



STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE

INVESTIGATIVE REPORT

THE CRITICAL INJURIES OF BABY DYLAN
FROM ABUSE AND NEGLECT WHILE IN
STATE CUSTODY.

OCTOBER 4, 2016

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SUMMARY OF THE CASE

This report details the Office of the Child Advocate's investigation into circumstances leading to the critical injuries and near-death of one-year-old Dylan C.¹ from child abuse and neglect while in the care of the Department of Children and Families in 2015. The report examines the actions of all state or state-funded actors who had responsibility for the safety and well-being of this young child and who contributed to the gross systems failures seen in this case. The report makes recommendations for change to ensure that no child completely dependent on the state for his or her care will languish in similar deprivation or experience such abuse.

On June 12, 2015, thirteen (13) month old Dylan was removed from his home, along with his three young siblings, due to concerns about chronic and escalating neglect by his biological parents. The siblings were separated and placed with different relative caregivers that DCF preliminarily approved to be foster parents, pending completion of the licensing process.² Dylan was placed into the home of Crystal Magee, a cousin of Dylan's mother, and Crystal's husband Donald. The placement was conducted under DCF's supervision the same day Dylan was removed from his parents' home. DCF's decision to place Dylan in the Magees' home was made despite the agency's information that Mrs. Magee had been the subject of multiple prior allegations of abuse and neglect,³ Mrs. Magee had a previous substantiation for neglect of her own son⁴, Mr. Magee had a criminal history including a prior conviction for assault,⁵ both Magees had "health issues," and both adults' driver's licenses were indefinitely suspended. The Magees also had no employment income, relying on state disability benefits to make ends meet. Despite these issues, Dylan's placement went forward and no regulatory waivers were sought.⁶ During interviews at DCF conducted between April and September, 2016 as part of a Human Resources investigation, various employees responsible for Dylan's care stated that

¹ The child's name has been changed to protect his identity.

² The law does not allow placement of children in unlicensed homes, but makes an exception to permit the placement of a child by the state in a relative or kin home so long as a preliminary assessment has been made regarding the suitability of the relative for placement consideration. The home then must be licensed as soon as possible but no later than 150 days (information regarding 150 day time limit obtained from DCF). Federal and state laws governing such placements do not require immediate licensure, but do require a focus on safety factors such as whether a prospective caregiver has a prior criminal and child protective services history. Conn. Gen. Stat. § 17a-114.

³ Several allegations appear to have been made anonymously or by the same person, alleging physical neglect by Mrs. Magee of her biological son and/or drug abuse. Three calls were made by health care and educational professionals.

⁴ Agency regulations provide that absent a waiver from the Commissioner, the "granting of a license ... shall be denied if any member of the household of a foster family... (4) has been convicted of a violent crime against a person... (6) has ever had an allegation of child abuse or neglect substantiated."

⁵ This prior assault conviction presented, by law, an immediate obstacle to placing Dylan in the home and required, at a minimum, a review by the DCF Commissioner before any child could be placed in the home by DCF.

⁶ State law provides that "[t]he [DCF] commissioner may grant a waiver from such regulations, including any standard regarding separate bedrooms or room-sharing arrangements, for a child placed with a relative, on a case-by-case basis, if such placement is otherwise in the best interests of such child, provided no procedure or standard that is safety-related may be so waived. The commissioner shall document, in writing, the reason for granting any waiver from such regulations." Placement of children in an unlicensed home where a waiver is required but not yet received is not permitted.

they did not know at the time of his placement that the foster parents had criminal or child protective service history; and multiple employees described practices associated with relative foster home placements that are inconsistent with agency policy and state law.

Contemporaneous to removing Dylan from his home, DCF filed a request with the Juvenile Court for an Order of Temporary Custody (OTC) on the grounds that Dylan and his siblings were so neglected in their parents' care that they were at risk of imminent physical harm.⁷ The court granted the OTC and the state, within days, appointed a lawyer to represent Dylan and his siblings. Shortly thereafter, the parents sought and obtained state-funded counsel to represent them.

Dylan came into foster care presenting with global developmental delays. Inexplicably, during the five months Dylan lived in the Magee foster home he received almost no medical follow up⁸, almost no developmental supports and no structured child care. He missed numerous appointments in the community, including multiple visits with his family.⁹ The early intervention service provider¹⁰ who was supposed to be helping Dylan make developmental gains called or spoke with DCF on nine (9) occasions between July and November, 2015,¹¹ often expressing concern that the foster parents were cancelling appointments or not letting her into the foster home. On September 17, 2015 this provider called DCF immediately after a scheduled visit gave rise to new concerns about the foster mother's and Dylan's presentation. She reported her concerns to the DCF caseworker and asked that he follow up and make sure Dylan was okay. Records indicate however that the DCF worker failed to conduct a visit with Dylan for another eleven (11) days at which time it was observed only that Dylan was "sleeping." Of the seven visits conducted with Dylan by a DCF caseworker between June and November 2015, Dylan was "asleep" for five of them.¹²

⁷ State law allows DCF to remove a child from his or home pending court approval if the state "has probable cause to believe that the child or any other child in the household is in imminent risk of physical harm from the child's surroundings and that immediate removal from such surroundings is necessary to ensure the child's safety." Such removal may not exceed ninety-six hours. Conn. Gen. Stat. § 17a-101g.

⁸ Though legally Dylan was in DCF's custody, medical records show that his biological mother took him to the Pequod Emergency Center on June 15, 2015 with concern that Dylan was sick and vomiting. Records reveal no other visit until Dylan was hospitalized in November. Recommendations for additional developmental and medical evaluations issued in early July were not followed.

⁹ Dylan's mother raised concerns with the DCF caseworker that Dylan had missed multiple sibling visits during the fall of 2015. The contracted visitation supervisor also reported to the DCF Special Investigations Unit that Dylan had missed multiple visits in October and early November, 2015; and another relative foster parent also reported Dylan missed multiple family visits.

¹⁰ DCF had previously assisted Dylan's biological parents with connecting to the state's Birth to Three program, an early intervention service delivery program administered by the State's Office of Early Childhood. Birth to Three had begun delivering services to Dylan in his biological home prior to his removal and placement in DCF foster care.

¹¹ The first call in July was with the DCF Special Investigations Unit (SIU). The SIU spoke with the Birth to Three provider about the foster home after allegations surfaced that the foster mother may be abusing substances. This allegation was not substantiated. The Birth to Three provider told SIU that she had only met with the foster mother one time.

¹² According to a regional DCF review Dylan was asleep for 5 of 7 visits. According to a DCF Human Resources Department investigation Dylan was asleep for at least the last 3 home visits (Sept., Oct., Nov. 2015).

OCA's review of the foster care record indicates that the Magees did not meet the standards for licensure, they did not complete any of the requirements of licensure, they did not cooperate with DCF training mandates and they did not complete a substance abuse evaluation. Due to escalating concerns about the capacity and willingness of the Magees to meet Dylan's needs, on November 10, 2015, DCF took steps to have Dylan moved into another relative foster home.¹³

On November 11, 2015, the new relative foster mother attempted to dress and give Dylan breakfast, looking at him for the first time in the morning light. Startled by his appearance, "just skin and bones," she later told doctors, she saw that Dylan's eyes were sunken in, his skin was sagging from his body and his arm looked swollen. She contacted a community health provider but when told that they were unable to schedule an appointment right away, she rushed Dylan to a local emergency room where hospital professionals assessed and transferred him by ambulance to Connecticut Children's Medical Center (CCMC).

Dylan was described by doctors as "significantly emaciated." He was so undernourished that he had poor muscle tone and head control. Health care providers told the DCF Careline that day that at nineteen months old, Dylan was "unable to walk, talk or feed himself." He had loose skin on his body, his ribs were very prominent, his eyes were sunken in and his temple muscles appeared wasted. He had swelling in his face and hands. His left elbow was swollen, and he could not extend his arm completely. His right wrist was swollen, and he had an old scar that appeared to be from a burn. His hair and skin were extremely dry from malnutrition and low protein, and he had developed a fine hair over his body that grows when a child is starving. At nineteen months of age he weighed only seventeen pounds, *less* than he weighed when he was last seen by his pediatrician, seven months earlier. Doctors noted that Dylan was so underdeveloped and delayed that he had to be treated as an infant. Dylan was described as very weak, preferring to be held, and records note that while in the hospital he would rest his head on whoever would hold him.

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 Magees' explanation that Dylan had recently been sick and had lost weight in the last few weeks as "implausible."

Specialists at CCMC evaluated Dylan and found that he also had broken bones in both arms, several weeks old. According to his doctors, 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." He had a healing burn on his wrist and a torn frenulum (tissue that extends underneath the tongue) in the inside of his mouth. He had multiple bruises and abrasions of different ages on his chest, shoulder, abdomen, elbow, back and arm. Per medical records "many of the skin injuries noted [were] in uncommon areas for accidental injury and are unexplained." Dylan had sparse hair at the back of his head, a sign that he had been lying down on the back of his head for significant periods of time. Medical evaluation showed

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.

¹³ After Dylan was hospitalized with significant injuries in November, 2015, DCF denied the Magees' license application. Dylan's placement was the second time that DCF had relied on the Magees to care for a maltreated baby without ever licensing them as caregivers.

evidence of a retinal hemorrhage and old bleeding into Dylan's brain that was deemed "most likely the result of inflicted trauma." His doctors concluded that Dylan's injuries were "highly suspicious for inflicted injury or abuse."

Dylan presented to doctors as having "very significant developmental delays," to which "neglect and malnutrition certainly contributed." Doctors opined that "the coming months and years will demonstrate how much recovery the child will experience...Dylan must be nurtured and protected from further injury." The healthcare provider that called the DCF Careline to report Dylan's condition told a Careline supervisor that she was "appalled" that Dylan had been seen the night before by the DCF caseworker and yet the child had not been brought in for urgently needed medical care, which the doctor described as appearing "very obvious."¹⁴

Police subsequently arrested Dylan's previous foster mother, Crystal Magee, for Felony Risk of Injury to a Child and Intentional Cruelty to a Child.¹⁵ The OCA was notified by multiple individuals regarding the injuries Dylan sustained, and the OCA received specific requests to investigate the circumstances leading to the critical injury of a child in state custody, including the actions and inactions of state workers in the performance of their responsibilities to protect Dylan from harm.

More than a dozen DCF employees across four different DCF units were responsible for ensuring Dylan's safety and well-being in foster care between June 12 and November 11, 2015:

- 1) DCF child protective services (CPS) unit: responsible for managing Dylan's case, keeping him safe, nurtured and making sure he would eventually have a family (biological or otherwise) to care for him permanently.¹⁶ Between July 31 and November 10, 2015 (**102 days**) the DCF caseworker did not see Dylan awake in his foster home.¹⁷ Reports repeatedly document that Dylan was "sleeping" during visits. Though Dylan entered foster care with global developmental delays and outstanding health care issues the CPS unit failed to ensure Dylan received follow up care. During internal Human Resources interviews at DCF, the caseworker purportedly stated that Dylan was the most delayed of his siblings and that the caseworker had never seen an 18 month old child that could not talk or walk.¹⁸ Yet the CPS unit failed to timely address glaring red flags about Dylan's care, including an advisory received by the caseworker on July 15, 2015 that Dylan's foster mother had called the local police department to ask if she could get in trouble for letting Dylan cry for long periods of time. Despite escalating concerns about the foster parents, including speculation by DCF employees that the foster mother may have a "personality

¹⁴ The DCF caseworker told DCF investigators on November 13, 2015, that he had seen Dylan the afternoon before and "picked him up." According to the caseworker Dylan "was awake [and dressed] and looked okay." Per DCF Special Investigations Protocol, interview documented November 13, 2015.

¹⁵ Conn. Gen. Stat. § 53-20 and 21.

¹⁶ In part due to workload issues as well as staffing changes, there were 3 different CPS supervisors and 2 different CPS caseworkers assigned to Dylan's case just over this five month period.

¹⁷ There is some inconsistency in the DCF case record regarding whether Dylan was awake on the foster mother's lap during the August 13, 2015 visit or whether he was asleep. An internal quality assurance review conducted by the regional office indicated however that Dylan was asleep during this visit. The caseworker's record of the visit does not specify. It is clear that Dylan was asleep in all subsequent visits by the caseworker.

¹⁸ The HR investigation documents received by OCA on September 29, 2016 contain pages of statements attributed by HR employees to various DCF staff members.

issue” or a substance abuse problem, the missed appointments for medical and support services for Dylan, at no time did a DCF supervisor, a manager or a DCF nurse visit the home to assess the child’s condition.

- 2) DCF licensing unit: responsible for the assessment and approval of the foster home, which the law allows to be completed after placement of a child in relative care. This unit utterly failed in every imaginable way to assess the safety and appropriateness of Dylan’s foster home or even record its work activities. Of the twenty-one (21) entries into the DCF electronic record regarding the unit’s licensing activities between June 12, 2015 and November 11, 2015, eighteen (18) entries were found to have been entered on November 12th, the day after DCF was notified of Dylan’s critical injuries.¹⁹ Such belated record-keeping is a glaring violation of DCF policy, limits the ability of other units to check in on the licensing work and raises skepticism about the accuracy of the work itself. The licensing unit also failed to seek a regulatory waiver to address the multiple barriers to the foster parents’ licensure, failed to review the concerning deficiencies and misrepresentations in the foster parents’ written application for licensure, failed to address a prior DCF-approved placement of *another* baby in this same home without *any* formal assessment, and allegedly failed to even inform the CPS team of the concerns in the Magees’ background prior to placement.²⁰ The licensing social worker, interviewed internally by DCF, reported that she noticed during visits that the foster mother was “always crying... [and] complained about the child always wanting her to hold him.” The worker observed that Dylan “never smiled and did not make any baby noise,” but the worker also acknowledged that she did not document any concerns and she stated that she did not “interact” with Dylan “because that is not part of her job.”
- 3) DCF special investigations unit (SIU): responsible for addressing allegations of abuse or neglect in a DCF-run or DCF-licensed program, facility or foster home. The SIU was called in to investigate the foster home twice, once in July, 2015 when an allegation was made to the DCF Careline that the foster mother abused substances, and again in

¹⁹ Entries into the DCF electronic case record are coded with a date-stamp that cannot be altered. An email obtained by OCA from DCF on September 6, 2015 contains the following exchange between the licensing unit staff members:

From: LICENSING UNIT SUPERVISOR

Sent: Thursday, November 12, 2015, 9:05 AM

To: LICENSING UNIT WORKER

Subject: FW: Critical Incident re Crystal Magee [CASE RECORD NUMBER]

Let’s talk. Both of us need to spend this morning putting narratives in LINK! Thanks, SUPERVISOR.

DCF Policy requires that “each worker, supervisor and manager shall assume responsibility for compiling and entering in LINK and/or the Uniform Case Record, relevant information concerning each case in a descriptive and timely manner.” Policy Chapter 31-7-1.3. Additionally all DCF staff are directed to ensure that narrative entries into the electronic case record are completed within “five working days of the occurrence” of the activity. Directives clarify that recordable activities include “in-person contacts; behavioral and health care visits; telephone calls; conferences; consultations; other case related activities; decisions, including supervisory and managerial decisions and directives, and transfer and closing summaries.”

²⁰ This allegation was made by various DCF employees during the HR interviews conducted between April and September, 2016.

November after Dylan’s extensive injuries were discovered.²¹ In both investigations the SIU—staffed by experienced DCF social workers--failed to adequately raise red flags about how a fragile and developmentally delayed baby was even placed into a foster home where the caregivers had prior CPS/criminal history and chronic health issues.

- 4) DCF Administrative Case Review Unit (ACR): a quality assurance unit responsible for reviewing the electronic record²², meeting with the case participants and making sure that Dylan’s needs were being appropriately addressed while in DCF care. The ACR unit also failed to identify numerous red flags regarding Dylan’s placement, inexplicably rating the placement a “strength” and the Magees’ home as “safe” even though the home was under a Special Investigation. The ACR unit failed to observe or alert anyone that there were virtually no activities from the licensing unit even entered in the DCF case file—a major red flag in and of itself.²³

During this investigation OCA inquired with DCF regarding any Human Resources investigations that it conducted in the immediate aftermath of Dylan’s emergency hospital admission in November. A review of agency correspondence received by OCA indicates that though there was an immediate discussion of an internal investigation into employees’ conduct, no investigation actually commenced until after Crystal Magee’s arrest in late February, 2016 and the subsequent media attention.²⁴ It appears that the Hartford Courant’s reporting triggered a re-visiting of the Human Resources review.

A key professional outside of DCF who was responsible for advocating for Dylan was his state-appointed lawyer. All children removed from their homes due to abuse or neglect and for whom legal petitions are filed with the Superior Court are automatically appointed counsel to represent them. Per the state’s performance guidelines for lawyers representing children, the lawyer was entrusted to ensure Dylan’s needs were identified and met for medical care, developmental supports, family contact, nurturance and permanency. 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.²⁵ The state’s contract with the child’s “assigned counsel” echoes these expectations. A review of the DCF case records, the court record,

²¹ OCA’s concerns about whether SIU—an internal department at DCF-- is empowered and structured to effectively investigate agency actions or inactions with regard to DCF-licensed or DCF-run programs and facilities were also outlined in OCA’s report on conditions of confinement in the Connecticut Juvenile Training School and Pueblo Unit, published July 22, 2015. OCA anticipates further investigative activities related to these concerns. DCF’s September 20, 2016 response to OCA regarding this matter includes DCF’s disagreement with OCA about the role and responsibility of the SIU. See page 39 for further discussion.

²² For the Period Under Review, in this case June 12, 2015 through August, 14, 2015 , the date of the ACR meeting.

²³ As part of its September 20, 2016 response to OCA’s draft report, DCF expressed disagreement with OCA regarding the role and responsibility of the ACR unit. See pg. 35 for discussion.

²⁴ Review of emails from February 18, 2015 between the DCF Commissioner’s Office and the DCF Regional Office where Dylan was served indicate that the Hartford Courant obtained a police warrant for Crystal Magee and sought a statement from DCF, at which point it was internally discovered that a Human Resources Investigation had not occurred.

²⁵ See Performance Guidelines for Lawyers Representing Children, promulgated by the State Division of Public Defender Services and available on the Public Defender’s website http://www.ct.gov/ocpd/lib/ocpd/Child_Protection/CP_Procedures_Assigned_Counsel/Performance_Standards_For_Counsel_In_Child_Protection_Matters_FINAL_AS_APPROVED.pdf.

and a chronology of activities submitted by Dylan’s lawyer to the State Division of Public Defender Services as part of this review, documents that the lawyer saw Dylan one time between June 12 and November 11, 2015 during a sibling visit, did not see him in his foster home, and he filed no motions in Court on Dylan’s behalf.²⁶

OCA finds that information legally available to counsel for the child, such as the DCF case record, contained red flags regarding Dylan’s care and condition including escalating concerns about his missed medical and Birth to Three appointments and the SIU investigation of the foster mother and her reluctance to participate in a substance abuse evaluation. OCA also finds that a lawyer for a child is empowered to inform the Court of any concerns and the lawyer is expected to take steps to protect a child whose needs are not met. These activities are mandated by the state’s performance guidelines’ for lawyers and the requirement that the lawyer for the child “investigate and take necessary legal action regarding the child’s medical, mental health, social, education, and overall well-being.”²⁷ Dylan’s lawyer did not agree to participate in an interview with OCA as part of this investigation.²⁸

Dylan’s near-death from starvation and abuse—a stunning event in a state-monitored placement for a child—could occur only as a result of the utter collapse of all safeguards. This report examines those safeguards to determine how they failed to identify and respond to Dylan’s increasingly desperate state.

In meeting with DCF agency professionals during the pendency of this investigation and reviewing the hundreds of employee emails, OCA observed that many employees and administrators approach their work with effort, often working rapidly and with difficult caseloads. Yet the institutional failures and omissions in this case are staggering and raise grave concern about the pace and reliability of the practices observed. The case investigation presents a concerning dynamic of adaptation to the abnormal—working day after day in a world of neglect and abuse, the risk is that a professional’s measurement, judgment, perception and evaluation of what is acceptable shifts. That so many eyes were on Dylan’s case and none pressed the alarm strongly to halt this tragic trajectory is a cultural warning sign that bears urgent attention by the public. The repeated failure to follow agency protocols,

²⁶ Lawyers are empowered to file motions for orders from the Juvenile Court seeking relief for their clients, including Motions for Emergency relief to address deficiencies in the provision of care or support. Conn. Gen. Stat. § 46b-121, Connecticut P.B. Rule 34a-23. The chronology of activities submitted by the lawyer to the State Division of Public Defender Services (the Division) in response to OCA’s investigative inquiry documents his office’s participation in Dylan’s August, 2015 ACR, and that the lawyer reviewed information submitted by DCF to the Juvenile Court, but the chronology contains no documentation that the lawyer sought any other information from DCF or any of Dylan’s service providers. DCF reported to the OCA on September 20, 2016 that it reviewed “the legal log of requests for confidential documents and [the agency] has no record that the child’s attorney requested anything from the case record.”

²⁷ See Performance Guidelines, supra n. 24 at 11.

²⁸ The OCA sought to interview Dylan’s lawyer as part of this investigation to confirm whether there any other activities he pursued on Dylan’s behalf that he did not document in the chronology and that are not documented in the DCF case record, or in the records of any of Dylan’s providers, but ultimately the lawyer declined to answer questions on the advice of counsel, asserting that any question OCA might pose would be subject to Attorney Client Privilege. The OCA initiated a written request for the interview but then sent a subpoena to compel the lawyer’s attendance. The OCA is currently evaluating the merits of the legal dispute to determine next steps in OCA’s request for information from Dylan’s publicly-funded attorney.

almost leading to the death of this child, raises concerns about the underlying reasons for these failures, how workload concerns or staffing may affect the quality of work, and how well agency protocols and expectations are monitored and enforced. As concerning are the repeated assertions regarding who has what job at the agency and with whom the buck stops regarding protecting the safety and well-being of children.

The OCA submits this investigative report with the utmost respect to Dylan and those that care for him. A review of near-death injuries as well as transparency and accountability for state-funded care for children can assist the state to better support children and families and prevent future tragedies through the development of clear protocols and practices that protect very young children from abuse and neglect. Infants and toddlers such as Dylan are most at risk for critical injuries from abuse and neglect and from sudden and untimely death. They are completely dependent on a competent adult caretaker and they are the most vulnerable *and least visible* children in our community. Both here in Connecticut and around the country, the overwhelming majority of deaths due to abuse or neglect are children younger than four years old.²⁹

OCA'S INVESTIGATION OF DYLAN'S CRITICAL INJURIES LED TO ADDITIONAL SYSTEMIC PRACTICE CONCERNS

On April 26, 2016 after OCA reviewed the entire DCF electronic record this office sent a written request to DCF for all other records, not already contained in the electronic case file, that were “generated or obtained [by DCF] between January 1, 2015 and January 1, 2016, including any documents filed with the Juvenile Court.”³⁰ After careful review of all electronic and hard copy records and a subsequent interview with DCF regional office leadership OCA concluded that there were gaps in the case record and it was likely that additional records may exist and would need to be requested.³¹

Beginning on August 23rd and continuing through September, 2016, OCA received substantial additional records from DCF mostly containing electronic communications between DCF employees, some of which contained information material to the management of Dylan’s case and containing *additional* concerns about the foster family or how Dylan’s needs (or his siblings needs) were being met in other relative foster homes. The volume of information obtained by OCA in the late stage of this investigation and the light the information shed on gaps in the case record raised new alarms regarding

²⁹ Nationally, “four-fifths (82%) of children who died from *maltreatment* [as opposed to accidental or other preventable manners of death] were under the age of 4 years; 42% were younger than 12 months.” CHILD WELFARE LEAGUE OF AMERICA, QUALITY IMPROVEMENT REPORT 32 (2014).

