led to concerns that records were not complete. OCA made subsequent request for additional electronic records created or obtained by DCF staff.
  - Majority of electronic licensing record had been back-filled!
  - Case management entries left major holes in timeline.
  - Review of electronic records leads to several additional concerns and findings in report.

# Findings: OCA Report

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- Baby Dylan was removed from his home, along with siblings on June 12, 2015 due to concerns of chronic and escalating neglect.
- He was 13 months old
- Dylan was separated from siblings and placed by DCF into the home of his mother's cousin and the cousin's husband.

# **OCA Findings: Dylan came into relative foster care**

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- Dylan spent approximately 5 months in first foster home before being moved to another relative home due to rising concerns about capabilities of his foster parents.
- New foster mother takes child to Local Emergency Room on November 11, 2015 due to concerns about his physical appearance.

# OCA findings: Dylan's injuries

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- Dylan transferred by ambulance to Connecticut Children's Medical Center, admitted.
- "Significantly emaciated."
- Poor muscle tone and head control. Unable to walk, talk or feed himself.
- Lost weight in foster care. Weighed only 17 pounds. Needs to "treated as an infant."

# OCA Findings: Dylan's injuries

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- Doctors found that “given his history of normal growth previous to his foster placement and absence of a reported illness that could explain this malnutrition, his [appearance] was most likely the result of nutritional neglect” and abuse. Doctors deemed the foster parents’ explanation that Dylan had recently been sick and had lost weight in the last few weeks as “implausible.”

# OCA Findings: Dylan's injuries

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- Child injured.
- Broken bones in both arms, several weeks old.
- Healing burns on his wrist.
- Torn frenulum.
- Multiple bruises and abrasions of different ages on his chest, shoulder, abdomen, elbow, back and arm.
- Retinal hemorrhage, old bleeding into Dylan's brain.
- Injuries “highly suspicious for inflicted injury or abuse.” Foster mother arrested.

# OCA findings: Injuries due to abuse and neglect over time.

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- Medical records: Dylan's arm fractures "would have been obvious to caregivers due to the trauma events causing the injuries, associated pain behavior, and disuse of extremity following injury."
- Doctors concluded that Dylan's extreme malnutrition and the failure to seek care for his multiple fractures constituted gross neglect, and that his pain, suffering and condition should have been obvious to caregivers.
- Doctors appalled that child seen the day before by a DCF caseworker—child's need for medical attention characterized as "very obvious."

# OCA findings: Dylan's Placement was Unsafe

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- Dylan was placed in an unlicensed home and proper procedures to allow placement were *not followed*.
- Conn. Gen. Stat. 17a-114.
  - Law does not allow placement of children in unlicensed homes
  - Exception to permit placement of child by DCF in a relative/kin home so long as
    1. Preliminary assessment/walk-through of foster parents' home.
    2. Background checks completed on foster parents/adults in home.
    3. Where background check reveals prior criminal/DCF history by an adult in home/foster parent, law requires that the DCF Commissioner assess and determine appropriateness of issuing a statutory/regulatory waiver. Waiver must be issued prior to placement of a child.
    4. Waiver permitted if placement is **in the best interests of the child** and provided the **waived standard is *not safety related***.
    5. **Licensure must be completed within 150 days (previous requirement: 90 days)**

# OCA Findings : Dylan's Placement was Unsafe

1. The relative foster home had a prior DCF history, including a substantiation for neglect of the foster mother's own special needs son, and a criminal history (foster father)—limited income, no employment, no drivers' licenses (suspended), chronic health issues.
2. No Commissioner's waiver was sought to effectuate child's placement.
3. No walk-through/preliminary assessment done.
4. Employees reported later to DCF (April-September, 2016, internal interviews/HR) that they did not know results of foster parents' background checks.

# Findings—Dylan's Placement Unsafe

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- Foster parents **lied on their foster parent application**—no follow up by licensing unit—not clear that this application was even read.
- Foster parents **did not complete any training** required by DCF.
- No follow up **on chronic health impairments** of foster parents.
- July, 2015 a report to the DCF Careline **alleging substance abuse/physical** neglect by foster mother. Investigated by DCF Special Investigations Unit. No substantiation. Foster mother would not agree to substance abuse screen/evaluation.

