FATALITY INVESTIGATION FINDINGS & RECOMMENDATIONS
LIAM RIVERA

OCTOBER 24, 2023

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
165 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106
www.ct.gov/oca

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Child Advocate

INTRODUCTION AND METHODOLOGY

The Office of the Child Advocate is issuing this Fatality Investigation Findings & Recommendations Report ("Findings Report") following the death by homicide of 2-year-old Liam Rivera. Liam's family had an open child abuse/neglect case with the Department of Children and Families (DCF) and the Superior Court for Juvenile Matters (Juvenile Court) at the time of his death. Liam's father was on Adult Probation supervision administered by the Connecticut Judicial Branch Court Support Services Division (JB-CSSD) at the time of Liam's death. OCA examined the circumstances preceding Liam's death: the supports and services provided by DCF, the supervision of Liam's father by JB-CSSD, the role of the Juvenile Court in overseeing Liam's best interests, and the legal representation provided for Liam in the child protection proceeding.

In accordance with OCA's statutory obligations and authority, OCA undertook a broader review of child protection and adult probation system issues implicated by findings in Liam's death, focusing on the systems' checks and balances and the efficacy of existing quality assurance frameworks to ensure child safety. The purpose of fatality and critical incident review is to inform statewide child injury prevention efforts.

As a preface for this review, OCA references findings issued by this office in three previous fatality reviews.

1. In February 2023 OCA published a report regarding the death of 1 year old Kaylee from Fentanyl intoxication. Like Liam, Kaylee and her family had an open case with DCF at the time of her death. OCA found that DCF's safety planning, service delivery, and quality assurance framework for open cases needed improvement. OCA made several recommendations to support consistent child protection practice and ensure public transparency and accountability for system improvements that support the safety and wellbeing of abused and neglected children.
2. In July 2023 OCA and state Child Fatality Review Panel co-chair Dr. Kirsten Bechtel published a report regarding the preventable deaths of children age birth to three across Connecticut during a recent 3-year period. The report recommended an accountable multi-agency plan to prevent child deaths, noting that many families or caregivers whose child died were receiving state-services, supervision, or benefits at the time of the child's death.
3. In 2017 and 2022, OCA issued fatality reports regarding the death of Matthew Tirado, a child with a recent DCF and juvenile court case who died from child abuse, and the death of Alex Medina, a child in foster care. These reports highlighted children's legal right to adequate representation by lawyers assigned to represent them in child protection proceedings and recommended additional resources and oversight for this system.

OCA's Methodology for Liam's Fatality Investigation included:

1. A review of DCF records regarding Liam Rivera and his family, including agency emails, cell phone records, and invoices.
2. A review of Juvenile Court records regarding Liam Rivera and his family.
3. A review of JB-CSSD records regarding Mr. Ismalej-Gomez.
4. A review of relevant state agency policies, practice manuals, and data.
5. A review of billing records from the Office of the Chief Public Defender (OCPD) applicable to the representation of Liam Rivera.
6. Review of medical and Birth to Three records for Liam Rivera.
7. Review of police records and reports regarding Liam Rivera and his parents.
8. Interviews with medical professionals, law enforcement personnel, and state agency representatives.
9. Consultation with medical experts.

OCA shared a draft of this Report with all the agencies identified herein, and incorporated responses and feedback to the final Report. Formal agency responses are included at the conclusion of the OCA's Findings and Recommendations. OCA also shared a draft of this Report with the State's Attorney for the Judicial District of Stamford, and with the Office of the Chief Medical Examiner.

CASE FINDINGS- CIRCUMSTANCES PRECEDING THE DEATH OF 2-YEAR-OLD LIAM RIVERA

2017- 2020

Liam's family had a history with DCF due to reported allegations of child maltreatment prior to Liam's birth.

Prior to Liam's birth, three reports were made to DCF alleging child abuse or neglect of children in Ms. Rivera's household between 2017 and 2021.