³⁰ In response the OCA received Dylan’s medical records, certain provider records obtained by DCF, court filings, and the hard-copy of the Magees’ licensing application and background check information.

³¹ On August 3, 2016 the OCA, through Child Advocate Sarah Eagan, sent a written request to DCF that outlined a concern that the licensing unit’s case activities were very belatedly entered into the electronic record (almost all records date-stamped November 12th) and that OCA was seeking any outstanding records, including “any hand written documents, electronic emails, or field notes regarding [this] case.” OCA also requested “any records generated in connection with the Human Resources investigation of [this case]” and that OCA be provided any “documentation regarding the origination of the request for human resources involvement and confirmation of the date/source such investigation was requested.” OCA does not typically request agency emails, but the significant concerns raised in this review as well as the inexplicable gaps in the case record led OCA to seek these additional records.

DCF employees' failure to appropriately enter information about Dylan into the case record, whether deliberately or through omission, and the contribution of this failure to the tragic results in this case—a vulnerable baby that fell through the cracks of our state's child welfare system and emerged battered and near death.

On September 29, 2016 OCA received additional documents from DCF pertaining to its internal Human Resources (HR) investigation (conducted between April and September, 2016). These interviews contained a number of serious concerns and appear to reference widespread regional practices associated with the approval of relative foster homes that are inconsistent with state law and regulations. Employees also frequently deflected responsibility for the final approval of the foster homes, and employees provided inconsistent and unclear answers regarding who was accountable for the safe placement of children.

- Several employees, including supervisors and a manager, made statements that relative foster parents' misdemeanor criminal histories do not raise red flags. The licensing program manager stated her belief that at the time of Dylan's placement no staff in the region required a waiver for a foster parent's misdemeanor criminal history—this view conflicts with state law and regulation.
- While the licensing unit manager acknowledged that waivers *are* required for prior child protective service substantiations (though none were sought here), another unit employee stated her belief that where CPS/criminal history was “minor” a waiver might not be needed—this assumption conflicts with state law and regulation.
- A manager stated that when a child is placed in relative foster care (as opposed to non-relative foster care) the child can be placed *prior* to the receipt of an approved waiver³² so long as the licensing unit has done a preliminary assessment (which was also not done here)—this view conflicts with state law.
- Employees gave various answers regarding who is ultimately responsible for assessing the licenseability and suitability of a relative foster parent. One supervisor stated that concerning history was subject to “administrative review prior to placement.” Another supervisor said that the CPS unit relies on the *licensing team* to assess prior “history,” while a senior administrator stated that both units' managers should assess such history together, and multiple employees conceded that only the CPS unit could approve the final placement of a child into a foster home. This lack of clarity about role and responsibility is extremely concerning and is reflected throughout Dylan's case.
- Employees gave various answers regarding who could approve regulatory waivers. A program manager stated that she used to approve waivers herself but now they are supposed to go to the Commissioner. But a senior regional administrator stated that a CPS program manager was *not* able to sign off on such waivers. Another regional administrator stated that at the time of Dylan's placement the region was “working on the idea of 5 year limits on crimes versus people [like assault] when needing a waiver,” but the same administrator acknowledged that state law does not permit this 5 year limitation.

³² This reference to a waiver appears to include waivers due to the foster parent's criminal or CPS history.

- 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.*”

The statements and descriptions included above raise significant concern about staffs’ lack of clarity regarding legal expectations and the roles and responsibilities of various units at DCF when it comes to evaluating caregivers and ensuring the safety of children in DCF foster care. The interview responses depict incoherent, ill-informed and chaotic decision-making regarding what can be life and death situations for children. The responses raise the specter of numerous children that have been placed in foster homes without appropriate assessments, checks or balances to ensure their safety.

Lastly, due to OCA’s concerns about how a vulnerable baby such as Dylan could have been placed in such an ill-equipped foster home, OCA also sought information from DCF regarding the number of foster care regulatory waivers actually seen and approved by the Commissioner between 2015 and 2016 that addressed a prospective foster parent’s prior criminal or child protective service history. Though no waivers were ever sought in Dylan’s case (and other cases despite being legally required) the purpose of OCA’s request was to learn more about the continuum of prior conduct by a prospective foster parent that DCF was *willing* to waive as part of the licensing effort and to determine whether it was unusual to consider placement of a young child in a relative foster home where the caregivers had such history.

OCA learned that between 2015 and June, 2016 there were sixty-five (65) instances where the DCF Commissioner granted a regulatory waiver addressing a prospective foster parent’s criminal and/or child protective services history. The sixty-five waivers involved the placement of ninety (90) children, forty-nine (49) of whom were age seven or under at the time of the placement. OCA’s review of the waiver activities, and other agency activities related to the safety and well-being of the children in these placements, remains pending at the time of this publication.

OCA *does support* the granting of such waivers where prior misconduct or maltreatment is relatively minor, dated, and the caregiver/s currently presents with ample capability of meeting the needs of a young child. However OCA’s preliminary review of a cohort of these waiver cases has led to questions and concerns about the severity and recency of *some* relative foster parents’ criminal or child protective services history; and just as important, the post-placement effort by DCF to ensure adequate support and care for the children in the home.³³

³³ OCA has thus far begun review of approximately 25 of the 65 cases that involved placement of young children in relative foster care where a foster parent and/or caregiving or adult member of the household had a prior history of criminal and/or child protective services history and the home received a Commissioner’s waiver. Of these 25 cases, at least 14 foster parents had previously been substantiated for abuse or neglect by DCF and 4 had their own children removed from their care. The range of criminal histories included several foster parents with histories of assault and/or drug charges (charges may be *old*). A very concerning case involved a foster parent with multiple prior arrests for domestic violence, including assault and strangulation, and who had been the subject of protective orders with multiple intimate partners—he continued to present with such reactive and volatile behavior *during the licensing process* that the DCF worker asked for an internal domestic violence

At this time OCA has requested additional information regarding several of the foster homes and their applications for licensure. Not too long ago this state had a very poor track record for licensing relatives and obstacles as minor as room-sharing arrangements might obstruct or significantly delay an otherwise beneficial placement for a child. However as the state moves to broaden the availability of kinship care for abused and neglected children it must rigorously ensure that state law and regulations are followed, assessments remain focused on the demonstrated capacity of the caregiver to meet the needs of the child and that equal attention is paid to supporting the child's needs in the foster home after placement. Throughout the pendency of Dylan's case these assessments were poorly done with near fatal results. Agency protocols must also clearly delineate *who* in the chain of command is responsible for the final assessment of the foster home.

DCF was provided a draft of OCA's report on September 9th, and on September 20th the Department returned a memo outlining 1) the agency's concern about the preventable injuries sustained by Dylan; 2) a summary of action steps DCF is undertaking to address system concerns in the DCF region where Dylan was served; and 3) additional feedback regarding OCA's report. OCA will leave it for the Department to publish and discuss the components of its own memorandum.

METHODOLOGY

The Office of the Child Advocate (OCA) is an independent state oversight agency directed by law to investigate and report on the efficacy of child-serving systems, to investigate unexplained and unexpected child fatalities or critical incidents involving a child, and to review complaints of persons concerning the actions of any state or municipal agency providing services to children.³⁴ The OCA is a permanent member and current co-chair of the State Child Fatality Review Panel. The OCA was created in 1995 in response to the death of an infant involved with the Department of Children and Families.³⁵ OCA's methodology undertaken as part of this investigation included the following actions:

- Review of medical records, community provider, and visitation records pertaining to Dylan;
- Review of all DCF records pertaining to this child as well as Human Resources investigation documents;
- Review of court records pertaining to the active Juvenile Court case involving Dylan;

consult (a baby was placed in that home). Regarding the latter placement, DCF requested that OCA include information that DCF took the concerns "seriously and immediately addressed and there is ample documentation supporting that" and no additional reports of intimate partner violence arose. While OCA agrees that the licensing file contains ample documentation, OCA does not agree that these concerns were adequately resolved, and the placement of an abused/neglected infant in this home appears to have been grossly inappropriate and unnecessarily risky. DCF acknowledged that it was requesting a "more in-depth look at this placement" by agency staff. Of the 25 licensing files that OCA reviewed, not all were concerning and criminal histories were at times *very dated*. Multiple foster parents did appear to be appropriate candidates for waivers. OCA's review is ongoing.

³⁴ Conn. Gen. Stat. § 46a-13 *et seq.*

³⁵ OCA was initially established after the tragic homicide of a baby with an open child welfare case. Subsequently, child death review has become an integral component of the OCA-enabling statute and a particular focus of the work of the Office. OCA has regularly monitored and reported on child deaths in Connecticut and has prepared and published numerous child death investigative reports for the purpose of informing the public regarding the causes of preventable child death and strategies for prevention.

- Review of chronology of activities conducted by state-appointed counsel for Dylan;
- Meetings and consultation with community providers and medical experts;
- Multiple interviews with individuals knowledgeable about the systems or services provided to Dylan;
- Meetings and discussions with DCF leadership from the geographic region where Dylan was served regarding OCA’s investigative findings;
- Review of DCF Commissioner-approved regulatory waivers in 2015 and 2016 permitting the licensing of prospective relative/kin foster parents with a child protection or criminal history;
- Review of DCF’s response to OCA’s draft report, dated September 20, 2016.

LAWS, RULES AND REGULATIONS PROTECTING ABUSED AND NEGLECTED CHILDREN

Protecting Children’s Health and Safety in DCF Care

The Federal Adoption and Safe Families Act (“ASFA”) requires that state child welfare agencies prioritize the health and safety of abused and neglected children.³⁶ Children in foster care must receive appropriate services to meet their education, physical and mental health needs,³⁷ and they are entitled to receive Early Periodic Screening Diagnosis and Treatment (“EPSDT”) services, including immunizations, and hearing, dental, vision, lead exposure screens, along with physical and mental health care to correct or ameliorate diagnosed conditions.³⁸

The Child Abuse Prevention and Treatment Act (CAPTA) mandates that states refer abused and neglected children under age three to early intervention services given the high rate of developmental delay and impairment among maltreated infants and toddlers.³⁹

Connecticut law requires that children in DCF custody receive immediate medical attention to identify outstanding medical needs. DCF is obligated to ensure that every child or youth in foster care receives “all necessary care,” provided DCF makes reasonable attempts to obtain consent from the child’s legal guardian if the parent’s rights are intact.⁴⁰

DCF is also obligated by state and federal law to create a case plan for each child in foster care, which must include the child’s diagnoses and identified treatment needs along with a schedule of services to be provided to the child.⁴¹ The case plan must be administratively reviewed at least every six months.

³⁶ 45 C.F.R. Part 1357 § 1355.33b(2). DCF health-related records must include information regarding the child’s medical providers, a record of the child’s immunizations, information about any medication needs, and any other relevant health information about the child. Section 475(1)(C) of Social Security Act.

³⁷ 45 C.F.R. Part 1357 § 1355.34b(1)(iii).

³⁸ 42 U.S.C § 1396d.

³⁹ Echoing this CAPTA requirement is the federal Individuals with Disabilities Education Act which requires that states ensure “policies and procedures that require the referral for Early Intervention Services of a child under the age of three who is involved in a substantiated case of abuse or neglect.”

⁴⁰ Conn. Gen. Stat. § 17a-101.

⁴¹ Conn. Gen. Stat. § 17a-15.

Children’s attorneys and community providers must be invited to participate in the creation and review of the plan.

CHILD’S RIGHT TO COUNSEL

CAPTA requires that states appoint and train representatives for children in child welfare proceedings,⁴² and that such representatives have “first hand” knowledge of the health, well-being and safety of the represented child.

Extensive literature exists on the legal rights of children and the need for children to have a legal representative when there are concerns for their safety. As one author writes:

The CAPTA requirement reflects the view that children have interests that may differ from the interests of their parents and the state. The idea is that even though the state has brought the action to protect the child, the voice and needs of the child may get lost in the fray of the arguments and allegations between the state’s lawyers, parents, and other adults that are parties to the case. Furthermore, the child needs an advocate should the state fail to deliver on necessary services and actions due to fiscal constraints and organizational failures.⁴³

Connecticut law requires that children in such proceedings are entitled to legal representation and state court rules provide that children are “legal parties” to juvenile court proceedings, entitled to representation in all phases of litigation.⁴⁴ The law provides that where a child cannot advocate for himself because of age or incapacity, the lawyer shall advocate for the child’s “best interests.” The Connecticut Division of Public Defender Services is responsible for the appointment of lawyers to represent children and parents in child protection proceedings in the Juvenile Court. The Division relies primarily, though not exclusively, on the appointment of “assigned counsel,” independent contractors who are paid per case to represent children or parents in these proceedings. The Division is also responsible, by statute, for establishing training, practice and caseload standards for the representation of children.⁴⁵

⁴² 42 U.S.C. § 5106a(b) (2010).

⁴³ Pitchal, 2006; Taylor, 2009.

⁴⁴ Conn. Gen. Stat. § 46b-129a. The statute provides that “In proceedings in the superior court for a neglected, uncared-for, or dependent child under § 46b-129, the child shall be represented by counsel knowledgeable about representing such children who shall be assigned to represent the child by the office of Chief Public Defender, or appointed by the court if there is an immediate need for the appointment of counsel during a court proceeding.... Counsel for the child shall act solely as attorney for the child. The primary role of any counsel for the child shall be to advocate for the child in accordance with the Rules of Professional Conduct, except that if the child is incapable of expressing the child’s wishes to the child’s counsel because of age or other incapacity, the counsel for the child shall advocate for the best interests of the child.”

⁴⁵ The Connecticut Division of Public Defender Services provides annual training for lawyers in child protection matters and such training addresses a range of topics including substantive law and practice in child protection proceedings. The Division provides “pre-service” training for lawyers new or newer to Juvenile Court practice. This training is four days in duration. Previous topics have addressed childhood trauma, the substance law of child abuse and neglect proceedings and “special issues in representing young children.” All lawyers new to the practice of juvenile law are required to participate in the training. The Division also provides “in-service” training for lawyers on a range of topics each year.

The Division has promulgated performance guidelines that provide additional direction regarding the representation of children.⁴⁶

1. A lawyer for a child should prepare for the meeting with the child client by “obtaining and reviewing relevant documents available,” and “consulting with the child’s caregiver or DCF social worker.”
2. When the child client is “non-verbal,” the lawyer “should conduct an initial visit with the client and should interview the child’s primary caregiver, DCF social worker, and other relevant family or caregivers.”
3. The lawyer shall, “at a minimum,” meet or consult with the child at least once each quarter.
4. The child’s lawyer “*shall, prior to every hearing, investigate and take necessary legal action regarding the child’s medical, mental health, social, education and overall well-being.*” (Emphasis added.)

The Division’s emphasis on the need for children’s lawyers to “investigate” a child’s circumstances and condition and act as “watchdogs” for very young clients in particular is echoed in the American Bar Association’s (ABA) 2011 Model Act Governing the Representation of Children in Abuse, Neglect and Dependency Proceedings. The ABA’s Model Act,⁴⁷ per the official commentary recognizes the right of every child to have “a voice in any abuse, neglect, dependency, or termination of parental rights proceeding, regardless of developmental level.” The ABA Model Act emphasizes the lawyer’s obligation to “*investigate and take necessary legal action regarding the child’s medical, mental health, social, education, and overall well-being...* [to seek] court orders or [take] any other necessary steps in accordance with the child’s direction to ensure that the child’s” needs are met.

FINDINGS RELATED TO DYLAN’S ENTRY INTO THE DCF FOSTER CARE SYSTEM JUNE 12-NOVEMBER 11, 2015 THE DAY HE WAS HOSPITALIZED

Dylan was born on April 21, 2014 in eastern Connecticut. His biological parents were both known to the child welfare system as children. As an adult Dylan’s mother struggled with mental health treatment compliance, housing instability and unemployment. Between 2011 and 2015 there were multiple reports to DCF alleging neglect of the young children in Dylan’s family. Concerns included domestic violence, untreated mental health issues and physical neglect of the children. Ultimately in

⁴⁶ The Division has recently disseminated a written memo to all lawyers representing children in child protection matters outlining the performance expectations for lawyers assigned to represent infants and toddlers. The Division pays lawyers a flat rate to represent a child or parent but offers additional hourly payment for lawyers to travel to and visit with their child clients and to participate in DCF case planning meetings. The Division invited the Office of the Child Advocate to participate in a training symposium for lawyers held on August 19, 2016 and to provide training regarding “Special Issues Representing Young Children.” As part of this review, the OCA discussed with the Division concerns about the performance of the contracted attorney and the Division responded with its own inquiry into the matter.

⁴⁷ Found on the web:

https://apps.americanbar.org/litigation/committees/childrights/docs/aba_model_act_2011.pdf

June 2015, due to rising concerns about unsanitary and unsafe conditions in the parents' home, Dylan and his three siblings, ranging in age from two weeks to four years old, were removed from their parents' care and placed in various DCF-approved relative foster care placements.

**DYLAN WAS PLACED BY DCF IN A RELATIVE FOSTER HOME
DESPITE NUMEROUS RED FLAGS AND REGULATORY BARRIERS TO
LICENSURE**

On Friday, June 12, 2015, the day of the children's removal from the home, staff from the DCF regional office for Eastern Connecticut met to make decisions regarding where to place Dylan and his siblings. Interviews conducted by the OCA as part of this investigation revealed that the regional office had "manpower issues" on that day, later described as contributing to a "perfect storm" of difficulties. Fridays, according to interviewed personnel, are a very difficult day to effectuate removals of children in the region and certain staff are not always available to assist with decision-making. Other documents obtained by OCA indicate that staffing levels in the region, including in the licensing unit, may have been low at the time Dylan came into care.

On that Friday in June DCF held a "considered removal meeting"-- a facilitated discussion with the biological parents and DCF staff for the purpose of determining, in part, whether concerns about the children's safety were significant enough to require their removal from the parents' home and if so, where the children should be placed. During the meeting DCF agreed to "assess" various individuals for "relative foster care," and to permit the biological parents "supervised contact with the children as arranged with the relatives."⁴⁸ The relatives would then be asked to supervise the parents' contact with the children.

DCF employees discussed with OCA the agency's practice of utilizing a "firewall" to promote the placement of children in relative foster care.⁴⁹ The firewall requires the CPS and licensing units to exhaust a review of potential relative placements prior to requesting a non-relative foster home for a child. The firewall means that all of the potentially identifiable relatives must be "ruled out," i.e. deemed not license-able or suitable before anyone else can be considered. According to DCF staff, the firewall supports the staff's effort to meet agency performance benchmarks for placing children in relative homes and is consistent with the more recent practices across the country and federal law provisions that encourage the placement of children with kin.⁵⁰

⁴⁸ DCF Considered Removal Child and Family Team Meeting Outline notes, dated June 12, 2015.

⁴⁹ DCF reported to the OCA that the firewall "is designed to ensure that CPS staff are held accountable for thoroughly identifying and assessing the suitability of potential kinship resources for placement prior to seeking a core foster care placement. Once that occurs, FASU's role is to determine immediate license-ability elements and, later, to complete the licensing process." OCA agrees with DCF that performance expectations are an appropriate institutional practice. However, as significant reforms are undertaken, comprehensive quality assurance activities are also needed to ensure that practice changes are well implemented on behalf of children.

⁵⁰ See also CT Mirror, September 6, 2016 *Malloy Celebrates a DCF milestone, undeterred by other setbacks* (reporting DCF's recent announcement that it has "reached an all-time high in placing children with relatives and friends, an approach [DCF] say[s] reduces trauma to children." There is research demonstrating that children in kinship care have greater placement stability than children placed with non-relatives, and that kinship care assists with keeping siblings together. Conway, T., Hutson, R., Center for Law and Social Policy *Is Kinship*

Key questions: what does it mean to be license-able and suitable? Who is ultimately responsible for these determinations at DCF? And what are the steps taken to evaluate these important considerations that must be made, often on a moment's notice?

DCF staff decided to place Dylan in the home of his mother's cousin Crystal Magee, and Crystal's husband Donald Magee. DCF's intention was to license the Magees as Dylan's foster parents. State law and regulations typically do not permit DCF to place any child with a person "unless such person is licensed for that purpose."⁵¹ The law permits an exception to the pre-licensure requirement, allowing DCF to place a child with a relative pending license approval, so long as the placement is 1) in the best interests of the child, 2) a satisfactory home visit is conducted by DCF,⁵² 3) a basic assessment of the family is completed, and 4) the relative "attests" that neither he/she nor any other adult living in the house has been convicted of a crime against a person or for the possession, use or sale of a controlled substance.⁵³ The Commissioner of DCF is allowed to "grant a waiver," in writing, from certain requirements "on a case-by-case basis," if the placement is "otherwise in the best interests of the child" and provided that the waived standard is not "safety-related."⁵⁴

Agency regulations require that foster parents' homes must be assessed to ensure an environment "that will advance the physical, mental, emotional, educational and societal development" of the foster child,⁵⁵ and that foster parents have "income sufficient to meet the needs of their family," as money received on behalf of the child is to be "expended for the care of the child."⁵⁶

In short, Dylan could legally only be placed with the Magees if DCF could quickly determine that the Magees were both potentially "license-able" and "suitable" to obtain a foster parent license for the child. DCF would then complete the licensure of the Magees after Dylan was placed.⁵⁷ If any

Care Good for Kids? (Mar. 2007) (citing Testa, M. 2001. *Kinship care and permanency*. Journal of Social Service Research, Vol. 28 (1) pp. 25 – 43.; Chamberlain, P., et al. 2006. *Who disrupts from placement in foster and kinship care?* Child Abuse & Neglect, Vol. 30, pp. 409 – 424.

Herrick, M. & Piccus, W. 2005. *Sibling Connections: The importance of nurturing sibling bonds in the foster care system*. Shlonsky, A., Webster, D., & Needell, B. 2003. *The ties that bind: A cross-sectional analysis of siblings in foster care*. Journal of Social Service Research, Vol. 29 (3) pp. 27 – 52.; Wulczyn, F. & Zimmerman, E. 2005. *Sibling placements in longitudinal perspective*. Children and Youth Services Review, Vol. 27, pp. 741-763.

⁵¹ Conn. Gen. Stat. § 17a-114 (emphasis added).

⁵² State agency regulations include numerous "physical requirements" of foster and prospective adoptive homes, including review of whether children have access to hazardous materials; peeling paint or lead paint related issues; access to medicines or other toxic materials; and adequate heating and plumbing systems. DCF Regulation § 17a-145-137.

⁵³ Conn. Gen. Stat. § 17a-114. Agency regulations provide that but for the issuance of a written waiver by the DCF Commissioner (or designee), a previous conviction of a violent crime against a person or a previous substantiation of child abuse or neglect shall result in the denial of a foster parent license.

⁵⁴ Id. State regulations require that a waiver be requested and granted in writing by the Commissioner or his/her designee *only if* the prospective foster family "is in substantial compliance with the relevant regulations." Regulation § 17a-145-159. The federal Fostering Connections to Success and Increasing Adoptions Act made numerous amendments to the Social Security Act including explicitly permitting child welfare agencies to waive non-safety related licensing standards for relative foster families on a case-by-case basis.

⁵⁵ Regulations of Connecticut State Agencies § 17a-145-132.

⁵⁶ Regulation § 17a-145-147.

⁵⁷ Regulations § 17a-145-153.

regulatory barriers existed that required a waiver, immediate placement of Dylan in the Magee home would not be possible.