# OCA findings: Dylan's Medical and Developmental Needs Unaddressed

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- Dylan identified as having global developmental delays upon entry into foster care
- Dylan identified as having need for medical and developmental follow-up.
- Dylan misses all of his scheduled doctor's appointments while in the foster home.
- Dylan misses repeated visits with Birth to Three— provider contacts DCF **8 times to express concerns.**

# OCA findings: Concerns Arose Right Away about Dylan's Safety and Care

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- **July.** Foster mother described by case aide as “overwhelmed” and “Exhausted” by caring for Dylan. Foster mother tells case aide that Dylan “will not let her sleep.”
- **July.** FM calls DCF and asks for more support. Claims that child “cries and screams constantly.”
- **July.** DCF receives **notice from police department** that FM called asking if she could get in trouble for allowing baby to “cry for long periods of time.” (**Not documented in case record.**) OCA learned of this after requesting employee emails.

# OCA findings: Concerns continue

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- **July 30, 2015:** Report to DCF Careline alleging FM uses substances.
- **August:** FM refuses to cooperate with s/a evaluation.
- **August:** Foster parents skip mandated training.
- **Internal emails** raise concern about FM's possible "**personality/mental health issues.**" **Manager: demand compliance with substance abuse eval or will change placement.** Not documented in case record. No follow up.
- **September:** multiple reports from **Birth to Three** regarding missed appointments for Dylan. FM won't let provider into the home. Concerns about Dylan's appearance. No home visits by DCF for 11 more days.

# OCA findings

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- During an October 29th visit, the caseworker observed that Dylan was again sleeping in the pack and play, “curled up into a ball.” The caseworker wrote in his visit note that he was “**able to confirm that [Dylan] was indeed breathing.**” The worker reported that Dylan was “thin” *but that [he] “appear[ed] appropriately clothed and well cared for”* and “the home and child have been assessed to be safe during [the caseworker’s] visits.”

# OCA findings: Concerns continue

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- **October:** Still no substance abuse evaluation.
- **October.** Foster parents skip training again.
- **October,** continued calls from Birth to Three regarding missed appointments.

# OCA findings: Concerns continue.

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- **November:** another missed **doctor's** appointment and **Birth to Three** appointments.
- Home visit by DCF: **Dylan sleeping again.**
- Foster mother still refuses substance evaluation. Will not be associated with “drug addicts,” was “begged” by DCF to take Dylan.
- DCF decides on November 5 to have Dylan moved to a new foster home.
- Relatives exchange child on November 10. New relative foster parent takes Dylan to the hospital shortly thereafter due to concerns about his appearance.

# OCA findings

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- “After Dylan’s injuries were discovered (November 11, 2015) a DCF manager acknowledged in an internal email that they “didn’t suspect” how bad things were and that staff had been worried his “global needs weren’t being met,” but not that he wasn’t getting “basic care.” These emails in conjunction with the visitation records highlight how inadequate the case practice was in that what Dylan was or wasn’t getting and what condition he was in *was never assessed.*” -- OCA report.

# OCA findings: Dylan repeatedly “sleeping” during DCF visits.

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- Dylan repeatedly found to be “**sleeping**” during visits by DCF caseworker. Between July 31, 2015 and November 10, 2015 (**102 days**) reports of home visits repeatedly document that Dylan is “sleeping.”

# **OCA Findings: 4 Units, and multiple managers at DCF touched Dylan's case**

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- Case management Unit (CPS)
- Licensing Unit (FASU)
- Quality Assurance (ACR)
- Special Investigations (SIU)

## **OCA findings: repeated red flags about Dylan's care not adequately addressed by CPS unit**

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- Case management unit (CPS unit) repeatedly failed to adequately follow up on red flags regarding Dylan's care.
  - Refusal of foster parent to cooperate with substance abuse evaluation.
  - Missed doctors' appointments.
  - Missed Birth to Three appointments.
  - Foster mother's call to police asking if she could get in trouble for letting baby cry all of the time.
  - Concern by supervisors that foster mother may have a "personality disorder."
  - No manager visits the home. DCF nurse not asked to visit the home and assess child.