On July 10, 2017, Stamford police responded to the home of Ms. Rivera following a call from an individual who alleged that Ms. Rivera "abuses her own children." The report to police from the individual indicated that Ms. Rivera had become upset with Liam's then 2-year-old sibling and "forcefully pushed" the child out of the room. The complainant alleged that Ms. Rivera hits another sibling, then age 6. Stamford police spoke to the individual and Ms. Rivera, and observed the 2-year-old, who had "sores" on his legs and a scratch on his nose. Ms. Rivera stated that the child had a rash on his legs, and she had taken him to Stamford Hospital for treatment and the scratch to the nose was a result of him falling. Stamford police informed the complainant that they would make a referral to DCF due to the allegation of "child abuse." Police records document that a referral to the DCF Careline was made on that date, which was not accepted by the Department for investigation. The

DCF system has no record of the non-accepted report due to the agency's automatic expungement practices.[1]

In November 2019, a report was made to DCF alleging that the reporter heard Ms. Rivera hitting one of Liam's siblings, and that Ms. Rivera leaves her children, then age 7 and 4, alone in the mornings. DCF accepted the report for investigation. Allegations of physical abuse were denied by the family and a referral to community support services was declined by Ms. Rivera. The earlier report from Stamford police had already been expunged from the DCF system and therefore there was no reference to the previous allegation in the 2019 case record. The case was closed after intake.

In December 2020, police made a report to the DCF Careline alleging that Ms. Rivera was in a verbal altercation with her roommate, that there was an allegation that the roommate was engaged in inappropriate behavior towards a child in the household, and that Ms. Rivera was "heavily intoxicated" when police arrived at the home at 5 a.m. DCF accepted the report for investigation. Allegations of inappropriate behavior were not substantiated. Ms. Rivera was assessed for substance misuse and determined to not meet criteria for treatment, and no recommendations for services ensued. Baby Liam was five months old at the time of this investigation.

January 2021

Six-month-old Liam was found to have multiple unexplained injuries-child abuse suspected.

On January 30, 2021, while the December 2020 investigation was still pending, Stamford Hospital contacted DCF after six-month-old Liam was brought to the hospital by his parents, Ms. Rivera and Mr. Ismalej-Gomez, and doctors determined that he had a broken arm. While an initial explanation was provided by the family that Liam may have fallen off the bed while in the care of Mr. Ismalej-Gomez and while Ms. Rivera was showering, the treating physician was concerned that the injury may not be consistent with the explanation provided by the family.

A subsequent full skeletal and physical exam revealed that in addition to the broken arm, Liam also had a healing fracture of his left tibia, thought to be at least two weeks old, and bruising to his left torso and abdomen. Liam's parents could not provide an explanation for the injuries, and child abuse doctors determined the child was too young to be mobile and therefore the injuries presented with a "high degree of concern that Liam was physically abused." Child abuse doctor/s concluded that given Liam's "age and developmental stage [he] could not have injured himself under his own power. While a fall from a bed could cause an arm fracture, the spiral nature of the child's injury is more suggestive

[1] DCF Policy regarding Records Management (6-4), indicates that expungement of non-accepted reports of abuse and neglect after three years, however, this report was not present in the system at the time of the 2019 report, and no reference was made to the previous allegations. In follow up discussion with DCF, it was reported that the LINK computer system automatically expunges non-accept reports, with no additional activity associated with the case participants after two years, inconsistent with Policy. Given the expungement, there is no record of why DCF did not accept the 2017 report for investigation. DCF was forwarded the police report from the 2017 incident on January 31, 2021, via email from the Stamford Police detective assigned to Liam's injury case.

of a twisting motion of his arm rather than a direct impact to it such as from a fall. [His] parents offered no explanation either accidentally or otherwise for [his] tibia fracture or bruising."[2]

At the time of Liam's medical evaluation, a young sibling was also examined with Ms. Rivera present. The sibling was reluctant to comply with the examination, but eventually revealed what was documented as an "acute," "large bruise" on his/her back that was "red-purple in color" with surrounding broken blood vessels. The child was interviewed alone and initially would not provide an explanation, eventually stating that another young child in the household caused the bruise. The child did not provide any further explanation as to how, when or where the injury occurred. The physician stated that without this disclosure, the cause of the injury could not be determined.