The background check on the family should have barred placing Dylan in the Magees' home. The errors committed during the placement process on that Friday were compounded in that DCF *failed to adequately revisit or remedy the placement decision over the ensuing days, weeks and months*. The immediate preliminary assessment of the Magees on June 12, 2015 revealed the following:

- Crystal Magee had been the alleged perpetrator in over a half-dozen reports to DCF for alleged physical abuse, emotional abuse and educational neglect of her own child. She was previously substantiated for neglect in 2009.
- Donald Magee has a history of criminal charges and convictions for drug possession (1999) and assault (2001).

DCF learned shortly after Dylan's placement the following information:

- The Magees had no employment income and received limited cash assistance and food stamps. Mr. Magee received state disability benefits.
- Both Magees' drivers' licenses were indefinitely suspended.

Internal DCF records note that the child protective and criminal histories were seen and reviewed *prior* to the placement decision. The note entered in the electronic case file by the DCF licensing unit references the foster mother's "10 [previous] unsubstantiated referrals [to DCF]" as well as the previous substantiation for educational neglect, and concluded that "it appears that there was *not* a history that would preclude licensing." (Emphasis added.) The case note claims that the information was discussed verbally with the licensing unit's Program Manager, and conveyed to the CPS unit managing Dylan's case. However, during interviews conducted by the DCF Human Resources staff between April and September, 2016 the CPS unit employees denied having this information prior to placement, and the licensing unit's activity note that such information was conveyed was date-stamped November 12, 2015, months after the placement activities purportedly took place. However it is difficult to fathom how a supervisor or program manager could consent to any child's placement without knowing or asking whether the licensing department learned of any risks or safety concerns during the background check.

As stated above, state and federal law permit the child welfare agency to waive regulatory licensing standards for prospective foster parents on a case-by-case basis if the standard being waived is "*non-safety-related*." Federal law grants discretion to states to determine what constitutes a non-safety standard. A 2011 federal report to Congress regarding the issuance of licensing waivers by state child welfare agencies found that the majority of waived licensing standards pertained to a child's sleeping arrangements or the space requirements in the home, but "a few states" utilized waivers to permit relatives with "past non-violent criminal histories" to become licensed as foster parents.⁵⁸

⁵⁸ Children's Bureau Administration on Children, Youth and Families, U.S. Department of Health and Human Services, *Report to Congress on States' Use of Waivers of Non-Safety Licensing Standards for Relative Foster Family Homes* (2011) at 8, found on the web:
http://www.acf.hhs.gov/sites/default/files/cb/report_congress_statesuse.pdf

The history seen and disregarded in Dylan’s case cannot be dismissed as “non-safety related,” and this investigation raises serious concerns about what other prior conduct by a prospective foster parent is waived (or not waived) on that basis. Additionally, while OCA supports the use of relative and kin foster care, emphasis must always remain on whether the proposed caregiver, relative or non-relative, has demonstrated *capacity* to meet the particular needs of the child that requires placement. The threshold question cannot simply be whether the proposed caregiver meets minimum licensing standards (though the Magees did not), but whether they are suitable to care for *this* child, understand his or her specialized needs and trauma and care for the child with available supports. Even without the criminal and child protective services history the Magees should have been considered unsuitable because their compromised health and related limitations made them less capable of meeting the intensive needs of a globally and developmentally delayed 13 month old already harmed by chronic neglect. Staff interviews conducted by DCF raise additional questions regarding *whose responsibility it is* to make these critical determinations.

Multiple staff also described workload pressures as hampering the quality of work, and one program manager stated that “when caseloads are at 200% things are going to be missed and not done.”⁵⁹ 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.”⁶⁰

OCA investigators found that the Magees had already “informally” fostered *another* infant from May, 2014 through June, 2015. The arrangement was effectuated and approved by DCF and the biological family in the wake of DCF’s concerns that this other infant was “failing to thrive,” and was extremely malnourished in his parents’ care. In 2014, DCF created a “safety agreement” with that infant’s parents that Mrs. Magee would take care of the infant and that the parents could have liberal amounts of time with the baby as their parenting skills developed. DCF indicated it would “assess” Mrs. Magee as part of the safety agreement, but OCA could not locate documentation in the electronic record regarding the scope of that assessment or the results related thereto. There is little mention of other members of the Magee household in that part of DCF’s record. There is also nothing documented in the electronic record from that time period regarding why that child’s caseworker would later tell the licensing unit workers on Dylan’s case that the Magees had “health issues,” could not be “overburdened,” or that Mrs. Magee was “dramatic and emotional.” The informal arrangement, effectuated without legal intervention or court involvement, raises several concerns that a very high risk infant, a child who not only was hospitalized for failure to thrive but had extensive special health care needs, was placed in a situation that can be characterized as foster care without the paperwork and without appropriate safeguards.⁶¹

⁵⁹ DCF internal HR investigative interviews, report received by OCA September 29, 2016.

⁶⁰ Id.

⁶¹ An email exchanged between DCF leadership and its employees in Region 3, dated August 9, 2016, articulates a concern that children were being placed with prospective relative foster parents or in relative care by DCF without appropriate assessments or requests for regulatory waivers. A regional office manager asked his team to “survey [their] minds to make sure we don’t have any situations that this may apply to,” and he conveyed a concern about “family arrangements that often turn into [DCF] placement situations. Bottom line, if there are sub issues [substantiations of prior child abuse or neglect] or [criminal history] issues, we should *not* be endorsing these as suitable options if we are not prepared to license eventually, request and defend waivers, etc.” Another manager responds to this email by saying “my worry is that there could be many out there from the pre-Dylan era in which those circumstances were at play, but we [Program

Though An Emergency Home Assessment (EHA) Is Required By State Law And Was Requested By The DCF Child Protective Services Unit, No EHA Ever Took Place.

The DCF licensing unit documented that because another DCF caseworker was already familiar with the Magee home from a previous case (see above) that no home assessment was required prior to placing Dylan. That other DCF caseworker appeared to vouch for the Magees and stated that he had no concerns with their care of the previous infant.⁶² The worker cautioned the licensing unit however that Crystal Magee and her husband have “health issues,” and could not be “overburdened,” and warned that the foster mother could be “dramatic and emotional.” The licensing unit and the child protective service units at DCF agreed to move forward with the licensing process and DCF placed Dylan with the Magees on the same day he was removed from his parents’ home.⁶³ The reference to the foster parents’ “health issues” was not addressed.

The Magees Made Several False Assertions In Their Foster Parent Application

In response to questions as to whether anyone in the home has ever been arrested or convicted of a crime, the Magees answered “no.”

1. When asked if anyone in the home had been convicted of a violent crime against another person, the Magees answered “no.”
2. When asked if an adult in the home had ever had an allegation of child abuse or neglect against them substantiated, the Magees answered “no.”
3. When asked if they had ever received services from DCF, the Magees answered “no.”
4. When asked if they had ever had any motor vehicle violations, the Magees answered “no.”
5. When asked if they had ever received psychological or psychiatric services for any period of time, the Magees answered “no.”

There is nothing documented in the DCF record that indicates any DCF employee addressed inconsistencies between the Magees’ self-report and the facts contained in DCF’s completed background check which contradicted virtually all of the information denied by the Magees. DCF Regulations state that grounds for revoking or denying a foster parent license exist if the applicant “furnishes or makes any false or misleading statements to the commissioner or child placing agency in order to obtain or retain a license or approval.”⁶⁴

Managers] and in some cases [Social Work Supervisors] were not notified.” These emails were exchanged as part of DCF’s effort to identify and address practice concerns in the region such as those that contributed to Dylan’s critical injuries.

⁶² He stated in an internal interview that he was asked for his “two cents” on the foster parents.

⁶³ An email obtained by OCA as part of this review indicates that a treatment unit manager was not included in the email chain regarding the home assessments possibly due to a personality conflict with the licensing supervisor. Email from program manager to office director: “If you recall, [supervisor] was not talking to me and also frequently not including me on emails (sent them directly to my Sups). I checked my emails from that week and did not get anything.”

⁶⁴ Regulations §17a-145-154.

DCF Staff Left Numerous Aspects Of The Magees' Foster Parent Application Blank Or Unaddressed

Regulatory language in the licensing application stating “no placement shall be made if there is a substantiation of abuse or neglect” was left blank and unaddressed in the physical application. Also left blank was information in the form regarding the criminal records check, including a regulatory directive on the form reminding that “no placement shall be made if the results of the police check indicate that the applicant or any member of the household has been convicted” of a violent crime against another person (e.g., assault).

DCF Did Not Address Statements In Foster Care Application That Mr. Magee Was Disabled, Nor Did DCF Explore How This Disability May Impact Dylan's Care.

State regulations require that prior to licensure of a foster family, the prospective foster family must provide a physician's statement that “each person living in the home has had a physical examination and has been found to be in good health...and the parents have been determined to be physically and mentally able to provide care to children.”⁶⁵

The DCF caseworker who previously worked with the Magees had specifically cautioned that the Magees had “health issues,” and could not be “overburdened.” A parent aide working with the Magees over a span of several years told DCF investigators in December of 2015 that she had previously reported to the DCF social worker that placing Dylan with the Magees was not a “good fit” due to both foster parents' medical issues, which the aide described as “chronic.” Yet Crystal Magee provided a physician's statement to DCF stating that she had no chronic or active medical or psychiatric conditions.⁶⁶

With regard to Mr. Magee, DCF's historical records on the family noted that Mr. Magee had health impairments that affected his ability to gain employment. Moreover, the Magees reported in their foster parent application that they were both unemployed and that Donald Magee received disability benefits in the form of State Administered General Assistance (SAGA), receipt of which is for individuals who have a “physical and/or mental impairment that will prevent employment for six months or more.”⁶⁷

No physician's statement was ever provided to DCF from Mr. Magee despite the fact that Mr. Magee was a co-applicant for the license. Assessment of Mr. Magees' health and capacity to care for Dylan was not addressed in the licensing record.

Emails reviewed by OCA indicate that from the first week of Dylan's placement with the Magees the licensing unit alerted the treatment unit that “there are health issues with both parents that need to be further assessed,” urging the two units to meet and discuss the family resources. A CPS unit manager

⁶⁵ Regulation § 17a-145-143.

⁶⁶ Following Dylan's hospitalization, Mrs. Magee contradicted these previous statement and reported to DCF investigators that she and her husband had many medical and mental health issues, and that her husband had “serious brain disease.” DCF documents also note that Mrs. Magee had previously been hospitalized due to a chronic health condition.

⁶⁷ <http://www.ct.gov/dss/cwp/view.asp?a=2353&q=305152#SAG>

responded that they “definitely should meet,” so that they could get the placements “as right as possible” and avoid additional disruptions for the children.⁶⁸

DCF Did Not Address Statements In Foster Care Application That Magees Used A Family Vehicle “As Needed,” Despite The “Indefinite” Suspension Of Their Licenses.

Records from the Department of Motor Vehicles received by DCF early in the licensing process revealed that both Crystal and Donald Magees’ licenses had been “indefinitely” suspended several years earlier. The Magees had reported in their foster parent application however that though they did not have a car payment they did borrow a car from Mr. Magees’ mother “as needed.”⁶⁹ These concerning inconsistencies and the Magees’ admission that they illegally drive were not addressed in the DCF record. The record indicated that DCF relied on the Magees to ensure Dylan was brought to medical appointments and sibling visits.⁷⁰

DCF Did Not Follow Up On A Statement In The Foster Care Application That The Magees’ Home May Not Be “Lead-Free” And Dylan Did Not Receive A Lead Screening While Living With The Magees.

Guidelines from the American Academy of Pediatrics provide that babies should be screened for lead levels at 12 months with appropriate risk assessments performed where indicated both at 12 and 18 months of age.⁷¹ A lead screening would also be routinely recommended for a child presenting with developmental delays like Dylan.⁷² When Dylan first came into DCF care, he was identified as having multiple developmental delays and his mandatory medical screen noted that his “lead levels were unknown.” The Magees’ foster care application included their statement that their home was not “lead-free,” and according to other DCF records regarding Mrs. Magee her biological child had also tested at a young age as having somewhat elevated lead levels. Dylan was never screened for lead while living with the Magees and there is no documentation in the DCF record that his lead levels were otherwise known at that time.⁷³

⁶⁸ Email correspondence sent by DCF for OCA’s review on September 6, 2016 included acknowledgement on June 12, 2015 (the date of Dylan’s placement with the Magees) that another DCF caseworker vouched for the Magees and that there are “some medical issues that [licensing unit] will *get more information about*. No concern with caring for the child but we don’t (sic) want to make sure we don’t overtax them.” (emphasis added.)

⁶⁹ The suspension of the Magees’ drivers’ licenses was also mentioned in a note by the licensing worker.

⁷⁰ Email correspondence sent by DCF for OCA’s review on September 6, 2016 included a note from the licensing unit dated the day of Dylan’s placement with the Magees that acknowledged the Magees did not have “valid driver’s licenses” and that the licensing staff would “discuss with them about how they are able to get around.” This email is not entered in the electronic DCF record and there are no further mentions in the record of this issue.

⁷¹ American Academy of Pediatrics *Recommendations for Preventative Pediatric Health Care* (updated 10/20/2015), found on the web: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

⁷² Id.

⁷³ OCA made an inquiry with the DCF regional office upon identifying the lack of lead screening as a potential health issue. DCF responded that a lead screen was later done in April, 2016 as part of Dylan’s two year well-child check. This was ten (10) months after Dylan entered DCF foster care.

Visit By DCF Licensing Unit Shortly After Dylan's Placement Raised Concerns About Foster Mother's Capacity To Care For Dylan

On June 22, 2015, ten days after his placement with the Magees, the DCF licensing unit worker visited the home to collect information for the foster parent application. Agency records corresponding to this day note that a family support worker from the community who was already working with the Magees in connection with their biological son told the DCF licensing worker, *when Crystal Magee was out of the room*, that she felt caring for Dylan was too much for Mrs. Magee. These statements echoed the caution from the previous DCF caseworker that the Magees had "health issues" and could not be "overburdened" with demands. The DCF licensing worker asked the provider to put the information in writing and send to DCF.⁷⁴ A CPS unit note from the same day indicates that DCF was going to make a referral for the foster parents to the Caregiver Support Team. But no services were ultimately put in place.⁷⁵

On July 5, 2015, a DCF case aide went to Dylan's foster home to conduct finger printing of the Magees as part of the application process. The case aide documented that the foster mother was emotional and claimed that Dylan had many "behavior problems that [foster mother] was not aware of." Foster mother reported that Dylan bit, scratched, banged his head, pulled his penis, took his diaper off and spread feces, cried loudly and wanted to eat a lot, and did not sleep well. The aide wrote in the case record that foster mother stated she was "*overwhelmed and needs direction*." She told the DCF case aide that she was exhausted because "Dylan would not let her sleep" and that DCF had not helped enough with Dylan's basic needs.⁷⁶ The case aide did not record whether Dylan was home or not during this visit.⁷⁷ **The case aide's note was one of the only entries timely entered into the licensing record, viewable to all relevant employees.**

On July 15, 2015, DCF records show that Dylan's foster mother called the DCF CPS unit caseworker and said that she needed the foster parent stipend and more support. The foster mother reiterated that Dylan had "issues," and that he "cries and screams constantly."

Of great concern is that previously on July 15th the CPS worker received an email notice from a DCF social worker embedded in the local police department that Crystal Magee had called the police department asking if she could "get in trouble for allowing a baby to cry for long period of time; if her neighbors were to hear and report her...the officer further indicated that [Mrs. Magee] seemed to

⁷⁴ Although this activity was not entered into the case management system by DCF employees until November 12th, the activity note avers that the licensing supervisor emailed the CPS unit, including the program manager, of the concern in a timely manner.

⁷⁵ A June 22, 2015 case note states that DCF was going to refer the foster family for a "caregiver support team" service. Interviews with DCF Regional Office leadership conducted by OCA revealed that the family support service was not put in place because the parents objected to the support team and DCF protocols required parental consent for the service. On August 13, 2015 the foster mother told DCF that Dylan's behavior was much better. However she later reported to the Birth to Three service provider that Dylan's behaviors again "escalated."

⁷⁶ Agency records indicate that the Magees received over \$3,500 in foster parent support payments over the five months they had Dylan in their home. They also received money for diapers, food, a car seat and a crib. The Magees were provided the support of the Birth to Three provider system though they cancelled almost all of Dylan's appointments.

⁷⁷ This activity note was timely entered into the case management system and visible to the CPS caseworker and supervisor.

be struggling a bit and admitted that she was having difficulty consoling Dylan and so he cries for very long periods of time.” The notice advised the caseworker that “this information *may be worthy* of reaching out to her, assessing her parenting struggles, and offering any needed/wanted services/help...”. The response that follows from the caseworker and supervisor is alarming:

From: CASE SUPERVISOR
Sent: Wednesday, July 15, 2015 9:59 AM
To: CASEWORKER, DCF WORKER IN POLICE DEPARTMENT
Subject: RE: Dylan
Is it possible the baby has colic? (I am being lazy, don't know how old Dylan is, but that is a possibility.)

From: CASEWORKER
Sent: Wednesday, July 15, 2015 10:33 AM
To: SUPERVISOR, DCF WORKER IN POLICE DEPARTMENT
Subject: RE: Dylan
He is 15 months old. I don't think he should be crying non-stop. Crystal is very difficult. She left me a long message and I understood all of about two words she said.

From: CASE SUPERVISOR
Sent: Wednesday, July 15, 2015 11:04 AM
To: CASEWORKER
Subject: RE: Dylan
OMG, I cannot stop laughing. ☺ Advise her to bring him to the pediatrician, or we can look for another placement for him. Way too much drama with this family.

The lack of knowledge or expressed concern about Dylan's age, developmental, and possible medical needs by this supervisor, combined with the supervisor's projected apathy regarding ensuring Dylan's needs were met or assessing the capacity or lack thereof of the entrusted and soon-to-be licensed foster care provider is breathtaking in its complacency.⁷⁸

The preceding email correspondence was obtained by OCA in the late stages of this investigation. The correspondence, including the information regarding the foster mother's call to the local police department, was *not* part of the record originally received from DCF and the content of the concern is not entered into the DCF electronic record.⁷⁹ The DCF caseworker did not conduct a follow up foster home visit with Dylan for another two weeks.⁸⁰ The caseworker did not ensure Dylan received a medical exam, and it does not appear that the contents of the concern was clearly shared with anyone else.

⁷⁸ The case transitioned to a different supervisor by August 2015.

⁷⁹ Another email from a DCF office director, dated December 22, 2015 queried how this “notification wasn't attended to or documented at the time” it was received.

⁸⁰ As stated above the worker spoke to Mrs. Magee by phone but when he offered to come visit that day she declined stating that she was sick.

By August DCF accepted Mrs. Magee's word that Dylan was fine and doing better.⁸¹ He still had not received medical care.

DCF Receives Allegation That Dylan's Foster Mother Abuses Substances, DCF Sought Outside Substance Abuse Evaluation. DCF Did Not Adequately Follow-Up On Concerns About The Foster Mother.

On July 30, 2015, the DCF special investigations unit (SIU) launched an investigation into allegations of substance abuse by Mrs. Magee conveyed to DCF by another state employee based on an anonymous source. This was the third DCF unit that interacted with the Magee foster home while Dylan was living there. Mrs. Magee denied illegal substance use and DCF investigators ultimately did not substantiate the allegation. However SIU and the DCF licensing unit jointly recommended that Mrs. Magee submit to a consultation with the DCF substance abuse specialist and a possible substance abuse evaluation. Because of multiple cancelled appointments by the Magees and slow follow up by DCF employees, the consult with the DCF substance abuse specialist did not take place until *October 30th*. The foster mother repeatedly refused DCF's requests that she submit to a substance abuse evaluation. She told the CPS caseworker that she had been "begged" to take Dylan in and that DCF's requirements were "uncalled for."⁸²

Emails authored by DCF staff and reviewed by OCA indicate that as early as July 31, 2015 multiple DCF employees were discussing the foster mother's possible "personality/mental health issues," even as they were uncertain regarding the truth of the substance abuse allegations. One employee suggested that the licensing and CPS units could "leverage" Mrs. Magee by requiring the substance abuse evaluation as part of the licensing process. But there was little follow up for months.

Record Reveals Lack Of Clear Communication Between The Various Units At DCF Regarding Concerns About Dylan And The Foster Parents

The DCF CPS Unit records include repeated notes from August through October 2015, regarding the need to connect with "the [DCF licensing unit] to assess appropriateness of [Dylan's foster home] for licensure." However, there are no electronic record entries from either unit during that time period other than a concerned email from the CPS unit on October 15th. The licensing unit had no activity entries that it contacted the CPS unit between June 22nd and November 4th.⁸³

⁸¹ Mrs. Magee was also under investigation by DCF at this time due to allegations of substance abuse by a reporter to the DCF Careline.

⁸² Statements attributed to Mrs. Magee were inputted into the DCF electronic case record. DCF regulations provide that the agency may "require a physical, mental or psychological examination" of any member of a foster or prospective adoptive household "if such person exhibits behaviors which indicate or could indicate that they are unable to provide for the care of the child." Regulation § 17a-145-143. The foster parent continued to refuse.

⁸³ On October 21st there was a note in the licensing unit case file regarding the foster parents' lack of cooperation with DCF. By this time Dylan has been in the Magee foster home for *four (4) months*. This was the first activity noted by the licensing unit since September 3rd, when the Magees had cancelled the appointment with DCF regarding substance abuse screening. There is no documented activity by the licensing unit following that cancellation for the next seven (7) weeks. The October 21st case note is also date/stamped November 12, 2015, the day after Dylan was hospitalized.

As a result of the gaps in the record described above, OCA made an August, 2016 request for any additional DCF records not already provided or entered into the case record, such as emails or handwritten notes. Email records received by OCA on September 2, 2016 revealed that there was a conference call among various DCF units (including SIU and licensing) in August, 2015 regarding concerns that Mrs. Magee would not complete a substance abuse evaluation, and consequently that Dylan *should be removed* from the Magees' home.⁸⁴ Neither the email nor the content of the conference call meeting or the recommendation that the child might need to be moved were entered in the DCF case record. There was no action plan written into the DCF record and no clear steps for follow up to ensure Dylan's safety.⁸⁵ The toxicology screens *were never completed*.

On October 7th a DCF supervisor attempted to follow up on the August discussion via email with the licensing unit, now raising additional concerns about the foster family's conduct and Dylan's lack of care:

From: CASE SUPERVISOR
Sent: Wednesday, October 07, 2015
To: LICENSING SUPERVISOR.
Cc: PROGRAM MANAGER, CASEWORKER
Subject: Crystal Magee/ BIOLOGICAL MOTHER FYI

Good afternoon,
I'm following up regarding the meeting and recommendations following an August, CPS report that was received and investigated which alleged SA [Substance Abuse] concerns on behalf of Crystal Magee who is a relative caretaker for 1.5 yo Dylan... We teamed on the case with FASU [licensing] support staff and SIU called in and one of the follow up recommendations was for Ms. Magee to complete a SAE to rule out SA given the recent and past SA concerns with the family.

During the intake, Ms. Magee refused to follow through with the recommended SAE so we planned to follow up with this as a recommendation in her licensing process. CASEWORKER reports that recently Ms. Magee has struggled with keeping various child appointments and has been unresponsive to phone calls and home visit attempts. CASEWORKER was able to successfully meet with Ms. Magee last week. We will be following up with the family via letter requesting that Ms. Magee complete the SAE on the CPS side within 10 days or we will need to reassess the situation.