# OCA findings: Failure to ensure safety of foster home. Failure to follow licensing laws and procedures. FASU unit.

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Numerous failures by DCF licensing department

1. Failure to timely conduct or document background checks on foster home.
2. Failure to document work in LINK. 18/21 entries electronically date-stamped as entered the day after Dylan injured.
3. Failure to seek waiver.
4. Failure to respond to red flags regarding foster home.
5. Licensing worker later tells DCF-HR that she noticed during visits that FM was “always crying and complained about [Dylan] always wanting her to hold him,” and that child “never smiled and did not make any baby noise,” but worker acknowledged that she did not document concerns and stated she did not “interact” with Dylan **“because that is not part of her job.”**

# OCA findings: Special Investigations Unit at DCF Does Not Raise Alarm About Child's Placement

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- SIU is made up of experienced social workers/investigators.
- SIU investigator told that all members of family have DCF history.
- SIU aware of allegation of substance abuse, failure to comply with substance abuse evaluation.
- SIU aware of specialized needs of child.
- SIU required to review foster care record, but does not note lack of documentation by licensing unit.
- While SIU's job is to substantiate (or not) an allegation of abuse or neglect in a licensed program/facility, it is also required to note regulatory problems. Child safety is responsibility of all units. Should have raised a red flag with leadership about placement.

# OCA findings: Quality Assurance Unit finds foster home placement “Strong” and “Safe.”

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Quality Assurance Unit—(Administrative Case Review Unit)- rates foster home placement a “Strength” and foster home as “safe”.

1. Findings made despite absence of electronic licensing records as required by agency policy. Absence of record not documented by reviewer.
2. Findings made despite absence of waiver and despite foster home’s DCF/criminal history.
3. Findings made despite active internal investigation regarding alleged substance abuse into home.

## OCA findings: Dylan's lawyer did not take steps to ensure child's needs were met and that he was safe.

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- Dylan's state-appointed lawyer did not bring any concerns about Dylan's care to the attention of the juvenile court.
- OCA investigation raises serious concerns as to whether lawyer adequately investigated or even was aware of any concerns about Dylan's placement or access to appropriate services and medical care.
- By statute and ethical rule, the lawyer's job is to *investigate*, identify and advocate for a young child's unmet needs, particularly when the child cannot speak for himself and is completely dependent on adults and the state for his care. Conn. Gen. Stat. 46b-129a.

## OCA findings: DCF did not inform the court of licensing barriers or rising concerns about foster home.

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- Court filings and transcripts of multiple proceedings during Dylan's tenure in first foster home reveal no mention of the following:
  1. Barriers to licensing of foster parents.
  2. DCF/criminal history of foster home.
  3. Need for commissioner's level waiver.
  4. Concern over missed appointments for medical and developmental support.
  5. Concern over new allegation of substance abuse in foster home or refusal by foster mother to cooperate with substance abuse evaluation.

## **OCA findings: DCF Employees/Managers in Region Not Knowledgeable or Well Trained on Laws/Regulations Regarding Kinship Foster Homes.**

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Examination of employee emails and human resource interview documents reveal the following:

1. Multiple supervisors and managers did not know state law and agency policy regarding licensing of relative foster parents.
2. Multiple employees did not know a Commissioner's waiver had been required to license the foster parents—or that area office managers could not issue certain waivers.
3. Multiple employees gave conflicting answers regarding who was ultimately responsible for assessing the license-ability and suitability of relative foster parents.

# OCA findings

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- A senior administrator reported that Dylan's was not the only case that the region was reviewing that should have had a waiver but didn't and that they are correcting these "When they discover this."