Due to the medical conclusion that Liam was abused, DCF sought an Order of Temporary Custody from the Juvenile Court for Liam and one of his siblings, and the third sibling went to live with another parent. The Juvenile Court sustained the Order of Temporary Custody finding that the children were at imminent risk of bodily harm.[3] The Court also issued findings that Liam and his siblings were abused and/or neglected and the Court ordered Liam and one of his siblings "committed" to the guardianship of DCF[4] and they were placed in separate foster homes.[5] The third sibling stayed with his/her other parent.

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[2] Warrant- affidavit. Edgar Ismalej-Gomez.

[3] Connecticut General Statute Section 46b-129(b) reads in relevant part: "if it appears from the specific allegations of the petition and other verified affirmations of fact accompanying the petition and application, or subsequent thereto, that there is reasonable cause to believe that (1) the child or youth is suffering from serious physical illness or serious physical injury or is in immediate physical danger from the child's or youth's surroundings, and (2) as a result of said conditions, the child's or youth's safety is endangered and immediate removal from such surroundings is necessary to ensure the child's or youth's safety, the court shall either (A) issue an order to the parents or other person having responsibility for the care of the child or youth to appear at such time as the court may designate to determine whether the court should vest the child's or youth's temporary care and custody in a person related to the child or youth by blood or marriage or in some other person or suitable agency pending disposition of the petition, or (B) issue an order ex parte vesting the child's or youth's temporary care and custody in a person related to the child or youth by blood or marriage or in some other person or suitable agency."

[4] Connecticut General Statute Section 46b-129(j) provides: "Upon finding and adjudging that any child or youth is uncared for, neglected or abused the court may (A) commit such child or youth to the Commissioner of Children and Families, and such commitment shall remain in effect until further order of the court, except that such commitment may be revoked or parental rights terminated at any time by the court; (B) vest such child's or youth's legal guardianship in any private or public agency that is permitted by law to care for neglected, uncared for or abused children or youths or with any other person or persons found to be suitable and worthy of such responsibility by the court, including, but not limited to, any relative of such child or youth by blood or marriage; (C) vest such child's or youth's permanent legal guardianship in any person or persons found to be suitable and worthy of such responsibility by the court, including, but not limited to, any relative of such child or youth by blood or marriage in accordance with the requirements set forth in subdivision (5) of this subsection; or (D) place the child or youth in the custody of the parent or guardian with protective supervision by the Commissioner of Children and Families subject to conditions established by the court."

[5] Liam's sibling was originally placed with an extended family member, however this turned out not to be permanent, necessitating his/her placement in DCF foster care.

February 2021

Liam had unmet medical needs upon entry into foster care – he was diagnosed as failure to thrive. Days after being placed in DCF foster care, Liam was seen in follow up by his pediatrician and diagnosed as Failure to Thrive. Liam was also deemed not up to date medically as he had already missed multiple medical appointments.[6]

Johns Hopkins Medical Center on Failure to Thrive

Children are diagnosed with failure to thrive when their weight or rate of weight gain is significantly below that of other children of similar age and sex. Infants or children that fail to thrive seem to be dramatically smaller or shorter than other children the same age.[1] …

In general, the rate of change in weight and height may be more important than the actual measurements.

Infants or children who fail to thrive have height, weight and head circumference that do not match standard growth charts. The person's weight falls lower than the third percentile (as outlined in standard growth charts) or 20 percent below the ideal weight for their height. Growing may have slowed or stopped after a previously established growth curve.

The following are delayed or slow to develop:

- Physical skills, such as rolling over, sitting, standing and walking
- Mental and social skills
- Secondary sexual characteristics (delayed in adolescents)

It is important to determine whether failure to thrive results from medical problems or factors in the environment, such as abuse or neglect.