Emails reviewed by OCA also contain numerous examples of personal or professional friction between certain members of the licensing and CPS units (e.g., concerns that one employee is trying to get another manager "in trouble" or that the right people are deliberately kept off email distribution lists). Given the relatively poor communication between all of the units working on Dylan's behalf it appears that personal/professional friction may have played a role in contributing to this pervasive problem.

Licensing Unit Records Include Few Mentions Of Dylan and No Visits After August 13th That Record Seeing Dylan In The Foster Home.

In late October, 2015 the licensing unit worker spoke to the CPS unit supervisor regarding the supervisor's growing concerns about the foster mother, but she assured the CPS supervisor that Dylan

⁸⁴ The licensing unit indicated that it was asking a "matcher" to look for a new placement for Dylan.

⁸⁵ DCF reported to OCA in its September 20, 2016 response that it is not the SIU's role to continue monitoring case activity after the investigation is concluded, and that the SIU worked to encourage the foster mother to acquiesce to the substance abuse evaluation but that the unit "was unable to gain her compliance before they needed to close the investigation due to the statutory time limit."

was “safe, alert and well cared for” during visits.⁸⁶ Electronic records revealed however that the licensing worker had not seen Dylan with Mrs. Magee since August 14th.⁸⁷ Later the licensing worker would tell a DCF SIU investigator that she had seen the child “regularly” and that he always looked “sickly.” The same worker also told a DCF Human Resources investigator that Dylan “always looked the same,” that he “never smiled and did not make any baby noise,” but that she did not have any documented concerns and that she “did not interact with [Dylan] because that is not part of her job.” The licensing program manager also stated during an HR interview that “[licensing unit] staff have no standard of visitation of the child in placement and there is no expectation that they interact with the children, however they try to visit every 30 days.”

The Magees Failed to Complete Mandated Training For Foster Parents

State regulations require that foster parents complete mandated training as part of the licensing process.⁸⁸ DCF sent a letter to the Magees on July 15, 2015 (Dylan was already placed with them for nearly 30 days), confirming their obligation to complete the “three modules of pre-licensing training” within 60 days of Dylan being placed in their care. DCF scheduled the Magees for a training session on August 1, 2015 in Norwich Connecticut. The Magees did not attend. DCF sent another letter to the Magees on August 5, 2015 providing a new date for the Magees to participate in training. The Magees did not attend. On October 6, 2015, DCF sent a third letter to the Magees reiterating the mandatory nature of training for foster parents. The Magees did not attend.

In September, 2015 the DCF Caseworker Is Asked Internally to Produce A Letter Of Support About Dylan’s Foster Placement:

From: LICENSING DEPARTMENT

Sent: Tuesday, September 01, 2015 4:55 PM

To: Caseworker

Subject: Crystal Magee

Hi Caseworker, as of today, 9-1-15, any foster home with a [PRIOR child abuse or neglect] substantiation needs a letter from the child’s SW about the benefits to being in the home. The memo will be read by the commissioner so make it good.⁸⁹

Dylan Was Removed From The Foster Home On November 10th

On November 10th the DCF treatment unit sought Dylan’s removal from the Magee foster home on the grounds that the Magees had limited capacity to care for Dylan. There was no finding that Dylan was in ill health or poorly developing in the Magees’ care. On November 11th, Dylan was hospitalized,

⁸⁶ Treatment supervisor’s note entered electronically and contemporaneously to the conversation on October 30, 2015.

⁸⁷ The case note recording the August, 2015 visit was not entered into the system until November 12th.

⁸⁸ Regulation § 17a-145-151, providing in part that “licensed or approved foster and prospective adoptive parents shall complete all assessment and training requirements as prescribed by the department of child placing agency.”

⁸⁹ On September 7, 2016 OCA reviewed this email correspondence and requested from the Department a copy of the letter produced by the caseworker. DCF responded to OCA in writing that the email referred to a “requirement that certain information from the CASEWORKER is required in the waiver documentation that goes to the Commissioner. No letter was written by CASEWORKER in response to this email. No waiver was ever sought regarding the Magee home.”

facilitated by his new foster parent. On November 12th, almost all of the licensing unit's activities relative to the licensing application of the Magees was officially entered into the DCF computer, months after the purported activities took place.

**DCF CPS UNIT FAILED TO ADEQUATELY ADDRESS OR INFORM
OTHER KEY STAKEHOLDERS REGARDING NUMEROUS CONCERNS
ABOUT DYLAN'S SAFETY AND CONDITION**

That Friday in June it was ultimately the DCF CPS unit that agreed to place Dylan with the Magees despite the numerous red flags for licensure identified by the licensing unit—later multiple employees stated that they were never informed of the concerns in the Magees' background check. While DCF administrators offered that the particular Friday contained a “perfect storm” of challenges from a personnel standpoint, the CPS unit never adequately followed up on the home assessment or how safe Dylan actually was in the Magees' care. The program manager later claimed that she was “blown away when she saw the [Magees'] CPS/criminal history.”⁹⁰ But it's not clear why the information would not have been sought prior to the placement approval.

Dylan's Medical, Developmental and Dental Needs Were Not Followed Up

Dylan's July 8, 2015 medical evaluation,⁹¹ conducted after his entry into DCF foster care, confirmed that he had multiple developmental delays and medical needs. The MDE recommended the following:

- 1. Birth to Three (early intervention support) services;**
- 2. A pediatric follow within one month to address excessive eating, vomiting and penile discharge;**
- 3. A neurodevelopmental screening and evaluation to address global developmental delays;**
- 4. Placement in an early learning environment to increase Dylan's exposure to consistent routine and peer interaction.**

⁹⁰ There are discrepancies in the program manager statements regarding whether she knew about the foster parents' prior history. One statement attributed to the program manager by the HR investigator/s alleges that she did not know of the criminal or CPS history of the Magees until Dylan was removed from their care in November 2015. But another statement attributed to the same program manager states that her concerns about the foster mother escalated when the substance abuse allegation came into the Careline in July. Documents related to that DCF investigation also contained all of the foster parents' prior CPS/criminal history. Finally, the program manager had also been assigned to the case of the previous special needs infant that had been placed with the Magees from 2014-15, raising additional questions concerns about what people knew or didn't know about this history and background of this family.

⁹¹ Dylan received, per DCF requirements, a Multi-Disciplinary Evaluation of his medical, developmental, and dental needs. State law and DCF policy require that all children removed from their homes due to abuse or neglect (unless removed from a hospital) receive a thorough medical and developmental evaluation upon entry into foster care so that unmet needs can be identified and services recommended. The MDEs are conducted by local providers and reports typically include a list of findings and recommendations along with a timeline for fulfilling the child's needs.

Dylan received none of the recommended follow up care during the ensuing months he lived with the Magees.⁹² An email from an internal quality assurance manager dated November 9, 2015 and transmitted to local DCF leadership continued to identify Dylan (and other unrelated children) as “overdue for medical and dental care.”⁹³ An email from the CPS unit manager in early November revealed frustration with the foster mother but reminded her staff that it was DCF that needed to ensure Dylan got to medical appointments as “all of this ultimately falls on us.”

Email correspondence received by the OCA on September 6, 2016 but that had *not been entered into the DCF electronic case record* indicates that Dylan’s biological parents arrived in-person at the DCF Ombudsman’s office on July 15th, 2015 and conveyed several concerns including their worry that Dylan was suddenly have eating problems in foster care but had not been seen by a pediatrician even though this could be a “medical issue.” The Ombudsman’s representative made an inquiry with the regional office regarding these concerns, but the region still failed to ensure Dylan’s medical needs were timely identified and addressed.⁹⁴

CPS Unit Failed To Follow Up On Concerns That Foster Mother Was Overwhelmed By Dylan And Limited By Health Impediments.

As stated above there were numerous times the CPS unit was notified of the foster mother’s stress level in caring for Dylan, but no referral was ultimately completed for support services. DCF ultimately concluded that Dylan’s biological parents’ consent was required and the parents reportedly (per DCF interviews) would not agree to sign releases. OCA notes that parents do retain some decision-making rights with regards to the care of their child when the state has temporary custody of the child (as was the case here). However nothing precludes the state from seeking a meeting with the parents to involve them with supporting the necessary services for the child, and at any time the state or child’s attorney may seek an order from the Juvenile Court and request that permission be given for necessary support services. There is no record of either activity occurring in this case.⁹⁵ A form created by DCF in preparation for securing the support team service, however, stated that both foster parents had “health issues,” and that the foster mother “cries all the time and apologizes a lot.”

⁹² DCF supervisory notes on August 10th and September 10, 2015 both reference the need for follow up on the medical and developmental recommendations. By October 7th, the supervisory note includes a discussion of problems in the foster home and concerns regarding the number of cancelled Birth to Three visits and the unwillingness of the foster mother to complete a substance abuse evaluation. An email dated September 21, 2015 from the regional office’s quality assurance reviewer asked the caseworker if Dylan had been seen by the pediatrician as scheduled that month, and the caseworker essentially responded that he did not know. Another email from the same quality assurance manager was sent to the case supervisor on October 14th asking about unmet medical and developmental needs. The supervisor responded *twelve days later* that he would touch base with the caseworker to discuss.

⁹³ The email includes a list of children, some overdue for one to two months for care, and some overdue for more than sixty days.

⁹⁴ Internal emails at the regional DCF office following the Ombudsman’s inquiry included affirmation to the caseworker from a supervisor reminding him that he was doing a nice job and to “keep up the good work,” even though the “case is a pain.”

⁹⁵ By August, 2015, with a new DCF investigation into allegations that Crystal Magee was substance abusing and was pending an evaluation, the foster mother told DCF that Dylan’s behaviors were improved and she longer needed in-home support.

CPS Unit Program Manager Concerned Early on Regarding Dylan’s Placement But Fails To Remove Dylan

In an email dated July 31, 2015, the CPS unit’s program manager reacted to a new allegation made to DCF that Mrs. Magee was abusing substances. She emailed the Special Investigations Unit team, copied to the CPS and licensing units, that she “had some concerns about [the foster mother]. She repeatedly went to different agencies and individuals stating that DCF had not helped her with anything and was looking for additional financial or supplies help” after DCF had just given her two debit cards within the first 10 days of Dylan’s placement. The manager queried that “maybe it’s more of a personality issue than substance abuse,” and asked whether DCF would require the foster mother to submit to a substance abuse evaluation and testing. During subsequent HR interviews a statement attributed to the manager claimed that “her unit *did* think substance abuse was occurring,” and that her concerns continued when the July Careline report came in about possible substance abuse. These concerns should have led to urgent action to ensure Dylan’s safety.

Birth to Three Provider Repeatedly Reported Concerns About Dylan’s Foster Home to DCF

Dylan’s treatment plan called for Birth to Three services three times per month to work assisting Dylan with standing, walking, playing and communicating. However, after only two home sessions with Dylan on July 22nd and August 10th, the Magees did not allow Birth to Three to enter the home or meet with Dylan again.⁹⁶ Birth to Three records obtained by the OCA confirm that the provider spoke with DCF on *nine (9) occasions* between July 31, 2015⁹⁷ and October 29, 2015, with eight contacts to the CPS unit focused on the Magees’ lack of cooperation and the lack of services for Dylan.⁹⁸

The Birth to Three record also confirms that the provider spoke with the DCF caseworker on September 18th about an encounter the provider had at the Magee home the previous day.⁹⁹ The provider reported by phone to DCF that during a service attempt for Dylan, Mrs. Magee did not allow the Birth to Three worker into the home and the visit had to be conducted outside on the steps. At that time, the Birth to Three worker saw Dylan outside and observed that his head was wrapped in a fabric rag, and he could not pull himself up to stand.¹⁰⁰

⁹⁶ A session scheduled for September 17, 2015 (the last session held between Birth to Three and Dylan prior to his hospitalization) was held in front of the house and Mrs. Magee reported that there was a problem with the pipes in the house. Birth to Three was so concerned about the encounter with the foster family that the provider called DCF the same day to discuss.

⁹⁷ The July 31, 2015 call was with the Special Investigations Unit regarding the allegations that Dylan’s foster mother abused substances. The Birth to Three provider explained her role and stated that she had only been in the home one time. The content of the call was documented in the DCF electronic case management system.

⁹⁸ Conversely, the DCF electronic case record includes only two entries documenting a telephone call with or letter from Birth to Three. The failure to document the phone calls and messages from the Birth to Three provider, like the licensing unit’s failure to enter case activities until November 12, 2015, violates agency policies regarding entry of all case contacts within five (5) working days. Despite the lack of documentation in the DCF record, the nature of concerns that were documented by DCF are consistent with Birth to Three’s record (and assertions to OCA during multiple interviews) that DCF was made aware on numerous occasions of concerns regarding Dylan’s care.

⁹⁹ The provider called the same day as the session but left a message for the caseworker to call her back.

¹⁰⁰ The Birth to Three provider repeated this encounter to the DCF investigator following Dylan’s hospitalization in November.

The provider reported to OCA that Mrs. Magee was “erratic” at the meeting, talking about many different things and not always making sense. She talked a lot about Dylan’s head and said that he had fallen, but then also told the provider that Dylan had not fallen that day but weeks earlier.¹⁰¹ Mrs. Magee told the provider that she could not let her in the house because the family members all had diarrhea from something in the pipes and that she could bring in a neighbor if needed to attest to the problems with the pipes. The foster mother told the provider that a nurse had come to the house to see Dylan and identified brown marks on him, which the nurse attributed to mosquito bites or eczema. The Birth to Three provider did not see any marks on Dylan at that time.

The Birth to Three provider immediately called and left a message for the DCF caseworker who returned her call the following day, September 18th. They talked at length about the encounter and according to the provider, the DCF caseworker “shared her concerns and said he would be talking with his supervisor and going out to check on Dylan.” The caseworker also stated that as far as he knew, no nurse had been to the home to see Dylan. The provider reported to OCA that though she wasn’t sure that Dylan was being abused, that the visit just didn’t “feel right,” and it was “awkward and anxious” and that after speaking with DCF she felt “relief” that someone was going to check on Dylan and make sure he was okay. The DCF electronic record however contains no entry regarding the call with Birth to Three or the content of the provider’s concern from that day. There is also no record of a visit attempt with Dylan by the CPS worker until September 29th, eleven days later.

Though the Birth to Three worker didn’t see Dylan in that foster home again due to repeated cancellations by the foster parents she called DCF almost weekly after that point expressing concerns and looking for updates about Dylan.

Dylan was not seen awake by the DCF caseworker for 102 days.

- On June 18th a DCF caseworker saw Dylan “briefly” in the Magee foster home, and documented that he was dressed appropriately and “sleeping.”
- On June 22nd, a new caseworker was directed to “conduct weekly visits for the first month with each child.” However, the caseworker did not see Dylan in the Magee foster home until July 30th, *seven weeks* after Dylan was placed there.¹⁰²
- The caseworker saw Dylan again on August 13th (internal DCF notes indicate the child was sleeping during this visit but the case record is not clear on this point), and then not until September 29th, *43 days later*, documenting that Dylan was again “asleep” in the pack and play.
- Despite escalating concerns about Dylan’s foster home in September and October and missed medical appointments, no additional visits were scheduled for Dylan and no supervisor or DCF nurse went to the home to assess his condition.

¹⁰¹ Birth to Three notes indicate that foster mother wanted Dylan outfitted for a helmet because he allegedly fell often.

¹⁰²On June 24th, 2015 the caseworker documented that he saw Dylan while conducting a visit in a sibling’s foster home. Later a program manager said that weekly visits had not been required as they were not mandated by DCF policy.

- 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.” (Emphasis added.) By this time Dylan had multiple outstanding health care needs, he had not had recommended evaluations, he had missed his scheduled medical appointments, and he missed almost all of his Birth to Three appointments.
- Though the supervisor emphasized the need for the caseworker to see Dylan awake during the next home visit, in November the caseworker once more observed that “Dylan [was] again sleeping in his pack and play in the living room.”

After Dylan’s injuries were discovered the unit 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*.

The September 29, 2015 visit attempt by DCF led to new alarms.¹⁰³ The case worker went to Dylan’s foster home to see him and discuss concerns regarding the missed appointments for Dylan. When the worker came to the door he heard the foster mother inside the house, but when he knocked to come in, the voice “became quiet and [the foster mother] refused to answer the door.”¹⁰⁴ After leaving messages for Mrs. Magee she agreed to have the worker come back to the home that evening to see Dylan. The worker saw Dylan asleep in his pack and play, and he spoke to Mrs. Magee about DCF’s concerns. He reiterated to Mrs. Magee that she must comply with DCF expectations and she must allow him access to the home whenever needed.

On October 7th with yet more calls from Birth to Three about missed appointments¹⁰⁵ along with the continued refusal by Mrs. Magee to participate in a substance abuse evaluation, the caseworker and supervisor met to discuss concerns that the foster parents were not compliant with DCF’s expectations. The licensing unit did not participate in this meeting. There is no recorded visit attempt with Dylan this week.

¹⁰³ The caseworker later told HR that he had not known the foster parents’ prior CPS/criminal history and that he later conducted “his own research and saw the history in September, 2015 when he had [his own] concerns.”

¹⁰⁴ Visit note from the caseworker entered into the electronic record.

¹⁰⁵ Birth to Three records document that the provider left a message with DCF on September 28th that Mrs. Magee had cancelled Dylan last two appointments and another message left with DCF on October 5th that the provider was unable to get in touch with the foster parents.

On October 16th, the caseworker wrote a letter to the foster mother about the agency's concerns, expressing frustration that Mrs. Magee was still cancelling Dylan's Birth to Three appointments¹⁰⁶ and that Mrs. Magee still refused to cooperate with the substance abuse evaluation. There is no recorded visit attempt with Dylan this week.

On October 22nd, the caseworker received a message from Mrs. Magee who stated that she would not do the substance abuse evaluation DCF had requested, and that she did not want to be associated with "drug addicts." The foster mother told DCF that she had been "begged" to take Dylan in and that the agency's requirements were "uncalled for." There was again no recorded visit attempt with Dylan this week.

On October 29th, **one month after the caseworker's previous alarming encounter with Mrs. Magee and with yet another call from Birth to Three**¹⁰⁷, the caseworker visited Dylan in his foster home, where he was again "sleeping" in the pack and play."¹⁰⁸ The meeting was supposed to be held jointly with Mrs. Magee and Birth to Three but the Magees had again cancelled Dylan's service appointment, claiming that everyone was sick. During the October 29th meeting in the home DCF discussed its concerns with Mrs. Magee and the follow up care for Dylan.

On November 2nd, per DCF records, Dylan's mother informed the caseworker that Dylan had missed yet another doctor's appointment and more Birth to Three sessions, and that he had also missed three weeks of visits with his siblings. The caseworker indicated that he did not know that Dylan had been missing visits.¹⁰⁹ The contracted visitation supervisor later told a DCF special investigator that she informed the caseworker regarding the missed visits.

Also on November 2nd, the program manager emailed the CPS team with her concerns that DCF was forcing the placement to work and needed to make changes to help Dylan. She asked for a meeting about Dylan, cautioning that she didn't "*Want another month to go by and for us to be in the same exact place again with Dylan still not having his needs met.*" (Emphasis added.)

On November 5th, the caseworker went to Dylan's foster home again where Dylan was noted once more to be sleeping. The caseworker subsequently informed the foster parents that Dylan was going to be moved to another foster home due to concerns over the Magees' inability or unwillingness to

¹⁰⁶ Birth to Three records document that the provider left a message with the DCF caseworker on October 9th that she still had not heard from the foster mother; the provider left DCF another message on October 16th to "please call her back to discuss [Dylan's] case" as she still had not heard from anyone in the family about Dylan.

¹⁰⁷ Birth to Three records document that the provider spoke with DCF on October 19th about concerns; DCF informed the provider it was going to seek "testing" of the foster parent and that DCF wanted to try and keep Birth to Three services in place for Dylan;

¹⁰⁸ Visit note from the caseworker entered into the electronic case record.

¹⁰⁹ In September, 2015 DCF contracted with a community-based organization to supervise visits between Dylan and his siblings and the parents. This was in part due to significant friction between the various family members and the desire to have a neutral party oversee and report on visits. Dylan allegedly missed several scheduled visits with his siblings and parents in October, 2015. Later the visitation supervisor reported to a DCF investigator that she had not seen Dylan for several weeks in October but then saw him on November 10th at one of the relative's homes. She said that "she did not recognize Dylan, as he had no affect, did not smile, and he looked very thin."

follow up with Dylan’s care. On November 10th DCF requested that the new foster mother work out a pick-up of Dylan from the Magees.

During a meeting with OCA about this investigation DCF regional leadership acknowledged many of the practice concerns cited here and discussion revolved around the question of how long it took the casework team to recognize the “pattern” of red flags regarding Dylan’s care. OCA’s position is that when the state is caring for a young and utterly dependent child that a pattern of poor care cannot be allowed to develop. Rather there must be protocols in place that ensure appropriate placement and care and all case review and supervision must focus on how the agency is ensuring adequate care and supervision for the child. If a child is asleep during the caseworker’s visit, for example, then the caseworker and supervisor must separately assess what they know of the child’s functioning and how: recent medical reports, provider reports, school/child care reports, other recent visits. But a period of time simply cannot develop where the answers to these questions remain unknown. Home visits with a child are not perfunctory and must serve a purpose and be part of a meaningful and ongoing assessment of a child’s safety.

THE DCF ADMINISTRATIVE CASE REVIEW UNIT FAILS TO IDENTIFY SAFETY ISSUES

The DCF Administrative Case Review (ACR) unit is a quality assurance unit whose members review children and family’s case plans on a periodic basis. Per DCF policy, the ACR unit must determine, no less frequently than once every six months:

1. The physical and psychological safety of the child;
2. The extent of compliance with the case plan;
3. The appropriateness of the child’s placement;
4. The treatment and monitoring of any trauma associated with maltreatment and removal [of the child] from home.¹¹⁰

The ACR unit is charged with reviewing the casework team’s “child in placement case plan” (CIP). ACR reviewers and supervisors are directed to conduct a “comprehensive and qualitative analysis of casework practice” and “review actual case practice against expectations, policy, procedures, protocols and other requirements.”¹¹¹ In preparation for the review, the ACR supervisor is “responsible for completing a comprehensive case record review of the [period under review].”¹¹² In Dylan’s case, the ACR unit conducted a review on August 14, 2015, completing the written record of the review on September 3, 2015.¹¹³ At the close of the review the ACR supervisor provided written feedback to the

¹¹⁰ DCF Policy Section 36-11-1, found on the web http://www.ct.gov/DCF/lib/DCF/policy/pdf/36-11-1_Introduction.pdf. Administrative case reviews emanate from federal regulatory requirements regarding case plans for children in state custody. 42 U.S.C. 675; see also Conn. Gen. Stat. §17a-15(b).

¹¹¹ DCF Policy section 36-11.

¹¹² The Department of Children and Families Family and CIP ACRI Guide, 2014, pg. 6.

¹¹³ The review includes a meeting with the caseworker, the foster parent, and other stakeholders who are invited to participate and offer relevant information about the child. DCF’s September 20, 2015 response to this report indicates that part of the ACR reviewer’s rationale for its findings was the information offered by the foster parent and caseworker regarding Dylan’s presentation in foster care and his involvement with Birth

CPS staff via the Administrative Case Review Instrument (ACRI), which documented the “strengths and areas needing improvement in case practice” during the Period Under Review.¹¹⁴ The ACR unit gave inadequate and inconsistent feedback regarding the case plan—missing a critical opportunity to intervene on Dylan’s behalf.