## **OCA findings: Concerns/lack of standards regarding DCF facilitated “family arrangements”**

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- Concerns about DCF-facilitated family arrangements (foster mother previously given another relative infant to care for due to concerns of abuse or neglect by infant’s parents—no formal assessment/background check completed).

# Findings: Concerns about licensing unit case loads.

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- Multiple employees pointed to excessive case loads as a primary barrier to good practice.
- “When caseloads are at 200% things are going to be missed and not done.” A supervisor stated that in Magees’ case, police reports and a home assessment would have been reviewed if they had more resources—according to this supervisor “there is way too much to do and not enough staff.” (HR interview, 9/29/2016).—OCA report.

# Dylan C.—OCA Communications with DCF

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- April, 2016: OCA notified DCF of pending investigation and requests complete DCF record on Dylan C.
- June, 2016: OCA meets with Regional Administration and DCF Legal Director regarding preliminary Dylan C. findings.
- August, 2016: OCA requests additional electronic records from DCF and additional information about other foster parents who received “waivers” for prior DCF/criminal records.
- September, 2016: OCA receives Human Resources report from DCF.
- September, 2016: OCA provides draft investigative report to DCF.
- October, 2016: OCA publishes final report.

# Dylan C. – DCF provides response: September, 2016

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- DCF memo to OCA in response to draft report outlines reforms undertaken to ensure timely HR response/internal review, review of “family arrangements,” new methods for tracking “waiver” cases, audit of “waiver” cases in Region 3, efforts to improve staff communication when there is a disagreement regarding a waiver case.
- DCF acknowledges poor practice by CPS unit and FASU unit; disagrees with OCA findings regarding SIU and ACR units.
- September, 2016– After receipt of the OCA draft report, DCF Commissioner issues multiple memos to “all staff” clarifying 1) waivers for foster parents with prior records; and 2) requirements for record-keeping and utilization of emails.

# Dylan C. Follow on Child.

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- OCA continued to review Dylan's care and treatment during our investigation and brought concerns or questions on multiple occasions to DCF regional leadership/management.
- Dylan was moved through 5 different foster placements during this time period.
- Dylan is now in a pre-adoptive relative foster home.

# Dylan C.– OCA follow up on foster care issues—system concerns

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- Review of other “waiver” foster care cases 2015-16.
- Examine similar issues to Dylan’s case:
  - 1) what was the barrier to the foster parent license? (criminal/DCF history?)
  - 2) was the law followed;
  - 3) was information shared with the Juvenile Court;
  - 4) did the Quality Assurance review (ACR) rate the placement a “strength”?
  - 5) was the license completed within federal/state time requirements?

# OCA-Follow Up Review

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- 2015-16 Relative Foster Families that Received Commissioner Waiver due to Prior DCF/Criminal History. N= 65 cases. Total of 90 children.
  - 40/65 cases involved placement of children age 7 or under (48 children placed)
  - OCA conducted preliminary review of 25/40 cases where younger children were placed.
    - OCA conducted in-depth records review of 11/25 cases that involved placement of younger children (age 7 or under).

# OCA review: methodology

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- Review of latest research regarding efficacy/outcomes associated with kinship care placements.
- Provided list of cases that were going to be reviewed to DCF and requested additional records to assist with review.
- Review of DCF case files, licensing records, quality assurance reports, court filings, and waiver applications with regard to 11 cases.

# Summary of Findings

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- Of the 25 cases examined by OCA where foster parents received Commissioner-level waivers for prior DCF/criminal history, *not all cases were concerning*, and some criminal histories were *very dated*. Multiple foster parents appeared to be appropriate candidates for waivers.
- Of the 11/25 cases that OCA conducted an in-depth review:
  - ✓ 5/11 foster families had prior criminal justice involvement within 5 years.
  - ✓ 6/11 foster families had prior substantiations for abuse/neglect. 2/6 were substantiated in the last 5 years.
  - ✓ 2/foster families had previously been placed on the central registry.
- OCA found several procedural/practice irregularities.
- OCA found some children resided in foster homes with active safety concerns.
- OCA found some children well-cared for by foster parents.