DCF records indicate that a Birth to Three (CT's early intervention service) referral was made on Liam's behalf due to hospital providers having concerns with possible developmental delays. Federal and state law require that states have a process for referring children who have been abused or neglected for developmental assessment and possible early intervention services.[7]

[6] While in his mother's care, Liam missed his 4 month and 6-month well child visits. It is unclear if the 4-month visit was a result of COVID pandemic impacting scheduling or a missed appointment by the caregiver. The 6-month checkup was documented as a "no-show" per the pediatric records.

[7] Federal Child Abuse Prevention and Treatment Act, Section 106(b)(2)(B)(xxi); Connecticut General Statute 17a-106e.

DCF obtained a multidisciplinary evaluation (MDE) for Liam—however primary care records not conveyed to evaluator.

On February 22, 2021, Liam received a DCF-contracted Multi-Disciplinary Evaluation (MDE). DCF facilitates a comprehensive physical for a child within 30 days of the child's commitment to the agency's care. The MDE report contains information about the child's physical, mental, and emotional needs. The MDE report submitted for Liam contains no reference to any medical documentation provided from either his hospitalization or his February 9 pediatrician follow-up visit. The MDE was completed without notes or recommendations regarding Liam's presenting weight or recent Failure to Thrive diagnosis. The MDE provider told OCA that they did not receive records or a report regarding Liam's recent pediatric care visit and were unaware of the Failure to Thrive diagnosis. The provider indicated that it is common not to receive a full report or record on a child recently placed in DCF custody.

DCF substantiated allegations of physical abuse against both parents.

Liam's parents were both substantiated by DCF for Physical Abuse and Physical Neglect. Neither parent was placed on the DCF Central Registry.[8]

Liam and his sister were appointed a lawyer to represent them in juvenile court.

State law requires that children for whom a petition of neglect is filed in the Superior Court for Juvenile Matters are "represented by counsel knowledgeable about representing such children."[9] By statute, the primary obligation of counsel for children is to represent the child in accordance with ethical requirements codified in the Rules of Professional Conduct, including providing client-directed representation to the extent possible. Any party or the Juvenile Court may also appoint a Guardian ad Litem (GAL) to report to the Court regarding the child's best interests--and the Court should outline the specific responsibilities of the GAL.[10]

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[8] Under state law, after finding that a child has been abused or neglected by an entrusted caregiver, DCF "shall also determine whether … such identifiable person poses a risk to the health, safety or wellbeing of children and should be recommended by the commissioner for placement on the child abuse and neglect registry." Conn. Gen. Stat. Sec. 17a-101g(b). Connecticut General Statute Section 17a-101k provides, in relevant part: "The Commissioner of Children and Families shall maintain a registry of the commissioner's findings of abuse or neglect of children pursuant to section 17a-101g that conforms to the requirements of this section. The regulations adopted pursuant to subsection (i) of this section shall provide for the use of the registry on a twenty-four-hour daily basis to prevent or discover abuse of children and the establishment of a hearing process for any appeal by a person of the commissioner's determination that such person is responsible for the abuse or neglect of a child pursuant to subsection (b) of section 17a-101g. The information contained in the registry and any other information relative to child abuse, wherever located, shall be confidential, subject to such statutes and regulations governing their use and access as shall conform to the requirements of federal law or regulations. Any violation of this section or the regulations adopted by the commissioner under this section shall be punishable by a fine of not more than one thousand dollars or imprisonment for not more than one year."

[9] Connecticut General Statute Section 46b-129a. When there are multiple siblings, the Court generally appoints one lawyer for all the children, unless a conflict of interests exists, and the cases are heard together.

[10] *In re Tayquon H.* 76 Conn. App. 693 (Conn. App. Ct. 2003).

In Liam's case, a lawyer was appointed for Liam (and for his two siblings) at the time of the filing of the DCF neglect petition in February 2021. On April 5, 2021, Liam's lawyer filed a Motion for the Appointment of a GAL in the matters regarding Liam's two older siblings. Counsel noted that Liam was not included in the Motion, and it was not docketed in Liam's case. The order was signed as granted and OCPD was notified. No specific orders were requested or issued regarding the scope of duties of the GAL or what, if anything, the GAL was being asked to report to the Court. On May 12, 2021, the GAL filed an appearance in the siblings' cases and Liam's case as well. From that point forward, the GAL served as Liam's GAL, including taking positions in court hearings and filing at least one position statement on Liam's behalf.