The ACR unit rated the August, 2015 case plan documentation regarding Dylan’s physical health as “needing improvement” given the failure of the social work team to ensure timely medical care for Dylan as previously recommended. The ACR unit also noted that DCF policies governing mandatory contacts with a child in foster care were violated when the DCF caseworker did not see Dylan in the Magee foster home until July 30th, 2015, *seven weeks* after Dylan was placed in the Magees’ care.¹¹⁵

However, despite these critical deficiencies, the ACR unit inexplicably rated as a “strength” DCF’s efforts to address Dylan’s developmental well-being, reasoning that Dylan’s needs were adequately assessed “*informally... through visits and interviews by the [DCF caseworker/s],*” and because Birth to Three was “working with Dylan.” (Emphasis added.)¹¹⁶ These findings by the ACR unit were not adequately supported by the case record which had led to the ACR unit’s *own concerns* about the adequacy of the caseworker’s visitation and which is devoid of documentation regarding the frequency of Birth to Three visits at that time.¹¹⁷ The ACR unit also found that the neurodevelopmental evaluation recommended for Dylan in July had not occurred or even been scheduled, nor had consent from the parents been discussed or obtained for the evaluation.

The ACR unit also found that DCF’s assessment of the foster home placement was a “strength,”¹¹⁸ and that the placement was “safe and stable.” Reviewers concluded that DCF had done a “Strong” job of ensuring Dylan’s safety in care because the caseworker had “documented the assessment of the home and the caretaker’s ability to meet [the child’s] needs, with no concerns noted to date.”

DCF’s official September 20th response to the OCA report includes the following:
“Finally, while the ACR [reviewer] did rate the foster home and safety as a ‘strength,’ this is a function of the tool’s categories for the options available to the [reviewer].”

to Three even though the information they share may or may not be thoroughly documented in the case record.

¹¹⁴ Id. DCF tracks data and trends regarding Strengths and Areas Needing Improvement as part of its quality assurance framework and the effort to ensure children’s needs are well met.

¹¹⁵ See DCF Policy Section 36-5 outlining *minimum* contact standards for a child placement. DCF’s minimum standard for visitation with a child in “out-of-home placement” requires “weekly contact for the first month after transfer from intake to ongoing services; and in-person contact at least once per month thereafter.”

¹¹⁶ Again, this likely was asserted by the meeting participants, but the *case record itself* had little information about the Birth to Three participation, goals, objectives or the anticipated schedule for services.

¹¹⁷ Per DCF’s internal ACR Manual (2014) the social worker must have contact with the service providers on a monthly basis and this should be documented in the electronic case record. “If verbal information is received from a collateral contact at an ACR, and the information/activity should have been known and documented prior to the ACR then the rating for this section would result in an [Area Needing Improvement.]” Manual, pg. 36.

¹¹⁸ Per DCF’s internal manual, an area of the case plan is to be considered a “Strength” if “the reviewer finds evidence that essential elements for the standard of compliance are substantially present given the review of relevant consideration items.”

It should not be interpreted as a conclusion that DCF did a ‘strong job of ensuring Dylan’s safety in care.’”

The ACR reviewer also concluded that “risk factors have been assessed and ... there are no risk factors identified in the home.” No mention was made of the foster parents’ criminal or child protective service history, whether prior CPS concerns had been resolved, the lack of required waivers needed to place Dylan in this home, any health or mental health issues that may limit the foster parents’ capacity to care for the child, *or that the home was under an active Special Investigation by DCF.*¹¹⁹

Of course the ACR unit also did not have the additional benefit of reviewing *all of the concerns* that were later found in emails (such as the call to the police department) but that were not entered into the case record. But ACR reviewers must have seen that there were virtually no electronic records from the licensing unit available for review, a significant red flag in itself.¹²⁰ The only two entries viewable by the ACR reviewers documented concerns. The lack of record should have raised alarms and immediate findings that the placement assessment review was inadequate.¹²¹ This was a significant missed opportunity to address the irregularities with Dylan’s placement and intervene on his behalf.

However DCF’s response to OCA’s draft report included its assertion that though the ACR unit “Reviews the family’s case record in preparation for the case review,” reviewers are *not* expected to review the foster care record¹²² and they are *not* trained in reviewing the licensing file” (emphasis added) and “*would not have been in a position to note the lack of documentation by the licensing staff.*”¹²³

Yet staff at DCF familiar with the ACR process and who spoke on condition of confidentiality to OCA shared a copy of DCF’s internal guidelines for the ACR unit,¹²⁴ dated 2014, which includes, in bold and capped letters, the following instruction:

¹¹⁹ A July 30, 2015 entry into the electronic case record, viewable to the ACR unit, references the new SIU investigation, the foster parents’ belief that a person known to them made a “malicious referral” against them, and the foster mother’s reluctance to comply with DCF’s request for a drug test. This same entry records that Dylan was “reportedly” doing well in the home and making strides with his behavior and development.

¹²⁰ By this time in a child’s case, two months after an emergency removal and placement in foster care, the electronic foster care narratives should have included information about the Emergency Home Assessment, any barriers to licensing, strengths and challenges of the caregivers, support needs and home visits.

¹²¹ At this point in time, two months after the child’s placement, electronic licensing records would be expected to contain information regarding the home assessment, the background of the foster parents, any strengths and concerns regarding the caregiving capacity of the foster parents, and whether any waivers were needed to address regulatory barriers to licensing.

¹²² DCF staff familiar with the ACR process reported to OCA agreed that the ACR reviewers *do not* review the hard copy of the case record, only the electronic records; staff are instructed that if “the information is not in LINK [the electronic DCF record] it didn’t happen,” but acknowledged that staff are also instructed to “accept the information provided verbally to the reviewer at the meeting,” essentially “to give the caseworker the benefit of the doubt even without appropriate documentation.”

¹²³ A telephone discussion held between OCA and DCF on September 26, 2016 seemed to clarify the expectation that ACR reviewers are in fact expected to review the foster parent provider narratives for the period under review.

¹²⁴ These were also later transmitted by DCF Central Office to OCA on September 26, 2016.

Reviewers MUST read the FASU [licensing unit] [foster parent] Provider Narratives.¹²⁵

A review of these provider narratives is what would have shown the lack of expected documentation.

DCF also stated that because the “time frame for licensing the home had not yet expired, there would be little to report by way of deficiencies.” But internal directives to the ACR unit specifically require the reviewer to describe “what *evidence* exists to help the Department determine appropriateness of the placement,” inclusive of “*any licensing barriers* or issues with overcapacity—how is this being resolved and what is the target date,” indicating the “source of [the reviewer’s] information.” DCF’s internal guide emphasizes that in preparation for the ACR review, “*The FASU [licensing] narratives should be reviewed as they contribute to risk, safety and needs assessments of children and the foster parent’s ability to meet their child’s needs.*” (Emphasis added.)

Per interviews conducted by OCA, ACR reviewers are also expected to “run” the foster parent provider’s name in LINK and see if anything comes up during the period under review. This would have, at a minimum, alerted the reviewer to the existence of a pending SIU investigation of the foster home, as well as the prior abuse/neglect history, and the current unresolved issue of the alleged substance abuse.

In assessing the safety of the child, the reviewer is also directed by the instrument to document whether there are “any past allegations against the placement that raise questions or safety concerns.” Despite the fact that the foster home was under active review by the DCF Special Investigations Unit and there were multiple “licensing barriers,” and no path to resolution of these barriers outlined in the case record,¹²⁶ the reviewer wrote the following in the feedback instrument:

During the period under review, there have not been any reported concerns around safety factors for [wrong name of child] in the current placement. The area office social worker has documented the assessment of this home and the caretaker’s ability to meet his needs, with no concerns noted to date. FASU licensing staff have not indicated any concerns.¹²⁷

The bottom line for the purposes of this investigation is that the DCF ACR unit is comprised of social work professionals who fulfill critical case review and quality assurance functions. The unit had access to information that should have raised concerns about the appropriateness of Dylan’s placement with the Magees and yet no concerns about the placement were urgently raised with the chain of command and the lack of documentation *wasn’t even noted*. The ACR reviewer’s role cannot be reduced to that of a stenographer, who without clear and enforced expectations for reliance on a comprehensive written record, makes critical (and here *unreliable*) findings regarding children’s safety in placement. OCA adds however, that the persistent lack of appropriate documentation entered into the case record by the CPS and FASU units contributed in some part to hampering the potential ACR quality assurance response. The ACR failings are especially concerning in light of the critical role it should play in

¹²⁵ FASU is the acronym for the licensing unit. ACR Manual (2014) pg. 58. The Manual also provides that in reviewing the appropriateness of the foster placement, the reviewer must read the “provider narratives” (i.e. the licensing activity entries regarding the foster parent provider) to “inform assessments.”

¹²⁶ Staff that spoke to OCA on condition of confidentiality indicated that limited or incomplete documentation at the time of review is not uncommon and may not be remarked upon by the reviewer, but may be addressed offline with the CPS team.

¹²⁷ This note seems to reflect a lack of knowledge regarding the pending SIU investigation.

ensuring the widespread shift to kinship care for abused and neglected children is done in a manner consistent with state law, regulations and agency policy.

OCA learned during the course of this investigation that quality assurance reports, sometimes called “Other Needs logs” were forwarded to the CPS unit’s Program Manager and Office Director on a monthly basis for distribution and follow up.¹²⁸ These logs attempt to identify and categorize children’s unmet needs as identified through the quality assurance/ACR processes. The log contained information about Dylan’s unmet needs for an “early learning environment,” a neurodevelopmental evaluation and pediatric care for outstanding medical issues. Despite the dissemination of this information log, a good quality assurance activity, the needs remained unmet until after Dylan’s hospitalization.

THE DCF SPECIAL INVESTIGATIONS UNIT FAILED TO IDENTIFY POSSIBLE OR ACTUAL VIOLATIONS OF AGENCY POLICY AND REGULATIONS

When there is a concern of suspected child abuse or neglect perpetrated by a DCF-licensed provider (such as a foster parent) or within a DCF-licensed or DCF-administered program or facility, the investigation is conducted by an internal department at DCF called the Special Investigations Unit (SIU). SIU is directed by agency policy to include a section in its report regarding any regulatory or program concerns, and must alert the licensing unit or child placing agency about any such concerns.¹²⁹ SIU policies *require* that the investigation include a “review [of the] foster home provider narratives and the licensing study” when the abuse or neglect is alleged to have occurred in a foster home or at the hands of a licensed provider. Per DCF Policy, the SIU may conduct a joint investigation that includes other DCF Central Office departments including DCF Human Resources, but that “in all joint investigations, the SIU Investigator shall maintain the lead role in conducting the investigation and interviews on behalf of DCF.”

On July 30, 2015, the DCF Careline was contacted with a concern regarding alleged substance abuse by Crystal Magee. The SIU began an investigation culminating in a non-substantiation but with an apparent shared recommendation with the licensing unit for the foster mother to participate in a formal substance abuse evaluation. The SIU had access to information regarding the Magees’ child protective and criminal histories as well as DCF records regarding Dylan’s placement in the home. During the course of this July/August 2015 investigation the SIU was also told by the licensing worker that “this entire family is huge and everyone has a history with DCF,” and the caseworker told the SIU that the foster father had applied for disability benefits due a significant impairment.

Like the ACR Unit, the SIU was obligated to review the licensing unit narratives and should have seen that there were virtually no electronic records associated with the Magees’ placement and licensing review—no evidence of an emergency home assessment, no evidence of a Commissioner waiver

¹²⁸ This may be a regional practice and per DCF it is not part of the ACR unit activities. In this Region the “other needs logs” are developed by the Regional Quality Assurance Social Worker from information derived from several sources including ACRIs

¹²⁹ DCF Policy Section 34-12-8, providing in relevant part that the investigator must include in his or her report “a section describing any regulatory or program concerns” regarding the foster home.

despite the prior DCF and criminal history of the foster parents, and no evidence of an assessment of the foster parents' health impairments and the impact on their capacity to care for the child, and the SIU should have *immediately* raised these deficiencies as a serious concern with its chain of command, necessitating urgent review and action.

On November 11, 2015, the SIU received a second referral on Donald and Crystal Magee, this time the allegation of child abuse and neglect following Dylan's hospitalization. During the course of the investigation, SIU interviews again documented concerns:

- Both foster parents had chronic medical issues that interfered with their daily lives and routines.
- The community support worker who had been engaged with the Magee family for several years alleged she told DCF that Dylan was not a good fit for the Magees.
- The foster father had multiple prior arrests, including an arrest in 2010 for Breach of Peace after Mr. Magee and his wife "got into an argument and the police came."¹³⁰

The SIU report noted that Mrs. Magee had child protective service history with regard to her own son. Additionally, there were concerning inconsistencies presented by statements of DCF employees to the SIU investigator:

- The licensing worker told the investigator that she saw Dylan regularly, and that he always looked "sickly."
- The caseworker told the investigator that he conducted a home visit with Dylan on both October 22nd and October 29th, culminating in a disruption conference in the home on November 5th.

Neither employee's statement is supported by the DCF case record. Over a six month period of time, the licensing worker entered only one case narrative regarding a foster home visit that even mentioned seeing Dylan and there is no record of a home visit *that even included Dylan* after August 13, 2015.¹³¹ There is no record that the licensing worker observed Dylan as "sickly," and there is no record that concerns about his presentation were reported to anyone. In fact, the electronic record indicates that on October 30th, the licensing worker assured the CPS supervisor that Dylan was *safe and well-cared for in the home*.

The caseworker's record shows that he *called* Mrs. Magee on October 22nd, but he did not in fact see Dylan in the home until October 29th, a month after his prior visit. Though all of this information was available to the SIU department at the time of its investigation, none of these inconsistencies were specifically addressed or *even flagged as inconsistencies* in the SIU report. The only "regulatory" or "program" concerns identified by the SIU team were that the foster mother had been arrested in connection with Dylan's injuries and that the foster parents had not cooperated with DCF's treatment plan.

¹³⁰ This incident was not disclosed by the foster parents as part of their license application.

¹³¹ This visit appears to actually have taken place on August 14th, concurrent with a visit by the SIU investigator. However, it was not entered into the record by the licensing worker until November 12th which may account for the inaccuracy.

DCF's September 20, 2016 response to a draft of this report contained its assertion that the OCA's understanding of the purpose and role of the SIU is "fundamentally flawed," and that the SIU's role "is to conduct a child protective services investigation into an allegation of suspected abuse or neglect," and it is *not* the SIU's role to document "policy violations."¹³² With regard to the agency's own mandate that SIU document regulatory or program concerns, DCF asserted that because the Magees were technically not licensed, they "could not have actually violated a regulation," and that a foster home is not a "program" within the meaning of DCF policy. DCF noted that both investigative reports documented relevant concerns about the home and that SIU helped develop the recommendation for the foster mother to complete a substance abuse evaluation.

DCF stated that "the SIU unit is not charged with nor staffed to monitor continued case activity once its investigation is closed," and "it is not the SIU's role to 'flag' DCF employee performance issues such as the lack of timely narrative entries." DCF stated that the SIU investigators are not "experts in foster care licensing," and are "not expected to document and address employee performance issues." However DCF acknowledged that the SIU is expected to "raise and address *obvious policy violations* relevant to its investigation with its chain of command, Region or facility management and in HR consultation and weekly legal consults" and that "DCF employee policy violations and performance concerns are the responsibility of each individual employee." (Emphasis added.)

DCF's response is concerning for several reasons:

- 1) While acknowledging that it's the responsibility of all DCF employees to address obvious policy violations with the chain of command, OCA's precise concern here is that none of the glaring regulatory and policy violations evident during the July-August 2015 investigation *regarding the placement of Dylan in the Magees' home* appear to have been specifically raised with the SIU's chain of command. OCA's review of the case record, the investigative documents, and all emails associated with this case contain no communication between the SIU and its chain of command regarding how a developmentally delayed baby was placed in this foster home without any proper procedures or assessments having been completed. The only email communications received by OCA related to the concern over whether the foster mother would comply with the substance abuse evaluation. It is not enough to document what people tell you about the home, if the concerns lay flat on the page and no action is taken to make sure anyone addresses the problem.
- 2) Though DCF asserts that the SIU are not experts in foster care licensing, this limitation conflicts with the agency's internal directive that SIU review the provider narratives and licensing study and document any program or regulatory concerns emanating from its investigation.
- 3) The fact that all of these concerns were documented in the first investigation record *but did not result in urgent attention to the regulatory violations or performance issues by anyone in DCF's regional or central office leadership* raises a concern that the issues were either not adequately raised or that they were not seen as remarkable.

¹³² Most of what is documented in this section involves *regulatory* violations, not just policy issues, and specifically regulations that are in place to protect the safety and well-being of the child.

The concerns outlined above raise questions about the agency's ability to investigate and regulate itself even where required as a matter of internal policy. The handling of this matter also raises a concern as to whether the SIU is practically *empowered* to make such findings where needed. SIU substantiated the foster parents for physical abuse and medical neglect, and while they were certainly entrusted caregivers and therefore appropriately substantiated, the reality is that Dylan's legal custodian and the entity responsible for his well-being and care was DCF itself.

Between the licensing unit, the treatment unit, the ACR unit, the SIU, and the specialty consultation unit at DCF (Regional Resource Group/RRG), issues regarding Dylan's placement or care were seen, documented, or reviewed by over a dozen different DCF line staff, supervisors and managers.

DCF HUMAN RESOURCES & RISK MANAGEMENT PROCESS REVEAL ADDITIONAL CONCERNS REGARDING INTERNAL QUALITY ASSURANCE

In the immediate aftermath of Dylan's hospitalization multiple employees and various units at DCF were alerted to the child's critical injuries, which were assumed to have likely been sustained while he was in foster care. A critical incident notification was generated on the same day as Dylan's hospitalization, triggering review by the DCF Commissioner's team, the DCF Careline, DCF Risk Management and the DCF Regional office.

The concerning thing is the child's current physically fragile condition, and that it appears that these are not just things that happened yesterday but [the child's] health has been deteriorating over time and we haven't addressed it...I wanted to bring this to your attention because from our seat it appears to be serious."

The Careline did an immediate review of the child's history with DCF, relying on the DCF electronic record. On November 12, 2016 the DCF Careline director sent the following to a Program Manager in the Regional Office: And yet the concern articulated by the Careline Director, which fairly identifies the primary concern in the case, i.e. that a baby almost died from ongoing physical neglect and abuse after being in a DCF foster home for 5 months, an outcome *that would be almost impossible* for a well-placed and well-monitored child, was *not* the primary DCF practice concern flagged for Human Resources review by the region.

The program manager in fact responded to the Careline director stating that "We and [licensing] were *actively addressing concerns* and moved to remove Dylan from the former relative foster home. We will be looking at all aspects of our practice on this case."

On November 17th, the DCF Risk Management Unit wrote to the DCF Regional office seeking identification of any case practice concerns for further review.¹³³ The region's response to Risk

¹³³ Risk Management, according to DCF's website, serves "as the central portal of communication related to quality of care for children and youth involved with the Department...[and] as the central portal, RM is the conduit for the receipt of information on quality of care and programmatic/system issues and the dissemination of said information to internal DCF staff and external stakeholders."

Management's inquiry stated concerns that the foster parents utilized a Pack n Play for Dylan's sleep space rather than a crib; that Dylan was not always seen awake during DCF visits; and that the coordination and sharing of information between various DCF units "could have been better." But the regional office management staff emphasized to Risk Management that there were "*positive case practice issues*" in that the caseworker addressed his "alarm with foster mother around her evasiveness and lack of follow through with appointments" and that the CPS team took steps to eventually have Dylan moved to a new foster home, and that the licensing unit had done a lot of work on the case despite its "limited resources."

The failure of the manager's response to Risk Management to see or acknowledge the central mistakes in the case (as clearly articulated by the Careline director) raises concerns about the capacity of the DCF region to conduct effective quality control or quality assurance activities. Emails between DCF executive leadership and the DCF regional office leadership team further suggest that the omissions of the DCF licensing unit were the initial issues flagged for review. But despite the involvement of Risk Management and the regional quality assurance staff, and an initial meeting between DCF administrators and the Human Resources Director, no formal internal investigation into *any* aspect of the case practice leading to Dylan's injuries was conducted until after the Hartford Courant reached out to DCF on February 18, 2016.

It was the arrest of Crystal Magee for Risk of Injury and Cruelty to persons that caught the attention of reporter Joshua Kovner from the Hartford Courant. Mr. Kovner then contacted DCF administration for a comment on the case. In crafting an appropriate response DCF administrators learned that no formal internal review of the case management or licensing process had ever taken place, leading to frustration and consternation among top DCF managers.

The DCF Commissioner expressed frustration and alarm that though an informal review had been conducted by the regional office which poorly characterized DCF's supervision and protection of Dylan these issues had not yet been formally investigated and dealt with by human resources.

From: DCF COMMISSIONER
Sent: Friday, February 19, 2016
To: REGIONAL LEADERSHIP, DEPUTY COMMISSIONER, LEGAL, HUMAN RESOURCES
Cc: DCF OMBUDSMAN; DEPUTY COMMISSIONER; DCF SPECIAL REVIEW TEAM
Subject: Norwich case

It would appear that I was under the mistaken belief that a review of the case was conducted by Regional staff and that the only referral required for HR purposes pertained to LICENSING. ... In reading [ADDITIONAL CASE SUMMARIES] I was alarmed and upon further review, appalled. I have asked HUMAN RESOURCES to conduct a thorough review...

I have to be able to rely on qa/qi work in the regions to advise HR and me of its findings and recommendations. If that is too onerous or a better system should be considered/invoked, I'm happy to consider it but when this process falls through the cracks, I lose confidence in our ability to monitor ourselves. And frankly that scares me more than anything. ...

Yet the Regional Administer still maintained in response that though his intent was to support a complete Human Resources investigation,¹³⁴ there were as yet undiscussed portions of the record that would shed a more favorable light on the casework done.

The region's insistence that the casework was not as bad as it looked, even though the program manager had conceded internally that they had not "suspected" how bad things were with Dylan and that they did not realize he was not getting his needs met for "basic care," is alarming. The region set the stage for whatever formal review was meant to take place but yet did not occur. The region maintained the same workers and managers on Dylan's case and the same licensing unit personnel continued to engage in what was later discovered to be other poor work activities in the months that followed. During HR interviews the caseworker questioned why he was assigned to his duties between November and February, 2016 if "he had done things wrong in this case."

It was months before action would be taken to address the patent concern aptly described by the Careline Director, that this child was not injured on a particular day or time but was allowed to deteriorate in a state-supervised home over a period of months. Whenever a child is injured in DCF care there must be an immediate internal review by individuals *separate and apart* from the region itself and deadlines for the commencement and completion of Human Resources investigations and the agency's development of remedial recommendations for practice changes, where required.

SCANT INFORMATION WAS SHARED WITH JUVENILE COURT REGARDING DYLAN'S WELL-BEING

State law requires that DCF investigate the suitability of a proposed relative foster placement prior to the first temporary custody hearing in Juvenile Court and that DCF "provide a report to the court at such hearing as to such relative's *suitability*."¹³⁵

¹³⁴ DCF Policy Section 7-12 provides that the DCF Human Resources Management "shall investigate all allegations of employee misconduct that may result in a violation of agency or state policy or regulation or performance issues that may result in disciplinary action.