## OCA Findings

### One: Information regarding foster home issues often *not shared* with juvenile court

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- Of the 11 cases reviewed in-depth by OCA, in 6/10, (1 unknown), no information was shared with the Juvenile Court at or near the time of the child's placement regarding identified barriers to the placement of the child or need for waiver.
- In 3/10 cases, *some* information was provided to the court.
- In 1/10 cases comprehensive information was provided to the court.
- OCA: juvenile court has ultimate decision-making and review authority regarding safety and well-being of child. See also NCJFCJ standards.

## OCA Findings

**Two: Several children placed into foster homes *prior* to receiving Commissioner's waiver.**

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- In 5/11 cases child was placed *prior* to receipt of Commissioner's waiver.
- In 2/11 cases, child was placed via “family arrangement” which later became a DCF licensed foster placement.
- In 4/11 cases DCF placed the child in the foster home *after* waiver was secured.

## OCA Findings

### Three-Several foster homes remained unlicensed beyond the permitted time for licensure.

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- In 5/11 cases the foster home was *not licensed* by DCF within the 150 day timeframe required. 2/5 required more than 1 year to complete licensure (refusal to let DCF in basement; family slow to provide DCF required information).
- 4/11 cases the licensing process occurred within 6 months.
- 2/11 cases the licensing issue was mooted because one child was reunified and in the other case the children were removed from the foster home, likely due to safety concerns. (record is silent at the time of removal).

## OCA Finding

**Four-DCF Quality Assurance Unit Found all Foster Homes to be a “Strength” of child’s case plan—even where safety concerns in the record.**

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- QA unit (ACR unit) did not consistently identify all foster parents/adults in home.
- Foster home in one case rated a “Strength” even though foster mother tested positive for cocaine and staff were concerned about her lying to DCF.
- Foster home in another case rated a “Strength” and does not document new concern that foster father/mother tested positive for marijuana and that a safety agreement was required to maintain the placement.
- Foster home in another case rated a “Strength” despite extensive history of foster father with domestic violence (restraining orders with multiple partners), a recent DCF investigation related to domestic violence, and contemporary concerns by licensing worker.
- QA reviewer at times notes other concerns (inadequate worker/child visitation; inadequate safety supports for child) but placements were always found to be a strength.

# Other issues emerged from case review

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- Electronic record documentation not always up-to-date and consistent.
- 2/11 cases the foster parent was documented to be drug-using while children placed in the home. In both cases, a decision was made to leave the children in the foster home; one case used a “safety agreement,” the other did not. In one case, the children were removed two months later, but with no documentation as to what catalyzed the placement change. No record of SIU investigation/subs.
- Front line workers in at least two cases raised serious concerns about safety/appropriateness of foster home but licensing process continued. (1 case involved concerns of domestic violence/anger issues; 1 case involved substance use—see above).

# Other issues emerge from case review

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- After DCF had to remove two children from one relative foster home, children (both with specialized needs/disabilities) placed with relative that DCF had just ruled out for licensure due to the prior removal of the relative's own children many years ago. Children also did not have adequate services in place to address their needs for several months.
- A baby was placed with paternal great-grandparents with a permanency plan of adoption. PGGPs were 77 and 87 years old. Though DCF court filings reported that another relative was the "back up"--no documentation of successful contact/discussion with that relative in the case record.
- Two foster parents had been previously placed on DCF Central Registry. Findings were reversed as part of the placement process.

# In Multiple Cases, Foster Parent provided adequate care to child

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- Despite irregularities cited above, OCA reviewers found in multiple cases that, per documentation, the foster parent/s sought to and often did provide nurturing care to the child while in foster care. This was true even where the foster parent/s had extensive prior DCF or criminal histories.
  - FM has prior Termination of Parental Rights and extensive (but dated) history of significant mental health treatment needs—records indicate foster child was well-cared for and nurtured while in foster home.
  - FM has prior felony convictions for assault and minor recent criminal history. OCA finds that, per documentation, FM was very attentive to foster child in her care, and presented as flexible and supportive to DCF and baby's family.
  - Elderly great-grandparents, per case records, provided nurturing care to baby, though there were ongoing concerns related to age-limitations and smoking in the home. Grandmother had prior DCF history.