April - May 2021

Additional reports made to DCF of alleged maltreatment of Liam/sibling/s.

In April 2021, two months after Liam was committed to DCF foster care, a report was made to the DCF Careline alleging there had been an altercation between Ms. Rivera and Mr. Ismalej-Gomez, purportedly captured on camera, that Ms. Rivera appeared under the influence, and that one of Ms. Rivera's other children (a third child who was not in foster care but who was living with family) was a witness. This report was not accepted for an investigation by DCF, but the allegations were quickly followed up by DCF area office staff and were denied by both parents. Mr. Ismalej-Gomez stated that he got into an altercation with someone else at the party, not Ms. Rivera. He reports that he had moved out of the family's home and that he and Ms. Rivera were separated.

In May 2021, a new report was made to the DCF Careline conveying allegations that the same sibling was subject to physical abuse by Mr. Ismalej-Gomez who would leave Ms. Rivera's home at night; and that Ms. Rivera and Mr. Ismalej-Gomez have been seen fighting outside the family's home (same allegation as above). Allegations were accepted by DCF for further investigation but unsubstantiated as there was a lack of evidence that Liam's sibling was unsupervised by Ms. Rivera or that Ms. Rivera was involved in the altercation. A video reviewed by DCF was deemed inconclusive as to the identity of the participants or activity. All interviewed parties denied an incident occurred, and the investigation was closed. Additional allegations made by the reporter that Ms. Rivera drank to excess, abused drugs and prostituted were not addressed in the investigation.

August 2021

Mr. Ismalej-Gomez was arrested in connection with Liam's broken arm - no pretrial supervision provided.

In June 2021, Stamford Police were informed that Mr. Ismalej-Gomez stated that he accidentally grabbed and twisted Liam's arm to catch him from falling from the bed and may have inadvertently caused Liam's arm injury. No statements were made by either parent regarding Liam's other injuries.

On August 26, 2021, Mr. Ismalej-Gomez was arrested for Risk of Injury and Assault and arraigned the following day. At the time of arraignment, a full no contact protective order was issued with Liam as the protected party. Mr. Ismalej-Gomez was also ordered to comply with DCF services and to surrender his passport while awaiting trial. JB-CSSD records and information indicate that Mr. Ismalej-Gomez did surrender his passport, and the pretrial conditions were closed. According to JB-CSSD,

pretrial services do not monitor protective orders. Such conditions are supervised by JB-CSSD Family Services if the Court refers the matter to Family Services, which did not occur in this case. Although contrary to agency policy, pretrial services also closed the condition to comply with DCF, which resulted in pretrial services neither monitoring this condition nor providing a progress report to the Court for two subsequent hearings, on November 2, 2021, and January 6, 2022, prior to Mr. Ismalej-Gomez's arrest on January 19, 2022 for violating the protective order.

<u>While DCF documented that Liam's father acknowledged responsibility for all of Liam's injuries. This was not accurate and responsibility for Liam's injuries remained undetermined.</u>

A September 28, 2021, DCF Supervisor case note provides that Mr. Ismalej-Gomez took responsibility for all of Liam's injuries in 2021, noting "the [Stamford Police] report indicated the Mr. Ismalej's charges are for all the injuries to Liam, including his chest bruise, leg fracture and the arm fracture." However, the Stamford arrest warrant states that, "Mr. Ismalej-Gomez recognized involuntary responsibility in the incident where the juvenile sustained an arm injury," and based on that statement an arrest warrant was requested for one count of Risk of Injury and Assault 2. Notably, a DCF Program Supervisor case entry (the supervisor's supervisor), created on February 28, 2022, but backdated to September 28, 2021, acknowledged that "there still is concern/questions surrounding Liam's unexplained injuries as neither parent have [sic] given explanation as to how this may have occurred."[11]

ARREST WARRANT APPLICATION
JD-CR-64a Rev. 3-11
C.G.S. § 54-2a
Pr. Bk. Sec. 36-1, 36-2, 36-3

STATE OF CONNECTICUT
SUPERIOR COURT
www.jud.ct.gov

Name *(Last, First, Middle Initial)*	Residence *(Town)* of accused	Court to be held at *(Town)*	Geographical Area number
Ismalej-Gomez, Edgar	**Stamford**	**Stamford**	**01**

Affidavit - Continued

30) That on Monday, June 7th 2021, a copy of Gomez' Medical Release of Info form was faxed to his service provider, Dr. [redacted].