¹³⁵ Conn. Gen. Stat. § 46b-129(b) provides in relevant part that the [child's] parents ... may request the Commissioner of Children and Families to investigate placing the child or youth with a person related to the child or youth by blood or marriage who might serve as a licensed foster parent or temporary custodian for such child or youth. The commissioner, where practicable, shall investigate such relative or relatives prior to the preliminary hearing and provide a report to the court at such hearing as to such relative's suitability." Section 46b-129(c) also provides that at the preliminary hearing on the order of temporary custody the court may "identify any persons related to the child or youth by blood or marriage residing in this state who might serve as licensed foster parents or temporary custodians and order the Commissioner of Children and Families to investigate and report to the court, not later than thirty days after the preliminary hearing, the appropriateness of placing the child or youth with such relative or relatives." OCA's position is that these similar provisions in the statute convey the legislature's directive that though administrative law grants DCF jurisdiction over the placement and licensure of foster homes that the court retains authority and jurisdiction to receive information regarding the license-ability and suitability of such relatives to care for a particular child. OCA believes that this language can be strengthened to clarify that in all cases where a child is placed in out-of-home care by DCF that the Department must report to the court at the preliminary OTC hearing and certainly by 30 days thereafter regarding its assessment of the appropriateness of the child's placement—regardless of whether the parent or DCF selected the or proposed the relative foster care provider.

On June 19, 2015, DCF along with its legal representative from the Attorney General's Office and the lawyers for the parents and children, appeared in the Juvenile Court to address the Order of Temporary Custody. The record of this hearing provides no indication that DCF offered the parties or the Court any information regarding the Magees' background, any regulatory barriers to licensure, the need for waivers of regulatory requirements for licensure, or the ongoing need to assess the Magees for "license-ability" or "suitability" as foster parents.¹³⁶ At this hearing, the Juvenile Court issued orders of Specific Steps for the parents to comply with in order to reunify with their children. Pursuant to the Specific Steps forms, DCF was also ordered to "take all necessary measures to ensure the children's safety and wellbeing; and monitor the welfare of the children and the circumstances surrounding their care." State law has been revised in recent years to ensure that children's permanency plans submitted to the Juvenile Court include information regarding how the child's need for services will be addressed.¹³⁷

On June 29, 2015, DCF filed a "social study" document with the Juvenile Court, copied to all of the parties, describing the current family conditions, the children's placements, and recommendations for next steps.¹³⁸ The Social Study informed the court that Dylan had been identified as having developmental delays and that Birth to Three was providing services.

DCF also notified the court that Dylan was placed with Mrs. Magee, the mother's maternal cousin. While the Social Study included ample information regarding the biological parents' history and limitations, no information was included regarding the foster parents' criminal or child protective service history, *or even that such history existed*, though the safety and appropriateness of the foster home was material to the question of appropriate disposition for the child.

On July 2, 2015, DCF filed a Status Report with the Juvenile Court updating information regarding Dylan's mother that was included in the previously-submitted Social Study. The status report informed the parties and the court that Dylan's mother had extensive prior history with child protective services when she was a minor and that she "failed to mention any of it to her previous [DCF] caseworker." In the Status Report, DCF recommended that the children "remain in their present [foster] placements." No additional information about the status of the children was included.

¹³⁶ OCA reviewed written memoranda associated with specific court hearing dates and also reviewed the transcripts of certain proceedings including the Order of Temporary Custody hearing.

¹³⁷ Conn. Gen. Stat. § 17a-15c, passed in 2012, requires that "permanency plan documents submitted by the Department of Children and families ... shall include (1) For a child five years of age and under, the steps the department has taken to make any necessary referrals of the child for early intervention, preschool or special education services, which are being provided or are scheduled to be provided in accordance with applicable law." Conn. Gen. Stat. § 17a-106e, passed in 2013, requires that DCF "ensure that each child thirty-six months of age or younger who has been substantiated as a victim of abuse or neglect is screened for both developmental and social-emotional delays... [and] the department shall refer any child exhibiting developmental or social-emotional delays pursuant to such screenings to the birth-to-three program." There is no statutory requirement that this information be reported to the court in a timely manner, either within a specific time frame or within the Social Study itself. OCA addresses this gap in the report's recommendations.

¹³⁸ Connecticut Practice Book § 35a-9 provides in relevant part that "[t]he judicial authority may admit into evidence any testimony relevant and material to the issue of the disposition, including events occurring through the close of the evidentiary hearing."

Opportunities to address Dylan's (and his siblings) well-being were missed. On July 7, 2015 DCF filed a motion with the Juvenile Court requesting a judicial order that Dylan's parents submit to a psychological evaluation by a court-appointed evaluator and that such evaluation include an observation of the interaction between the parents and their children. DCF requested that the evaluator address, in part, the functioning of each parent; whether the parents had a "good understanding of the children's needs and the capacity to meet them;" and what "permanent placement options" served the children's best interests. The Court ordered this evaluation on July 21st.

September 4, 2014, Court Ordered Psychological Evaluation Includes Observation of Dylan's Developmental Delays.

During the "interactional observation," the evaluator noted that while all of the children were "cooperative" with the parents, Dylan only "stared blankly." Dylan did not play but only sat on the floor, "watching the others." At one point, while his siblings engaged in "parallel play," seventeen month old Dylan sat nearby. His mother "dabbed at him," and according to the evaluator, "the boy neither withdrew nor approached her." He "said nothing, and made no noise."

When his mother asked him if he was tired and if he wanted to "come to mommy," he did not go to her. He made "limited eye contact," while his mother directed, "Dylan, look at mommy. I love you." His mother gathered him up and held her in his lap while he "occasionally sipped some juice... periodically [he] grunted but there were no recognizable vocalizations."

The evaluator also observed and noted Dylan's motor delays and commented about the need for the parents to have skills and preparation to meet their children's needs, which the evaluator described as appearing "complex."

The evaluation report was later discussed in a case status conference on October 6 (facilitated by a court services officer but not a judge), with DCF and all of the attorneys, including the children's attorney, present. Documents associated with the conference make no specific reference to Dylan's service needs and whether they were being met.

There is no documentation regarding a discussion about Dylan's missed health care appointments, the Birth to Three provider's alarming concerns, or any other issues from DCF.

No status reports were filed with the Juvenile Court by DCF or Dylan's attorney prior to Dylan's November, 2015 hospitalization regarding the escalating concerns about Dylan's well-being in the foster home, his lack of support services and medical care, or DCF's eventual plan to change Dylan's foster care placement.

DYLAN'S LAWYER WAS AUTHORIZED TO INVESTIGATE DYLAN'S SAFETY AND CONDITION AND INFORM THE COURT OF ANY UNMET NEEDS

The Public Defender Division has previously invited the Child Advocate to train assigned counsel regarding the representation of infants and toddlers in abuse/neglect proceedings. The Child Advocate previously developed curriculum on this topic and has facilitated numerous trainings for child protection attorneys over the years on the legal rights of very young children. The following

section is consistent with the training and guidance that the Child Advocate has previously provided to assigned counsel.

As the child's legal representative the lawyer has access to all DCF records created or obtained that are relevant to the child's safety and well-being,¹³⁹ as well as all child-specific records available from providers or already obtained by DCF.¹⁴⁰ At any time the lawyer should also seek necessary orders from the Juvenile Court to seek privileged records pertaining to the child for which consent or a court order are required to obtain and where no release of information has successfully been obtained.¹⁴¹ Records that a lawyer for a child should seek to review on behalf of his child-client include:

1. Medical records.
2. The child's Multi-Disciplinary Evaluation (often cut and pasted into the DCF case record) and containing medical and developmental findings and additional recommendations for care.
3. The DCF case record.
4. DCF investigation records regarding the family.
5. Developmental records from the Birth to Three provider, or updates from Birth to Three to DCF.
6. Visitation records, either directly from the contracted provider or from DCF.

The lawyer for the child should seek records obtained by DCF from other sources. Federal and state law require child welfare agencies to maintain health and education information regarding children in their case files.¹⁴² The lawyer for a young child must know the legal entitlements for the child, must understand the developmental and medical needs the child has, must ensure the child is in a safe and appropriate caregiver's home, and must take steps to expedite permanency for the child.

Dylan and his siblings were appointed a state-funded attorney automatically following DCF's removal of the children from their home and the issuance of an Order of Temporary Custody by the Juvenile Court.¹⁴³ As stated above, the lawyer's job is to advocate for the best interests of the very young client.

¹³⁹ Conn. Gen. Stat. § 17a-28 provides, in relevant part, that DCF must disclose records to "a guardian ad litem or attorney appointed to represent a child or youth in litigation affecting the best interests of the child or youth." The same statute defines "record" as "information created or obtained in connection with the department's child protection activities or other activities related to a child while in the care or custody of the department, including information in the registry of reports to be maintained by the commissioner pursuant to section 17a-101k."

¹⁴⁰ The Federal Health Insurance Portability and Accountability Act (HIPAA) does not prohibit DCF from sharing information regarding a child's health and well-being with the child's attorney, even if the information is obtained from a "covered entity" within the meaning of HIPAA. In its response to OCA's draft report DCF agreed that HIPAA does not prevent it from disclosing health information about a child to his or her attorney and the agency stated that it has no record of ever refusing such a request from a child's attorney on HIPAA grounds.

¹⁴¹ Conn. Gen. Stat. § 46b-121 provides, in relevant part, "In Juvenile matters, the Superior Court shall have authority to make and enforce such orders directed to parents, ... guardians, custodians or other adult persons owing some legal duty to a child or youth therein, as the court deems necessary or appropriate to secure the welfare, protection, proper care and suitable support of a child or youth subject to the court's jurisdiction or otherwise committed to or in the custody of the Commissioner of Children and Families."

¹⁴² Title IV-E of the Social Security Act (42 U.S.C. § 670 et seq.)

¹⁴³ Conn. Gen. Stat. § 46b-129a.

This entails investigating the circumstances of the child's removal and ensuring that the child is in a home that is nurturing and appropriate, has contact with loved ones, and is receiving all appropriate services. National and state guidelines for lawyers representing children emphasize the role of lawyer as protector and watchdog when it comes to representing infants and toddlers. Lawyers for children must be vigilant, zealous and knowledgeable about not only the substantive law and practice of child protection proceedings but also child development, the impact of child abuse and neglect on children and the availability and entitlements to appropriate supports and services.

In April, 2016, the OCA sought information from the Public Defender Division regarding the activities of Dylan's state-appointed attorney, an independent practitioner who had a contract with the state to provide legal representation to indigent parents and children in child protection proceedings.

On May 25, 2016 the Child Protection Unit of the Public Defender's Office sent a written response to the Office of the Child Advocate indicating that it had requested "information regarding the representation of minor children Dylan C... [And that] OCPD¹⁴⁴ requested that the attorney provide a summary of activity in the case. [The attorney was] told that the material would be forwarded to OCA." The response from Dylan's attorney was attached to the OCPD's communication. The Public Defenders' Office also stated that "as discussed... I am happy to work with OCA to examine the OCPD Performance Guidelines to see if modifications are appropriate regarding representation of very young children."

The letter crafted by Dylan's attorney and subsequently forwarded to the OCA is dated May 2, 2016, is four pages long, and it outlines the case chronology and the lawyer's activities on the case, including phone calls made and received, records reviewed, and court appearances.

In addition to reviewing the lawyer's chronology of activities, the OCA also reviewed the DCF record for any email or hard copy correspondence sent by Dylan's lawyer for the case record (there was no copy of correspondence found in the DCF electronic or hard copy record).¹⁴⁵ DCF also reported to the OCA on September 20, 2016 that it reviewed "the legal log of requests for confidential documents and [the agency] has no record that the child's attorney requested anything from the case record." The OCA reviewed Dylan's medical records, the supervised visitation records and the communication logs of the Birth to Three provider for any mention of any inquiry, request for information, or discussion with Dylan's lawyer. There was nothing reflected in these records. OCA also reviewed the court records and transcripts for multiple court hearings.

Consistent with the lack of documentation outlined above, the lawyer's chronology of activities does not document that the lawyer sought or reviewed the DCF case record, or sought and reviewed Dylan's medical or other treatment records or that he spoke directly to any of Dylan's providers, such as his previous pediatrician, the Birth to Three provider, or the supervised visitation provider.

¹⁴⁴ Acronym for Office of the Chief Public Defender.

¹⁴⁵ By comparison, there are several references in the DCF record to correspondence or interactions with the *parents'* individual attorneys, including the parents' lawyers' requests for meetings, their requests for records, requests for visitation, etc. Even emails about family visitation between the parents' lawyers and DCF and that copied the child's attorney received no response from the child's attorney. While the parents' lawyers appeared to be very active, there was little documented in the case record about the activities of the child's lawyer.

Based on the written records provided by DCF and Dylan's attorney, the July 24th visit appears to be the first and only visit between Dylan and his lawyer prior to Dylan's hospitalization in November.¹⁴⁶ This visit took place while Dylan was visiting in a sibling's foster home. The lawyer's chronology of activities contained no documentation that he saw Dylan in the foster home with Mr. and Mrs. Magee.¹⁴⁷ The chronology does document that the lawyer reviewed materials filed with the Juvenile Court, including DCF's pleadings and status reports and an evaluation report completed by a court-appointed expert, and that he participated by teleconference in Dylan's August, 2015 ACR meeting.¹⁴⁸

An attorney's reliance on records filed with the court by DCF (without also reviewing case records and other information about the child) would be concerning if for no other reason than the court records may not contain comprehensive information about the child's safety, health and well-being in placement.

In this case while court records contained little information about Dylan's circumstances in foster care, information in the DCF case record and information obtained from Dylan's providers (such as the Birth to Three provider) would have revealed the following information:

- Dylan's foster mother repeatedly conveyed she was overwhelmed caring for Dylan and that he had many urgent behavior issues;
- Dylan's Multi-Disciplinary Evaluation revealed the need for medical and developmental evaluations that remained unmet;
- Dylan's foster mother became the subject of a "Special Investigation" by DCF after the Department received concerns she was engaging in substance abuse behaviors;
- Dylan's foster mother would not agree to participate in a substance abuse evaluation;
- Dylan's Birth to Three provider was concerned about numerous missed appointments for Dylan;
- DCF had escalating concerns regarding the foster parents' capacity and willingness to care for Dylan given all of his miss medical and provider appointments.

The OCA sought to interview Dylan's lawyer as part of this investigation to confirm whether there any other activities he pursued on Dylan's behalf that he did not document in the chronology and that are not reflected in the DCF case record or in any of the provider records. The OCA sought to interview Dylan's lawyer and, via agreement with the lawyer, set an interview date for August 18, 2016. On the day of the interview, the lawyer indicated he could not appear and he questioned the purpose of the meeting. OCA responded and outlined the scope of OCA's statutory obligations and authority to investigate the death or critical injury of a child in state care. OCA did not receive a response and subsequently this office sent a subpoena to Dylan's lawyer to compel his cooperation with the OCA investigation.

¹⁴⁶ There is no documentation in the lawyer's chronology of activities that other attempts were made to see Dylan during this period of time.

¹⁴⁷ Information submitted by the lawyer to the Office of the Chief Public Defender (the appointing authority for lawyers in child protection proceedings) indicate that the lawyer did not meet with Dylan again prior to the injuries that led to Dylan's hospitalization in November, 2015.

¹⁴⁸ The reliance on court records is concerning if for no other reason that the court records contained no information regarding escalating concerns about the capacity or even mental health status of Dylan's foster mother and little other information regarding Dylan's safety and well-being.

Another interview date was set for September 6, 2016, at which time Dylan’s lawyer and his legal representative appeared. Dylan’s lawyer, on the advice of his counsel, declined to answer any questions regarding his work on Dylan’s behalf, citing attorney-client privilege and claiming that any question or record that OCA may seek from the lawyer as part of the interview was subject to that privilege. OCA is continuing to evaluate next steps in seeking additional information from Dylan’s attorney and to evaluate the quality of representation provided to this child and his siblings.¹⁴⁹

The information provided by Dylan’s lawyer to the Public Defender’s Office and the corresponding dearth of information about the role or activities of the attorney raise serious questions as to whether Dylan’s lawyer met his responsibility to independently assess and monitor his client’s condition and advocate on his behalf.

Per the contract agreement between the assigned counsel [the contractor] and the Office of the Chief Public Defender [OCPD], the legal representation for a child “shall include, but not be limited to, preparation, *investigation*, pretrial activities and court appearances through all stages of the proceedings.”¹⁵⁰ The lawyer must be knowledgeable regarding state laws applicable to representing children in juvenile matters,¹⁵¹ and must provide services consistent with the Rules of Professional Conduct and the Professional Guidelines of the OCPD.

The OCPD is empowered and authorized pursuant to the assigned counsel contract to inspect and evaluate the attorney’s work records, subject to the attorney/client privilege.¹⁵² The contract also provides a mechanism for a termination of the contract and the removal of the attorney from his or her cases for failing to adhere to the terms of the Agreement or “for other good cause as determined by the OCPD.”¹⁵³ The contract language further states that the OCPD “may terminate the Agreement and take any immediate action, without notice, it deems appropriate to protect the legal rights and interests of the clients.” The OCPD is also empowered to seek damages or withhold payment from assigned counsel in the event of a breach of contract.¹⁵⁴

OCA has spoken with OCPD administrators on multiple occasions about the procedures and emerging findings of this investigation. The OCPD took several steps to assist the OCA with this investigation and to emphasize and disseminate the standard of practice for lawyers representing children. These steps included the following:

1. OCPD participated in several discussions with the Child Advocate regarding the concerns which led to this investigation and OCA’s subsequent questions regarding the quality of legal representation provided to this child;
2. In May 2016, OCPD requested that Dylan’s lawyer provide information regarding the activities the lawyer conducted on Dylan’s behalf (disclosable to the OCA);

¹⁴⁹ While next steps with regard to OCA’s investigative subpoena remain pending, OCA did not want to further delay the release of a report about Dylan’s injuries, particularly given the pressing issues involved and the public interest in a release of the report.

¹⁵⁰ Assigned Counsel Contract, Section A.

¹⁵¹ Id. Section B.

¹⁵² Assigned Counsel Contract, Section D.

¹⁵³ Assigned Counsel Contract, Section Q.

¹⁵⁴ Assigned Counsel Contract, Section R.

3. The OCPD included the OCA in its August 19, 2016 symposium/training for assigned counsel and invited OCA to provide training to lawyers regarding legal representation of very young children;
4. In August, 2016 OCPD disseminated a memo to assigned counsel regarding the standards and expectations of practice for representing very young children in child protection proceedings.

On September 7, 2016 the OCA participated in a follow-up meeting with representatives of the OCPD at which time OCA outlined its investigation methodology and the concerns OCA developed regarding the quality of legal representation provided to Dylan in the months preceding his grave injuries. OCA emphasized its chief concern that had activities been undertaken consistent with the OCPD's performance standards for assigned counsel they would have or should have revealed significant concerns and unmet needs with regard to this child and may have prevented some of the maltreatment Dylan experienced. The OCA requested that the OCPD conduct an audit of this lawyer's records (and the records of another lawyer that OCA had received multiple complaints about) to determine whether quality legal representation was being provided to the lawyers' indigent and/or minor clients. OCA also requested that the OCPD take steps to provide new counsel to Dylan.

**CASE INVESTIGATION REVEALS SEVERAL CONCERNS REGARDING
HOW CHILDREN ARE PLACED WITH CERTAIN RELATIVES AS
LICENSED CAREGIVERS OR VIA "SAFETY PLANS"**

As stated in the introduction to this report, in August, 2016 OCA requested and subsequently received extensive electronic communications between various employees at DCF that were pertinent to this investigation. A review of these emails, along with recently received documents from DCF's internal Human Resources investigation, raised additional concerns about the practice issues addressed in this report, not only with regard to Dylan but with regard to other children as well. These concerns are apparent in the email exchanges copied below.

From: PROGRAM MANAGER
Sent: Wednesday, May 11, 2016
To: LICENSING MANAGER; OFFICE DIRECTOR; OFFICE MANAGER
Subject: FW: Baby and unborn baby girl-Norwich-MATCH [Dylan's sisters]

I just want to state for the record that I'm not going to place the newborn [from Dylan's biological mother] in another marginal relative resource within this family. FASU¹⁵⁵ is constantly sharing concerns with us about [OTHER RELATIVES IN THIS FAMILY] but when we¹⁵⁶ try to act on them, we're told it's not that bad and there's not enough to deny or remove (which, frankly, is not FASU'S call)—and, is feeling like what happened with the Magee situation). ...We do not feel this is an appropriate long-term legal permanency resource for [baby girl]. We have similar concerns [TO ANOTHER RELATIVE'S HOME]; however, the kids she is caring for are older and in (pre)school (visible to the community).

¹⁵⁵ FASU is the DCF licensing unit.

¹⁵⁶ The CPS unit.

Despite the concerns articulated by the CPS program manager about the appropriateness of the relative foster homes for Dylan's siblings, the baby girl identified in the email remained in this home after the email exchange and the mother's *new baby* was also placed in the home. On September 6, 2016 the OCA reviewed this email exchange as part of Dylan's investigation. OCA then reviewed the licensing record and saw that no waiver had been requested to facilitate the placement of the newborn into the relative foster home, despite agency regulations *requiring this waiver* as the newborn was the 4th child under the age 6 to be placed in the home.¹⁵⁷ The content of the program manager's email exchange with regional leadership was also not entered into the electronic case record. After reviewing the email, OCA wrote the following to the DCF Regional leader and DCF Central Office:

From: OFFICE OF THE CHILD ADVOCATE

To: DCF Regional Administrator

CC: DCF Legal Director, OCA STAFF

Re: re

Hi REGIONAL ADMINISTRATOR,

I have been reviewing the DCF correspondence ...forwarded this morning and there is, among other things, a very concerning exchange between CPS, FASU and AO leadership from May, 2016 regarding the appropriateness of [SOME OF THE RELATIVE foster homes of Dylan's siblings] and their capacity to provide adequate and reliable care for the children in their homes. [EXCERPT FROM ABOVE EMAIL CHAIN]... The email correspondence raises concerns regarding the following:

1. The implacability of the so-called "firewall" used to assist with placing children in licensed relative foster care;
2. The hierarchy of the decision-making regarding licensing, assessment and placement decisions;
3. The adequacy of the post-placement assessment (including clear communication practices between licensing and CPS), a necessity with immediate relative placements and the impact on the developmental needs of the child for high quality care and permanency;
4. Practices regarding what does and does not get inputted into LINK¹⁵⁸ and who gets copied on various aspects of case management or concerns about case practice. ... OCA's review is, as you know, ongoing, both with regard to Dylan's case but also with regard to some concerns our review has developed regarding relative licensing practices. However, given the immediacy of these issues I wanted to raise them with you as soon as possible. I am copying LEGAL on this correspondence. Thank you in advance for your review and response. If you can confirm as soon as possible whether a waiver was requested to facilitate NEWBORN'S placement with the FOSTER HOME, I would appreciate that.

DCF responded shortly thereafter to confirm that central office leadership was also concerned about the contents of the emails and that the two young children were being removed from that foster home and would be "placed together in a core foster home;" and that ongoing assessment was moving forward with regard to the other children placed in the home. DCF's response also included, in relevant part, "The Commissioner has made it clear... [that the] Regional Administrator [] will address

¹⁵⁷ These activities took place months after Dylan's removal from the Magee foster home and months after the irregularities concerning the licensing activities in *his* case were identified.

¹⁵⁸ The DCF electronic case record.

the systems issues identified in this case and come up with a plan to address them.” DCF also confirmed that no waiver was processed to place the newborn in the foster home.

As stated earlier in this report, OCA’s review of interoffice emails and HR documents raised significant alarms regarding both the management of Dylan’s case, but also about the reliability of quality case practices associated with placing children in foster homes. The issue is not only whether the various DCF units comply with the regulatory requirements, but how do units work together to ensure appropriate assessments and decisions are made.