# Conclusion to OCA's review

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- OCA strongly supports the state's shift to kinship care for children when such placements serve the best interest of a child.
- OCA supports a statutory-regulatory framework that will permit the granting of waivers to proposed relative foster parents but *only where* assessment of the caregiver clearly demonstrates that the relative has rehabilitated from prior concerns and has ample capacity to meet the needs of the children, with needed supports.
- Practices regarding suitability-licensing assessments must be strengthened, clarified, and actively reinforced with staff through training, supervision and quality assurance checks.
- **Information regarding the suitability and license-ability of foster homes must be shared with the Juvenile Court when children are placed in state custody.**

# Conclusion/Questions

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- Safety audits.
- How is this assessed?
- What parameters are used/methodology?
- In cases reviewed by OCA, no investigations or substantiations. Not the only measure of safety and well-being.

# OCA Reviews Research Regarding Kinship Care

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- 2014 Study (Campbell Collaboration)-found health and well-being of children in kin care is better than children in traditional foster care. No difference with regard to rates of reunification with birth parents, length of stay in placement, educational attainment. Children in foster care more likely to use mental health services, more likely to be adopted.
- 2008 Study citing research from national survey of child and adolescent well-being: kin care supports greater placement stability, and lower risk of behavioral problems.

# Research.

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- One study shows children in traditional foster care improved more sharply in academics over time.
- Chapin Hall Study/Univ. of Chicago (2013) found unmet mental health needs in many children in kinship care, and found that 25% of children were placed with a caregiver about whom the caseworker expressed some degree of concern regarding their capacity to meet the needs/mental health needs of the child. Authors of the study support use of kinship care, but emphasize that “Front-end child welfare assessments must consider not only a child’s need for mental health services but a caregiver’s capacity to meet those needs,” and the child welfare system must be responsive to the complexity of needs presented by substitute caregivers.”

# Research

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- A 2016 Child Trends study regarding kinship care found the following:
  - States practices regarding relative assessments are “inconsistent” and often lacked formal guidelines and standards for caseworkers to follow.
  - Practices with regard to information sharing varied from worker to worker.
  - Use of “Safety plans” common to address services and contact between child and parent.

# OCA Recommendations

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## Examination of foster care licensing practices

1. Statute: DCF examine and report regarding foster care licensing practices, including quality assurance processes, number of concerns brought, special investigations, actions taken, support for foster homes/foster care providers, adherence to statutory-regulatory framework, utilization of waiver process for *non-safety related regulatory criteria*.
2. Set standards for role of CPS unit and role of FASU unit. All units must be required to document information relative to the health and safety of a child after a home visit.

# OCA Recommendations

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**State law amended to ensure Juvenile Court/parties informed regarding suitability of foster home and child's needs met.**

1. Within 30 days of a child coming into care: Brief report regarding license-ability and suitability of child's foster parent/proposed placement, including information regarding any barriers to licensing. Ongoing obligation to report regarding safety concerns that arise.
2. Within 60 days of a child coming into care—identified treatment/education/developmental needs and timetable for meeting child's needs.

# OCA Recommendations

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**Statute: 17a-114. Revise timeframes for licensure completion.**

- Revise statutory timeframe for licensure of foster parents back to 90 days, absent a finding from DCF Commissioner that longer is needed to serve the best interests of the child.

# OCA Recommendations

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## **Heightened Case Review/Supervision for Infant-Toddler Cases**

That specific protocols be developed as part of DCF's practice guide for young children that includes specific requirements for:

1. Heightened case supervision;
2. Frequent visitation between caseworker and child/family;
3. Expected documentation of case activities relevant to the safety and well-being of the child;
4. Development of a case supervision tool specific to the unique needs and risk status of infants and toddlers.