OCA does not seek to send the message that kinship care places all children at risk. Kinship care can be the best support for a traumatized young child who must be removed from his or her primary caregiver. However, placement decisions must adhere to regulatory and other legal requirements, must reflect best practice decisions, quality assessments, adequate support for foster parents or other substitute caregivers, and must be subjected to adequate monitoring and quality assurance activities. An August 9, 2016 email from the DCF Commissioner echoes some of OCA’s concerns:

From: DCF Commissioner
Sent: Tuesday, August 9, 2016
To: DCF REGION 3 MANAGEMENT AND LEADERSHIP
Subject: waivers

It has come to my attention that there may be several families for whom waivers for criminal and CPS histories were not done prior to placement and that your office is of the opinion that at this point these waivers will not be done until the families are up for renewals of their license. This is incorrect.

All placements that require a waiver but did not get one must be examined immediately. There must be a careful assessment of the current situation and consensus from all that there are no outstanding safety factors resulting from the criminal or CPS history.

It should also be documented that this is the most appropriate placement for the child(ren). The form to be used is the one sent by DCF LEGAL in June, 2014.

An internal response to the Commissioner’s email within the region questioned why the concern was raised and noted that “since September 2015 FASU has sought commissioner waivers prior to placement for waivers for criminal and CPS history.” It is not clear why commissioner waivers would *not* have been sought for such background issues *prior* to September 2015 as they were required by law but subsequent HR interviews confirmed that regional practices did not adhere to statutory-regulatory requirements and that various DCF staff were under differing and often mistaken impressions about what checks and balances were required prior to placement of a child with a foster parent who had CPS/criminal misconduct in their past. After receiving the Commissioner’s August 2016 email, an administrator asked his office managers to “review all open kin families” and assure that waivers were in place immediately. But a member of the regional leadership team conveyed a concern that has been troubling OCA as well as a result of this investigation:

From: OFFICE LEADER
Sent: Tuesday, August 9, 2016
To: REGIONAL MANAGERS
Subject: FW: waivers
Importance: High

Please survey your minds to make sure we don't have any situations that this may apply to...Where I am concerned about is with Family Arrangements that often turn into placement situations. Bottom line, if there are sub issues or CR [criminal record] issues, we should not be endorsing these as suitable options if we are not prepared to license eventually, request and defend waivers, etc.

Another manager responds to this email by saying:

My worry is that there could be many out there from the pre-Dylan era in which those circumstances were at play, but we [Program Managers] and in some cases [Social Work Supervisors] were not notified.

The reference to the “pre Dylan era” raises a concern that even DCF management perceived less than reliable and careful practices have been undertaken with regard to the placement of abused and neglected children. As stated in the first section of the report, OCA quickly learned that Crystal Magee and her husband had already cared for another kin infant from 2014-15. This arrangement was facilitated by DCF after a team meeting with the family and a determination that the infant's health and care was at-risk with his biological parents. The infant had already been hospitalized for malnourishment and he had special health care needs, requiring vigilant attention and care. DCF had essentially effectuated, or at a minimum *endorsed*, the removal of the special-needs infant from his parents' care into the care of the Magees, but without court involvement, the appointment of lawyers, judicial oversight, or a formal licensing process. The implications of such decision-making, while likely meant to reduce the adversarial engagement with the family and to support family-informed decision-making, creates considerable concern regarding the lack of checks, balances and oversight that ensures the safety of children in such arrangements. The office leader's email above correctly identifies the concern with so-called Family Arrangements, particularly those that are facilitated with DCF's approval or influence and tacitly endorsed yet without being formally assessed and approved. All of these issues bear ongoing scrutiny and examination by the agency *and in a public forum*.

While placement with a known and nurturing caregiver is often the least detrimental alternative for the child (and may also be in the best interests of the child) the logistics of such a placement essentially create an obligation that the child welfare agency *immediately assess* the suitability (and not just the minimum license-ability) of the relative *prior* to or concurrent with the placement. Realistically this may sometimes be very difficult and will result in a post hoc suitability and capacity assessment by the agency. Meaning, the children are placed in the relative's home and *over time* DCF determines how well the children's needs are being met and whether the licensed or soon-to-be licensed relative is well suited to care for them. Sometimes this works out well and sometimes it may not. In Dylan's case, this process *repeatedly* did not work and the effort to maintain him with the parents' relatives led to several

placement disruptions, culminating in his fifth and most recent foster placement.¹⁵⁹ DCF documents repeatedly reflect the grave concern that decision-making and assessments with regard to certain relative foster parents in this region have been ill-informed and chaotic, with employee activities that do not reflect adherence to clear protocols regarding role and responsibility.

OCA is also concerned that given how many child welfare and licensing professionals reviewed or had access to the facts in this case that no one was really raising alarms about the numerous red flags in the foster parents' backgrounds and how they reflected *on their capacity to care for this child*. The lack of alarm about the Magees and the lack of urgency to remove Dylan from their care then raised additional concerns for OCA regarding how many other children may be placed or have been placed with individuals who did not truly meet licensing and suitability criteria. Put another way, if this didn't look that bad, what else doesn't look that bad?

CONCLUSION AND POST-SCRIPT

DCF published an internal review of infants and toddlers following release of an OCA report in 2014 regarding the deaths of infants and toddlers in Connecticut. These two reports illustrated the significant vulnerability of this young population; children under the age of three are at the most risk for poor outcomes. When the state removes a child from his or her parents and assumes a "parental" role, the state must do an exemplary job. As this report lays out, DCF's system for monitoring and ensuring the safety and well-being of this young child completely failed, raising questions regarding how reliable these safeguards were to begin with.

OCA's investigation also raises grave questions as to whether Dylan's lawyer took adequate steps to investigate, discover and ensure his client's safety and well-being, and whether his performance met minimum standards that the state sets for lawyers who represent children. The lawyer for a child fulfills the critical function of giving voice to the voiceless and ensuring that every child, no matter how small, how young, how disabled, how incapacitated, will be fully seen and heard by a legal and regulatory system that exists, above all else, to protect and promote that child's welfare. To quote an esteemed advocate for children "If we don't stand up for children...then we don't stand for much."¹⁶⁰ Children depend on their adult advocates not just to speak *for* them, but to speak *up for them*. Dylan appeared to become invisible to the adults responsible for his care and protection—a young child who did not talk or walk, who neither sought nor obtained the attention and care that he needed.

Dylan's physical injuries are healing but the trauma he suffered is likely to have life-long impact. And while he has been described as engaging and outgoing, he is now identified as a "medically complex" child with extensive needs for developmental, medical and family support. Unfortunately for Dylan, during his time with DCF he has lived in five (5) different foster placements. His case has been managed by four (4) different caseworkers and he has had three (3) different pediatricians in his young life—no medical home. In finalizing details of this report, OCA also learned that for a couple of months starting in January, 2016, not yet two-year-old Dylan was transported to visits with his siblings and parents by being placed alone in a DCF-contracted livery cab, unaccompanied by any familiar

¹⁵⁹ A statement attributed by HR to a regional senior administrator from July of this year included his observation that "removal [of a child] from one relative to another relative is *routine* and that it was a very common case."

¹⁶⁰ Marian W. Edelman, Executive Director, The Children's Defense Fund

adult to assist or comfort him during transport and separations, raising additional concerns about his emotional and physical safety¹⁶¹ and whether his developmental needs are, even now, fully appreciated by his DCF CPS team. Upon learning of the transportation arrangement, OCA contacted the DCF Ombudsman's office which responded immediately and appropriately to rectify the matter and ensure that steps will be taken to prevent recurrence.¹⁶²

Given the widespread systemic concerns raised by this investigation (as well as by DCF's internal Human Resources Investigation), it will be critical to thoroughly examine DCF's practices with regard to relative foster care. The state must ensure the goal of maintaining children with kin is achieved with rigorous adherence to state law and agency protocols, attention to staff training, adequate staffing and effective and publicly reported quality assurance activities. OCA finds that the basic statutory-regulatory framework essentially exists to support good case practice but that gaps remain in terms of implementation protocols, monitoring, and information sharing. The shift to kinship care means that the agency is doing a lot of assessment and placement matching at the front end of a child's case, creating a need for clear protocols and guidance regarding how to conduct ongoing monitoring of the capacity and suitability of the foster care provider and the safety and wellbeing of the child in the home. The recommendations below address this issue.

In moving ahead for Dylan, OCA repeats the words offered by Dylan's doctors after he was hospitalized late last year: "the coming months and years will demonstrate how much recovery the child will experience...Dylan must be nurtured and protected from further injury."

RECOMMENDATIONS FOR CHILD WELFARE CASE PLANNING AND MONITORING

- As DCF moves forward with implementing a practice guide for cases involving infants and toddlers, it should consider heightened requirements for case supervision, visitation contacts and *documentation of case activities*.
- DCF should consider requiring periodic multi-disciplinary or multi-unit visitation contacts with high risk babies in both in-home and out-of-home cases, and DCF should require visitation contacts by the DCF supervisor or manager. DCF should examine its requirements for documentation and expectations related to visits with children, with an eye to the developmental stage of the child, and ensure that observations are made with regard to the child's development,

¹⁶¹ A manager later stated that with regard to this arrangement the child's medical needs concerned them so that they made sure his inhaler went with him in the cab. Though how a 20 month old baby would self-administer this inhaler is not clear nor is it clear that the expectation was the cab driver would know what to do.

¹⁶² Email correspondence received by OCA on September 6, 2016 included correspondence from January 4, 2016 indicating that DCF was having a hard time finding a "livery service provider" for Dylan as they are "not supposed to transport under age 5." Dylan's DCF caseworker team was hoping to find a livery service provider that would make "an exception." Other correspondence later indicated that the social work team felt under pressure to maintain the visitation schedule but did not feel it had adequate resources (such as case aides) to ensure that Dylan was transported by agency personnel. The same correspondence revealed that the foster parents and the visitation supervisor all thought the arrangement was inappropriate and that Dylan was too young to be transported alone by a contracted cab service. DCF subsequently informed OCA that it has internally audited this practice agency-wide and determined that only Dylan was transported this way.

- DCF should create a case supervision tool for infant-toddler cases and ensure that it is reviewed every fourteen (14) days and addresses the child’s medical, developmental, educational and permanency needs. Supervision conferences must include attention to documentation deficiencies with a set number of days permitted for remedying any documentation concerns.
- DCF should request an immediate legal consult whenever a parent/legal guardian of a child under an Order of Temporary Custody that is vested in DCF refuses to allow provision of support services to a child, including but not limited to therapeutic and developmental support services.
- DCF must ensure it is adequately staffing its licensing units; that such units are complying with state law and agency regulations; that documentation is adequate with regard to licensing activities; and that the role and responsibility of the licensing unit social workers is clarified with regard to assessing the safety of the child in the home during home visits.
- DCF must examine its expectations regarding the role and responsibility of employees in conducting ongoing assessments of the suitability and capacity of foster care providers, particularly when the preliminary assessments are done urgently and children are placed quickly--these immediate placements place a heavy reliance on the accuracy of initial assessments but also necessitate comprehensive and timely follow up and monitoring. All employees interacting with the family should know what their role is contributing to these assessments and protections for children.
- DCF should develop an interdisciplinary team to examine its use of relative and special study foster care, keeping in mind that research supports the placement of children with caregivers who are known to them, but which can examine agency practices regarding assessment, regulatory compliance and the request for waivers, timeliness of relative licensure, support for relative caregivers, and barriers to supporting children with relatives. Focus should always remain on the rights and wellbeing of the children and not on the preferences of adults. This team should develop a public report within six (6) months. This report should specifically address compliance with state law and agency regulations, clarification of employee roles and responsibilities, as well as safeguards and additional assessments that will be utilized when the Department seeks to license a caregiver with a previous child abuse/neglect history, a significant psychiatric history or other history of significant disability, or a criminal record.
- DCF should require that Administrative Case Review findings regarding a child’s unmet needs and the adequacy of a child’s case plan include specific reference to the case record, including records obtained or generated by DCF in connection with a child or family. No findings should be permitted without adequate and specific factual foundation, supervisory reviews of case reviews should pay close attention to this issue, and quality assurance outcome measures should be created to monitor this requirement. ACR reviewers must be required to note whether case record documentation is adequate.
- DCF should ensure that members of its Administrative Case Review Unit have adequate training and clear directives to effectively review the appropriateness of a child’s placement and the role of the ACR unit in reviewing kinship care placement should be clarified.
- DCF should review the adequacy of its protocols and policy guidance for the Special Investigations Unit and its capacity to identify and communicate programmatic and regulatory concerns within its jurisdiction and how exactly the functions of SIU and Human Resources Departments intersect.
- State law should require that, within sixty days of a child coming into DCF care, DCF must submit a court filing about the children’s well-being, treatment needs identified in the Multi-disciplinary Evaluation, and the timetable for ensuring those needs are addressed.

- DCF should evaluate and publicly report regarding the timeliness and thoroughness with which it implements the Multi-disciplinary evaluation recommendations for children in foster care. The current federal court outcome measures review only whether the MDEs are completed, but not necessarily whether the recommendations are timely and full implemented.
- State law should be amended to clarify that in all cases where a child is taken into DCF's temporary custody or placed under DCF's guardianship that DCF submit to the Juvenile Court, within thirty (30) days of the placement, a statement regarding the agency's assessment and findings regarding the license-ability and suitability of the caretaker for the particular child.
- Whenever a child in DCF care is seriously injured or injured as a result of abuse or neglect there must be an immediate internal review by individuals *separate and apart* from the region itself and deadlines for the commencement and completion of Human Resources investigations and the development of remedial recommendations for practice changes, where required.

RECOMMENDATIONS FOR CHILD WELFARE AND EARLY INTERVENTION (BIRTH TO THREE) SYSTEM

- State law should be amended to ensure all Birth to Three providers are identified as mandatory reporters of suspected child abuse or neglect pursuant to Conn. Gen. Stat. § 17a-101.
- DCF and the Office of Early Childhood should review its current Memorandum of Agreement to ensure protocols for effective communication and seamless service delivery for abused and neglected infants and toddlers involved with DCF or living under DCF's guardianship. The two agencies should evaluate whether current protocols are sufficient to address the following:
 1. Communication and consent issues involving a child under an Order of Temporary Custody;
 2. Protocols that an Early Intervention provider agency should follow to assist the foster parent (or other substitute caregiver) and the biological parent (or other legal guardian) in learning about and supporting the child's developmental growth;
 3. Protocols that an Early Intervention provider agency should follow to communicate any concerns regarding the child and family's participation in services (such as missed appointments) or any other concerns that develop while services are being provided;
 4. Protocols that assist the Early Intervention Service provider with implementing or following mandated reporter obligations, including analysis of when refusal of services for a child may constitute abuse or neglect or may constitute a report of suspected abuse or neglect;
 5. Protocols for joint case-planning between child welfare and the early intervention service provider and inclusion of the early intervention provider in the Administrative Case Review process;
 6. Protocols for sharing case updates between child welfare and early intervention for both "in-home" DCF cases and for children in foster care.

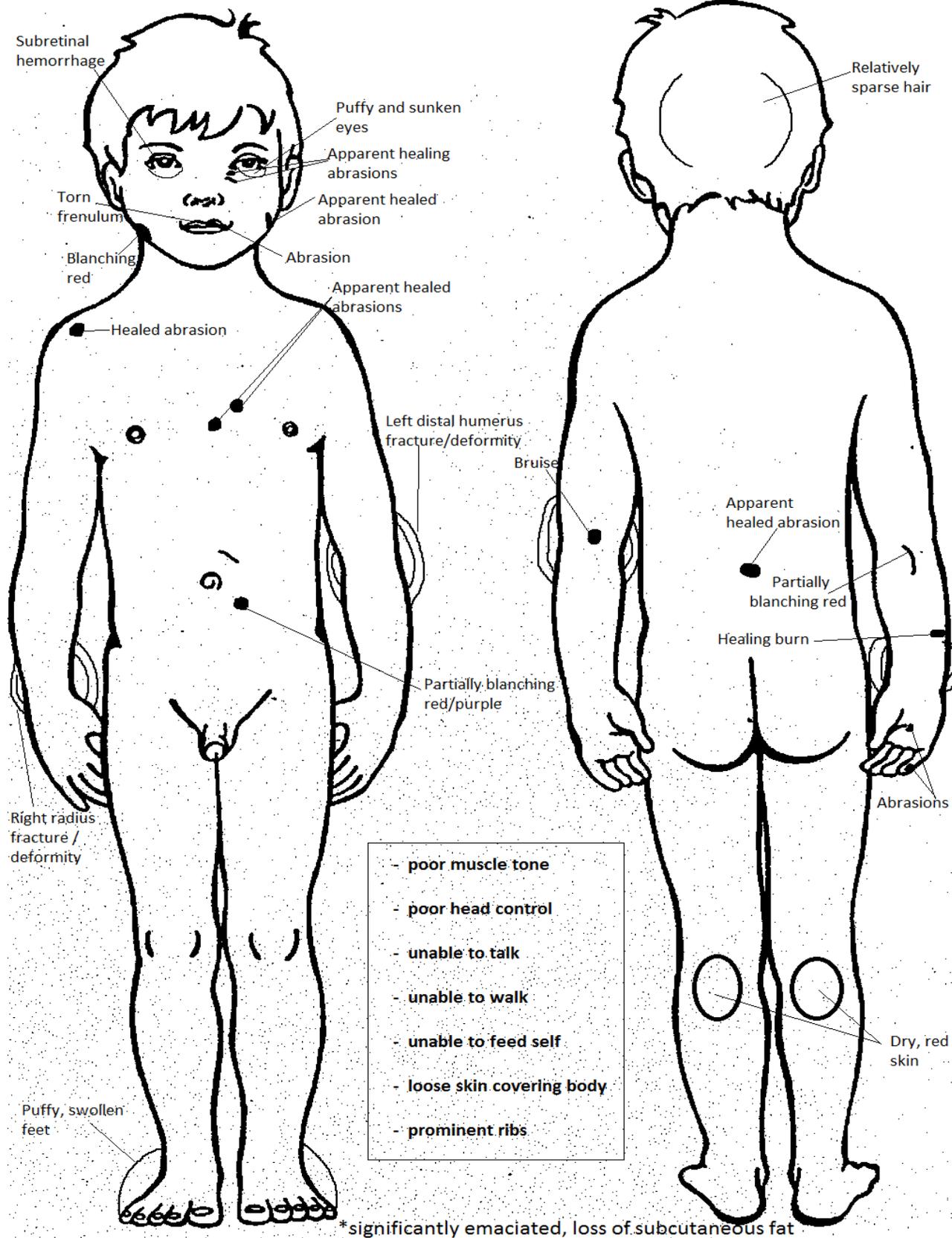
RECOMMENDATIONS FOR LEGAL SERVICE DELIVERY TO INFANTS AND TODDLERS

- Amend the Performance Guidelines for lawyers promulgated by the Office of the Public Defender to include the following:
 1. Specific reference to investigating and taking necessary legal action to ensure the young child’s *developmental* needs are addressed and their rights to early intervention services honored;
 2. Ensuring that the child client is visited by his or her lawyer in the home that the child is living;
 3. Clarify (if clarification is deemed necessary) that in “obtaining and reviewing relevant documents available” the lawyer for the child shall review the child welfare case record and records obtained by DCF that pertain to the child’s condition in foster care and the safety of the child’s placement.
- Ensure that training regarding the representation of clients with diminished capacity (and of varying ages) is included in all pre-service training and is regularly provided as in-service training for lawyers representing children in juvenile court child welfare proceedings.
- Continue to develop quality assurance oversight capacity and protocols for addressing lawyers who have been found not to be providing legal services consistent with the Division’s Professional Guidelines.

RECOMMENDATIONS FOR THE JUDICIAL BRANCH

- Develop or use an existing bench card to assist with case review for child protection matters involving infants and toddlers (Appendix B of this report). An existing bench card in use comes from the Permanent Judicial Commission on Justice for Children in New York.
- Attorneys for children, just like adults, should be canvassed at various points in litigation as to whether they have consulted (or met) with their child client, and ascertained their position or, in the case of a client with diminished capacity, sought and obtained adequate information to take necessary protective actions and make recommendations consistent with the child’s best interests.

Appendix A: Injuries to Dylan (representation)



- poor muscle tone
- poor head control
- unable to talk
- unable to walk
- unable to feed self
- loose skin covering body
- prominent ribs

Appendix B: Checklist for the Healthy Development of Infants & Toddlers in Foster Care

BACKGROUND: From birth to age three, children experience the most rapid brain growth in their life. Brain growth and development that occur during this narrow window is heavily influenced by experiences and early relationships. These experiences and relationships lay the foundation for an infant or toddler's later learning, greatly influencing a child's chance at growing up to live a happy, healthy, and productive life. For more information, please visit: Texans Care For Children on the web at www.texanscareforchildren.org.

Adapted from materials developed by the Permanent Judicial Commission on Justice For Children in New York, the following questions can elicit important information concerning the healthy development of infants and toddlers in foster care - an essential component of foster case review and permanency planning.

✓ What are the MEDICAL NEEDS of this young child?

1. What health problems and risks are identified in the child's birth and medical records (e.g. low birth weight, prematurity, prenatal exposure to toxic substances)?
2. Does the young child have a medical home?
3. Are the child's immunizations complete and up-to-date?

Common Medical Diagnoses Seen in Infants in Foster Care

- *Fetal Alcohol Syndrome*
- *Growth failure, failure to thrive*
- *Lead poisoning*
- *Hearing and vision problems*
- *Congenital infections-HIV, hepatitis and syphilis*
- *Shaken Baby Syndrome*
- *Respiratory illness*

✓ What are the DEVELOPMENTAL NEEDS of this child?

1. What are the young child's risks for developmental delay or disability?
2. Has the young child had a developmental screening/assessment?
3. Has the young infant been referred to the Early Intervention Program?

Developmental Red Flags

- *Premature birth*
- *Abuse or neglect*
- *Low-birth weight*
- *Prenatal exposure to substance abuse*

✓ **What are the ATTACHMENT and EMOTIONAL NEEDS of this young child?**

1. Has the young child had a mental health assessment?
2. Does the young child exhibit any red flags for emotional health problems?
3. Has the young child demonstrated attachment to a caregiver?
4. Has concurrent planning been initiated?

Emotional Health Red Flags

- *Chronic sleeping or feeding disturbances*
- *Excessive fussiness*
- *Failure to thrive*
- *Multiple foster care placements*
- *Incessant crying with little ability to be consoled*

✓ **What challenges does this CAREGIVER face that could impact his or her capacity to parent this young child?**

1. What are the specific challenges faced by the caregiver in caring for this infant (e.g. addiction to drugs and/or alcohol, mental illness, cognitive limitations)?
2. What are the learning requirements for caregivers to meet the infant's needs?
3. What are specific illustrations of this caregiver's ability to meet the infant's needs?

Caregiver Capacity Red Flags

- *Noncompliance with the child's scheduled health appointments and medication or therapeutic regimens*
- *Caregiver substance abuse and noncompliance with psychiatric treatment and medications*
- *Confirmed instances of child abuse or neglect*
- *Incomplete immunizations and a child's poor growth or arrested development*

✓ **What RESOURCES are available to enhance this young child's healthy development and prospects for permanency?**

1. Does the young child have Medicaid, CHIP, or other health insurance?
2. Is the child receiving services under the Early Intervention Program?
3. Have the infant and caregiver been referred to Early Head Start or another quality early childhood program?

Appendix C: Foster Care Regulations

Agency Regulations

Foster and Prospective Adoptive Families

Section 17a-145-130. Definitions

As used in Sections 17a-145-130 through 17a-145-160, inclusive, of the Regulations of Connecticut State Agencies, the following definitions apply:

- (a) "Approved" means to be granted permission by a child placing agency, licensed by the department, to be a foster family or prospective adoptive family.
- (b) "Bedroom" means a room used by a foster or adoptive child for sleeping.
- (c) "Child" means any person under eighteen years of age not related to the foster or prospective adoptive family.
- (d) "Child-placing agency" means an agency, association, corporation, institution, society, or other public or private organization licensed by the department to approve foster or prospective adoptive families and to place a child into an approved foster or prospective adoptive family.
- (e) "Commissioner" means the commissioner of the Department of Children and Families.
- (f) "Department" means the Department of Children and Families.
- (g) "Emergency" means any situation in which an immediate threat to the health or welfare of a child or children exists or is suspected.
- (h) "Firearms or other types of dangerous weapons" means those items defined in Sections 53a-3(19) and 53a-3(21) of the Connecticut General Statutes.
- (i) "Foster family" means a person or persons, licensed or certified by the department of children and families or approved by a licensed child placing agency, for the care of a child or children in a private home, herein after referred to as a foster family, foster home or foster parents.
- (j) "Licensed" means to be granted permission by the department.
- (k) "Member of the household" means a person who lives in or has regular access to a foster or prospective adoptive home including, but not limited to boarders, roomers, relatives and friends.
- (l) "Prospective adoptive family" means a person or persons, licensed by the department of children and families or approved by a licensed child placing agency, who is awaiting the placement of, or who has a child or children placed in their home for purposes of adoption, herein after referred to as a prospective adoptive family, prospective adoptive home or prospective adoptive parents.

(m) "Summary suspension" means the immediate termination of the right to provide care as a foster or prospective adoptive family as granted in a department issued license, pending proceedings for revocation or other licensure action.

(n) "Trigger guard lock" means a lock which prevents the discharge of a firearm unless unlocked by a key or combination.

Section 17a-145-131 Application of Regulations to the Department and Child Placing Agencies

The provisions of sections 17a-145-130 through 17a-145-160, inclusive, of the Regulations of Connecticut State Agencies shall apply to the process of licensing or approving a foster or prospective adoptive family by the department or child placing agencies except where otherwise referenced in such regulations.

Section 17a-145-132 Assessment of Foster or Prospective Adoptive Parents and members of the household

The department and each child placing agency shall conduct an assessment of any applicant for a foster family or prospective adoptive family license or for the renewal of such a license. Such assessment shall include the applicant as well as all members of the applicant's household. The assessment shall determine the ability of the applicant to comply with the requirements of sections 17a-145-130 through 17a-145-160, inclusive, of the Regulations of Connecticut State Agencies. Such assessment shall include, but not necessarily be limited to, the physical condition of the home, the health of the applicant and other members of the household, and the ability of the applicant to provide an environment that will advance the physical, mental, emotional educational and societal development of each foster or adoptive child who may be placed in such home. In the case of a foster family the assessment shall also determine the ability of the foster family or applicant to work with the department to pursue the child's treatment plan including reunification with the biological family.

Section 17a-145-133. Issuance of license or granting of approval. Not transferable or assignable

(a) A license to care for or board a child shall be issued by the department only to the foster family or prospective adoptive family for which application is made and only for the address shown on the application and shall not be transferable or assignable. Foster families or prospective adoptive families approved through a licensed child placing agency shall be granted such approval by a licensed child placing agency only to the foster family or prospective adoptive family for which application is made and only for the address shown on the application and shall not be transferable or assignable.

(b) No foster or prospective adoptive home shall possess more than one (1) license or approval for adoption or other form of out of home care either through the department, an entity licensed by the department or licensed or otherwise approved through any other entity.

(c) In the case that there are changes to any member of the household or dwelling structure, the department or child placing agency may require a new assessment of the foster or prospective adoptive family. Such assessment shall result in the issuance of a new license or approval or the initiation of action to revoke such license or approval.

(d) A foster care license or approval is not an entitlement.

Section 17a-145-134. Access to license or documentation of approval

Each foster family or prospective adoptive family to which a license has been granted by the commissioner for the care of a child shall keep such license at the residence and shall make such license available to the commissioner or his designee upon request. Foster families or prospective adoptive families approved through a child placing agency shall keep a letter or other form of documentation from such agency proving they are

approved and shall make such letter or documentation available to the child placing agency, commissioner or his designee upon request.

Section 17a-145-135. Access of commissioner or child placing agency to premises

Each foster family or prospective adoptive family shall grant the commissioner or his designee or child placing agency access to the child, premises and documents related to the child at any reasonable time as deemed necessary with respect to non-emergency child related issues. In emergency circumstances unrestricted access shall be granted.

Section 17a-145-136. Interstate placement of children

Each child placing agency, foster family or prospective adoptive family shall comply with state statutes and regulations regarding the interstate placement of children prior to accepting placement of a child from out of state.

Section 17-145-137 Physical Requirements of Foster and Prospective Adoptive Homes

(a) Dwelling and furnishings shall be clean and comfortable and in good repair.

(b) State and local fire codes shall be observed by all foster families and prospective adoptive families. A determination of reasonable fire safety shall be established for all foster families or prospective adoptive families. In the event of a disagreement between the department and a foster family or prospective adoptive family regarding fire safety issues, the final determination shall be vested in the local fire marshal.

(c) The home and grounds shall be reasonably free from anything that constitutes a hazard to children including, but not limited to:

(1) Any peeling paint inside or outside of the house which is accessible to the children shall be determined to be non-toxic in compliance with requirements of the department of public health;

(2) equipment used by the children shall not be painted or covered by any material which is poisonous;

(3) all swimming pools shall comply with state and local regulations; and

(4) medicines and toxic and flammable materials shall be kept out of the reach of children.

(d) There shall be sufficient indoor and outdoor space, ventilation, toilet facilities, light and heat to ensure the health and comfort of all members of the household.

(e) All heating systems shall comply with the state and local building and fire codes.

(f) Adequate sewage and garbage facilities shall be maintained.

(g) All power driven machines or other hazardous equipment shall be properly safeguarded and their use by any foster or adoptive child properly supervised by an adult.

(h) Emergency evacuation plans shall be established and practiced at least quarterly with the children.

(i) If a furnace is on the same floor as a living space it shall be enclosed.

(j) All foster and prospective adoptive homes shall have smoke detectors in operating condition so as to protect sleep areas, play areas and the basement.

Section 17-145-138 Telephone

All foster and prospective adoptive homes shall have a working telephone with emergency numbers posted in an easily visible location. The department or child placing agency shall be notified within one (1) business day of any change in the home's telephone number or telephone status.

Section 17-145-139 Children's Bedroom, Clothing and Privacy

(a) (1) Each bedroom shall be enclosed on all sides, with a window and a door that leads into a hallway or other common living area.

(2) Each bedroom shall have at least two approved means of exit capable of providing for escape in the event of fire or disaster

(3) Bedrooms for children shall be used for sleeping purposes and customary childrens' activities only. The child's bedroom shall not be used for general purposes of other members of the family.

(4) Children under the age of five placed in foster families and prospective adoptive families shall sleep on the same floor and in close proximity to foster or prospective adoptive parents or a responsible adult.

(5) A separate bed shall be provided for each child except that siblings of the same sex may sleep together in a double sized or larger bed with the approval of the commissioner or his designee.

(6) No child three years of age or older shall be permitted to share a bedroom with another child of the opposite sex or a same sex child of disparate age. No child over the age of one shall share a room with an adult without the permission of the commissioner or his designee.

(7) No more than four (4) children including the foster or prospective adoptive parents own children shall sleep in the same room without the permission of the commissioner or his designee.

(b) The child's clothing shall be kept clean and in good condition in keeping with the standards of the community. Provision shall be made for the safe storage of the child's clothing and personal possessions.

(c) Each child shall be afforded privacy appropriate to his growth and development.

Section 17-145-140 Food and Water

(a) All food for human consumption, food storage and preparation, personal cleanliness and general care of the home shall meet generally accepted health standards.

(b) No non-pasteurized milk products shall be provided by, or with the approval or knowledge of, a foster family or prospective adoptive family to any child in care.

(c) The water supply shall be safe and adequate to meet the needs of the household. If the home is not served by a public water supply, the water shall be analyzed and approved by the state or local department of health or by a private water testing laboratory approved by the department of public health and addiction services at

the time of initial licensure or approval and at any subsequent time the department or child placing agency deems such testing necessary.

Section 17-145-141 Firearms and Weapons

Firearms or other types of dangerous weapons are discouraged in foster and prospective adoptive homes. The department or child placing agency shall be notified by any foster or prospective adoptive parents if they or a resident in their home possess, prior to licensure or approval or obtained subsequent to licensure or approval, a firearm or other type of dangerous weapon. A foster or prospective adoptive parents shall ensure that: (1) Firearms and ammunition shall each be locked in separate places inaccessible to all children; firearms; (2) whenever practicable, firearms are equipped with a trigger guard lock; (3) other types of dangerous weapons shall be unstrung or unloaded and shall be stored in locked containers out of the reach of children; and, (4) keys to the locked storage area of firearms, other types of dangerous weapons, trigger guards, and ammunition shall be kept in the secure possession of an adult or reasonably secure from children.

Section 17-145-142 Animals

All animals in the foster family or prospective adoptive family shall be kept in a safe and sanitary manner and shall be in compliance with all statutes and regulations regarding vaccination, and generally accepted veterinary care.

Section 17a-145-143 Health Standards for Foster or Prospective Adoptive Parents and Members of the Household

(a) The health of persons living in the foster or prospective adoptive family shall not present a hazard to the children. Prior to licensure or approval applicants to become a foster family or prospective adoptive family shall supply a statement from a physician on such forms as approved by the commissioner or child placing agency that within the previous twelve (12) months:

(1) Each person living in the home has had a physical examination and has been found to be in good health or that specified members of the family are receiving all necessary continuing medical care and are free of communicable disease; and

(2) the parents have been determined to be physically and mentally able to provide care to children.

(b) Once licensed, foster or prospective adoptive parents shall notify the department whenever they or a member of the household develop a physical or mental infirmity which may interfere with their ability to care for and meet the needs of the child.

(c) The department or child placing agency may require a physical, mental or psychological examination of any member of the foster or prospective adoptive household if such person exhibits characteristics or behaviors which indicate or could indicate that they are unable to provide for the care of the child. Such examination shall be done at the expense of the department or child placing agency if such person is uninsured.

Section 17a-145-144 Character Standards for Foster or Prospective Adoptive Parents and Members of the Household

Foster and prospective adoptive parents and others members of the household shall be of good character, habits and reputation.

Section 17a-145-145 Change in Licensed Conditions

Foster and prospective adoptive parents shall notify the department or child placing agency, in writing, prior to or not later than one (1) business day following any change in circumstance or member of the household which alters the statement of fact made in the application for licensure or approval or which effect the ability of the foster or prospective adoptive parent to provide on-going care of the child.

Section 17a-145-146 Reporting of the Injury, Illness, Death, Fire or Absence of a Child From Placement

Foster and prospective adoptive parents shall report to the department or child placing agency, by telephone, within six (6) hours any serious injury, serious illness or death of a child, any fire in the home or any unauthorized absence of a child.

Section 17a-145-147 Financial Condition of the Foster or Prospective Adoptive Parent

Foster and prospective adoptive parents shall have an income sufficient to meet the needs of their family. Money received on behalf of the child shall be expended for the care of the child.

Section 17a-145-148 Substitute Child Care

When all adults in a foster home or prospective adoptive home are employed or otherwise occupied in substantial amount of time away from the foster home or prospective adoptive home, the plans for care and supervision of the child shall be provided by a competent individual and approved in advance by the commissioner or his designee.

Section 17a-145-149 Cooperation with the Department's Treatment Plan

(a) Foster parents shall comply with the treatment plan for the child and work cooperatively with the department or child placing agency in all matters pertaining to the child's welfare.

(b) Foster parents shall accept, cooperate with and support arrangements made for the child to have contact including visits and correspondence with the child's biological family in keeping with the frequency indicated by the treatment plan. Visits between children and biological parents shall take place in the foster home unless it is deemed not to be in the best interest of the child or foster family. Foster parents shall be active participants in reunification of the child with the child's biological family.

Section 17a-145-150 Limitation on the Number of Licenses or Approvals Allowed

A foster or prospective adoptive family shall be approved only by a child placing agency. No foster or prospective adoptive home shall possess more than one (1) license or approval for adoption or other form of out of home care either through the department, an entity licensed by the department or licensed or otherwise approved through any other entity. No foster or prospective adoptive family shall hold dual licensure or approval. No licensed or approved foster or prospective adoptive family shall accept, on a private basis, another child for placement.

Section 17a-145-151 General Requirements of Foster and Prospective Adoptive Parents

(a) Foster and prospective adoptive parents shall be physically, intellectually and emotionally capable of providing care, guidance and supervision of the child including:

(1) Insuring routine medical care, scheduling and transportation;

(2) obtaining and following instructions from the child's medical provider if medication or treatment are to be administered by the foster or prospective adoptive parents. Any medications provided shall be clearly labeled and kept out of the reach of children;

(3) establishing plans to respond to illness and emergencies, including serious injuries and the ingestion of poison, with appropriate first aid supplies available in the home out of reach of the children;

(4) maintaining all documentation as required by the department;

(5) providing for the child's physical needs including adequate hygiene, nutritional meals and snacks prepared in a safe and sanitary manner, readily available drinking water, a balanced schedule of rest, active play, indoor and outdoor activity appropriate to the age of the child in care;

(6) promoting the social, intellectual, emotional, and physical development of each child by providing activities that meet these needs or special needs if such exist;

(7) assuring adequate opportunity for cultural, and educational activities in the family and in the community. Children who do not share the same language, as their caretaker shall be provided with opportunities to practice their native language as they become bilingual or multi-lingual;

(8) assuring an environment of tolerance and sensitivity to a child's religion through providing adequate opportunity for religious training and participation appropriate to the child's religious denomination, and not requiring any child to participate in religious practices contrary to the child's beliefs;

(9) providing emotional support and an environment that meets the child's ethnic and cultural needs;

(10) assuring the child's participation in an approved education program, including regular school attendance. The foster or prospective adoptive parents shall cooperate with the proper authorities in relation to the child's educational needs;

(11) guiding the child in the acquisition of daily living skills including the assigning of daily chores to the child on the basis of the child's abilities and developmental level; and

(12) providing infants and toddlers with ample opportunity for freedom of movement each day outside of a crib or playpen, infants are to be held for all bottle feedings, as well as at other times, for attention and verbal communication.

(b) Foster and prospective adoptive parents, members of the household, substitute care providers, and other persons having regular access to children in the home shall give the child humane and affectionate care. They shall be a positive role model to the child and instruct the child in appropriate behavior. They shall establish limits and assist the child to develop self control and judgment skills. Children in the home shall be encouraged to assume age-appropriate responsibility for their decisions and actions.

(c) Discipline shall be appropriate to the child's age and level of development. Foster and prospective adoptive parents shall not use physically or verbally abusive, neglectful, , humiliating. frightening or corporal punishment, including but not limited to spanking, cursing or threats.

(d) When unusual circumstances require continued or frequent use of physical or mechanical restraints prior written approval shall be obtained from the commissioner or his designee.

(e) Licensed or approved foster and prospective adoptive parents shall complete all assessment and training requirements as prescribed by the department or child placing agency.

(f) The department or child placing agency may consider any unusual circumstances including but not limited to the health demands of other members of the household which may detract from the attention, structure and time required by a foster or prospective adoptive child.

Section 17a-145-152 Criminal History; Pending Criminal Actions; History of Child Abuse or Neglect

(a) The granting of a license or approval shall be denied if any member of the household of a foster family or prospective adoptive family:

- (1) Has been convicted of injury or risk of injury to minor or other similar offenses against a minor
- (2) has been convicted of impairing the morals of a minor or other similar offenses against a minor;
- (3) has been convicted of violent crime against a person or other similar offenses;
- (4) has been convicted of the possession, use, or sale of controlled substances within the past five (5) years;
- (5) has been convicted of illegal use of a firearm or other similar offenses;
- (6) has ever had an allegation of child abuse or neglect substantiated; or
- (7) has had a minor removed from their care because of child abuse or neglect.

(b) The renewal of a license or approval may be denied if any member of the household of a foster family or prospective adoptive family:

- (1) Has been convicted of injury or risk of injury to a minor or other similar offenses against a minor;
- (2) has been convicted of impairing the morals of a minor or other similar offenses against a minor;
- (3) has been convicted of violent crime against a person or other similar offenses;
- (4) has been convicted of the possession, use, or sale of controlled substances;
- (5) has been convicted of illegal use of a firearm or other similar offenses;
- (6) has ever had an allegation of child abuse or neglect substantiated; or
- (7) has had a minor removed from their care because of child abuse or neglect.

(c) The granting or renewal of a license or approval may be denied if any member of the household of a foster family or prospective adoptive family:

- (1) Is awaiting trial, or is on trial, for charges as described in subdivisions (1) through (5) of subsection (a) of this section;
- (2) has a criminal record that the department or child placing agency believes makes the home unsuitable; or

(3) has a current child abuse or neglect allegation pending;

(d) No approval shall be renewed if the holder of such approval knowingly arranges for the substitute care of a child by a person described in subsection (a) or (c) of this section.

Section 17a-145-153 Achieving compliance with regulatory requirements

(a) In the event that a foster family is found to be in non-compliance with any statutes or regulations the department shall identify in writing within twenty (20) business days of the determination of non-compliance the sections of the statutes or regulations in which such person is not in compliance.

(b) The foster family shall be given twenty (20) business days to show compliance with the statutes or regulations. When such person cannot demonstrate compliance within twenty (20) business days the commissioner or his designee may provide such person the opportunity to submit a written plan to the department outlining steps which will be taken to achieve compliance.

(c) Upon approval by the commissioner or his designee of a written plan to achieve compliance with all relevant statutes and regulations a foster family may be issued a provisional license. Each provisional license may be in force for up to a period of up to sixty (60) days per license. Additional provisional licenses may be issued for additional periods of up to sixty (60) days if adequate progress towards compliance as outlined in the written plan is being demonstrated. The total period for which a foster family may be issued provisional licenses shall not exceed one (1) year.

(d) In accordance with section 17a-151 of the Connecticut General Statutes a provisional license or a provisional approval may be revoked, suspended, denied or its renewal refused if the foster family does not supply a satisfactory plan for achieving compliance with all relevant regulations, does not make good faith efforts to achieve compliance, or does not achieve compliance within a period of not more than one (1) year.

(e) The commissioner or his designee shall not grant the opportunity for the submission of a written plan if the nature or severity of the non compliance is such that the commissioner or his designee determine that compliance is not achievable within a reasonable time period or would require such involvement by the department that the relative cost/benefit would be fiscally imprudent on the part of the department. The department shall document such instances when the opportunity to submit a written plan is not granted.

(f) If the department revokes, suspends, denies or refuses to renew a license pursuant to subsection(d) of this section or does not grant the submission of a plan pursuant to subsection (e) of this section the department shall provide the foster family with documentation of the nature of the non-compliance and the reasons for the department's action. The department shall promptly institute proceedings for revocation or non-renewal of such license.

Section 17a-145-154 Causes for, denying, revoking or refusing to renew a license.

(a) A license or approval may be denied, revoked, or its renewal refused if the applicant or holder of such license or approval:

(1) Fails to comply with applicable statutes and regulations regarding child care and child placement;

(2) fails to comply with applicable state and local laws, ordinances, rules and regulations relating to building, health, fire protection, safety, sanitation and zoning;

(3) violates any of the provisions under which the license or approval has been issued or granted;

(4) furnishes or makes any false or misleading statements to the commissioner or child placing agency in order to obtain or retain a license or approval;

(5) refuses or fails to submit reports or make records available when requested by the commissioner, designee or child placing agency; or

(6) fails or refuses to admit to the property or to discuss regulatory issues with the commissioner or his designee or child placing agency as required in section 17a-145-135 of the Regulations of Connecticut State Agencies.

Section 17a-145-155 Summary Suspension

If the department has reason to believe that a threat to the health or welfare of a child or children placed in a foster or prospective adoptive home exists, the department may summarily suspend the license or approval. The department shall immediately remove any foster or prospective adoptive child residing in a foster or prospective adoptive home which has had its license or approval summarily suspended. Any licensed foster or prospective adoptive home which has been issued a summary suspension shall be immediately notified by mail of its right to a hearing on the issue of summary suspension pursuant to section 17a-145-157 of the Regulations of Connecticut State Agencies. If the licensed foster or prospective adoptive home requests a hearing within ten (10) days of notification such hearing shall be held within thirty (30) days. If no hearing is requested the recommended action of the department is accepted. Regardless of a request for a hearing no additional children shall be placed in a foster or prospective adoptive home under summary suspension until a final decision is rendered on the matter.

Section 17a-145-156 Child Placing Agency Hearing

Any approved foster or prospective adoptive family may request a review, hearing or other method of appeal as shall be provided for by the child placing agency seeking any type of administrative hold, suspension, revocation or refusal to renew an approval granted a foster or prospective adoptive family.

Section 17a-157. Hearing on Summary Suspension, Revocation or Non-Renewal of License.

Any licensed foster or prospective adoptive home may, within ten (10) days after receipt by mail of notice of summary suspension, intended revocation or refusal to renew a license, request an administrative hearing concerning licensure in accordance with the Uniform Administrative Procedures Act, Chapter 54, Connecticut General Statutes. Summary suspension, intended revocation or refusal to renew a license shall be stayed until such hearing is held except in the case of an emergency removal. If no hearing is requested the recommended action of the department is accepted.

Section 17a-145-158 Disposition of license or approval documentation

In the case that any changes to the specifications set forth on license or approval documentation are made, a new assessment of the foster or prospective adoptive family shall be conducted by the department: A new license or approval documentation may be issued. In the event that a license or approval is revoked the revoked license or documentation of approval shall be returned to the department or child placing agency.

Section 17a-145-159 Waiver of Requirements for a Foster of Prospective Adoptive Family

A foster or prospective adoptive family shall comply with all relevant regulations unless a waiver for specific requirements of such regulations has been granted by the commissioner or his designee. A waiver shall only be issued if a foster or prospective adoptive family is in substantial compliance with the relevant regulations being exempted or that the specific requirement to be exempted will be satisfactorily achieved in a manner other than that prescribed by the requirement. A waiver shall specify the particular requirements to be exempted, the duration of the exemption and the terms under which the exemption is granted. If the foster or prospective adoptive family fails to comply with the waiver in any way the agreement shall be subject to immediate cancellation.

Section 17a-145-160 Limitations to Number of Placements in One Foster or Prospective Adoptive Family

(a) Children shall not be placed in a foster family or prospective adoptive family if that placement shall result in: (1) More than three foster or prospective adoptive children in that foster family or prospective adoptive family; (2) a total of six children including the foster or prospective adoptive family's natural and adoptive children; (3) more than two children under two years of age; or (4) more than three children under six years of age, except in the case of siblings as provided for in subsection (b) of this section.

(b) The commissioner or a department regional administrator, for their specific region, may authorize a placement which exceeds the population limitations proscribed in subsection (a) of this section, only if such placement is done to keep sibling groups together and such placement does not exceed the population levels of local ordinance as provided for in subsection (d) of this section.

(c) The commissioner may authorize the placement of a child or children which exceeds the population limitations proscribed in subsection (a) of this section in special circumstances as deemed appropriate by the commissioner if such placement does not exceed the population levels of local ordinance as provided for in subsection (d) of this section.

(d) When local ordinances specify that a smaller number of children may be in care than is provided for in subsection (a) of this section or as may be provided for by subsections (b) and (c) of this section, the local ordinance shall prevail.

(e) Notwithstanding the provisions of subsections (a), (b) and (c) of this section a foster family or prospective adoptive family shall not care for more than two (2) nonambulatory children who are incapable of self-preservation.

(Effective February 20, 1997)

Content Last Modified on 1/8/2016 11:52:17 AM