# OCA Recommendations: Safety Agreements--Standards

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- Amend Ch. 17a-101 to require that DCF create standards regarding the use of voluntary family safety agreements for children who are identified as victims of abuse/neglect or at high risk of abuse or neglect. Standards should address when the use of such agreements is appropriate based, in part, on the use of evidence-based risk and safety assessment tools. Standards shall also require that safety agreements document how safety concerns will be immediately addressed, what level of monitoring the DCF will provide to ensure implementation of the agreement, and what services will be put in place, and when, to ensure the safety of the child in the home. Standards shall ensure heightened requirements for safety agreements involving children under 36 months of age. Standards shall address how substitute caregivers will be assessed by DCF. DCF shall periodically audit the use of such agreements, and compile data regarding the efficacy of such agreements for promoting the safety, well-being and permanency for children.

# OCA Recommendations

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**Strengthen standards for utilization of DCF-facilitated family arrangements/kinship diversion agreements.**

Amend Ch. 17a-114 to require written standards and evaluation protocols for the use of “family arrangements” facilitated by DCF, when such agreements are used for children who are deemed at moderate or high risk of child abuse or neglect as determined by DCF’s utilization of evidence-based risk and safety assessment tools, or who are substantiated victims of abuse or neglect.

See addendum to this presentation.

**Rationale.** See Annie E. Casey Foundation report, *The Kinship Diversion Debate: Policy and Practice Implications for Children, Families and Child Welfare Agencies (2013)*

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- “Without an intentional approach to diversion policies and practices and appropriate data to measure their impact, child welfare agencies cannot adequately determine whether they are meeting their fundamental goals of safety, permanence and well-being for many children who come to their attention.”

# OCA Recommendations: Report re Risk and Safety Assessments

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- **(Statute: NEW) Risk and Safety Assessment Practice. Reporting Requirement.** The Department of Children and Families shall annually track and publicly report regarding the efficacy of its evidence-based risk and safety assessment practices with clear demonstration of the methodology for determining the reliability of its assessment practice, fidelity to evidence-based practice and tools, and the effectiveness of the assessment process for identifying children at risk of child abuse or neglect.
- See Addendum to this report.

# OCA Recommendations: Report regarding safety of infants and toddlers.

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Statute: (NEW) Specific to Infants and Toddlers

- DCF shall report annually regarding 1) the number of accepted reports of abuse and neglect regarding children age birth to three, 2) the number of such cases that included previous DCF involvement within the previous twelve, twenty-four and thirty-six months, 3) the number of critical incidents as defined by agency policy in the previous twelve months that involved abuse or neglect of a child under thirty-six months of age, and the percentage of those children that had current or previous DCF involvement within the last 36 months or who were assigned to a Family Assessment Response, 4) information regarding any identified trends that DCF has identified with regard to risk and protective factors for children birth to three who have experienced critical injuries or incidents of abuse/neglect that DCF has classified as “critical.”

# OCA Recommendations. ACR/Quality Assurance Unit

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- DCF should assess the workload of the quality assurance unit and the efficacy and *reliability* of its current framework for evaluating the safety and well-being of children in care.
- Over 14,000 ACRs in a given year. Approximately 50 staff in the ACR unit statewide. Current expectation is that each worker reviews the entire case record for the Period Under Review, facilitates a stakeholder meeting, and makes critical findings. DCF aggregates findings into reports regarding child well-being.

# OCA Recommendations: Licensing unit

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- Concerns raised with OCA regarding caseload/workload of front line licensing unit.
- Now that 30 to 40% of children placed into foster care are placed with kin (i.e. unlicensed home)—creates significant and important work load for licensing unit.
- DCF should assess whether the current capacity of the licensing units to meet this important demand and what changes can be made to support best practices.

# OCA Recommendations: Central Registry Reversals

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- DCF sought legislation on at least two occasions in the last 5 years seeking a state statute to set standards/framework for permitting individuals to be removed from the State's Central Registry.
- Bills did not pass. DCF has authority under Uniform Administrative Procedures Act.
- Current framework very different than previously proposed bills.
- Examine and address any gaps in this area.