31) That on Tuesday, June 29th 2021, the Affiant received a fax from Dr [redacted] containing a summary of Ms. Rivera-Santos and Mr. Gomez counseling services. This fax read the following in summary: both parents have been undergoing Psychotherapy since 2/20/21 and have maintained consistent attendance. The services both parents received explored their family situation and parenting abilities as it relates to their current situation. On 3/27/21 Mr. Gomez recognized involuntary responsibility in the incident where the juvenile victim sustained an arm injury. Mr. Gomez reported he was napping on his bed along with his son when he perceived the juvenile victim was slipping down and most likely falling from the bed. Mr. Gomez reported he reacted quickly to catch the juvenile victim by the arm which probably caused the arm injury.

32) That based on the aforementioned facts and circumstances, this Affiant believes that Probable Cause exists and respectfully requests that an Arrest Warrant be issued for Edgar Ismalej-Gomez (6/24/96) on the charges of 53a-21(a)(1) Risk of Injury & 53a-60 Assault 2nd.

[11] The Program Supervisor's entry, February 2022, was made after DCF had informally returned Liam to his mother's care and had developed concerns regarding his care. These issues are described in greater detail in the Report.

DCF determined that the parents had created separate households and that Liam's mother was benefitting from support services and intervention—DCF developed a plan for reunification of the children with Ms. Rivera.

While Liam and his sibling were in foster care, DCF referred Liam's parents for counseling and parenting classes. Ms. Rivera and Mr. Ismalej-Gomez reported to DCF that they had separated and established separate households. Ms. Rivera frequently told DCF that she remained financially dependent on Mr. Ismalej-Gomez and the paternal family for her basic needs, including rent and food. Providers gave positive feedback to DCF regarding Ms. Rivera's attendance and participation in services.

After the arrest and arraignment of Mr. Ismalej-Gomez, in August 2021, DCF staff conducted a permanency planning meeting which included both of Liam's parents and Liam's attorney and GAL. The DCF case record states:

> DCF presented all parties with a reunification plan which consist [sic] of the family being referred to the RTFT [Reunification and Therapeutic Family Time] program[12] **to begin the reunification process which can last between 3 – 6 months depending on the progress of the family. [sic] During which time the family will be assessed for reunification. The family will be provided with supervised contact/visitation with their children that will gradually move into unsupervised, overnight and the final goal being reunification**. The goal of reunification will soley [sic] depend on the progress the parents make while engaging in the program/service. It was agreed upon by all parties when the time comes to began [sic] transitioning the children back into the home [LIAM'S SIBLING] will be reunified first based on the age of the child and the purpose of acclimation into the school system shortly followed by Liam transitioning back into the home. All attendees are in favor of the plan and have no reservation about the children reunifying with the biological parents.

According to the DCF service contract:

> The RTFT model consists of three "service types that may be used in combination with one another or requested by [DCF] as individual components based on the needs of the family:" Reunification Readiness Assessment (30 days length of service), Reunification Services (4-6 months, with an additional two months of step-down services), and Therapeutic Family Time - an intervention between children and their parent(s) used to assist them in maintaining and/or re-establishing relationships that are healthy for the child. RTFT will provide direct consultation, assessment, direct

[12] RTFT is an evidenced-informed DCF funded program that aids DCF in determining family readiness for reunification, coaches parents/primary caregivers on parenting skills, and works with the child, biological family and foster family as a team to support a healthy, successful transition and achieve a higher rate of reunification permanency.

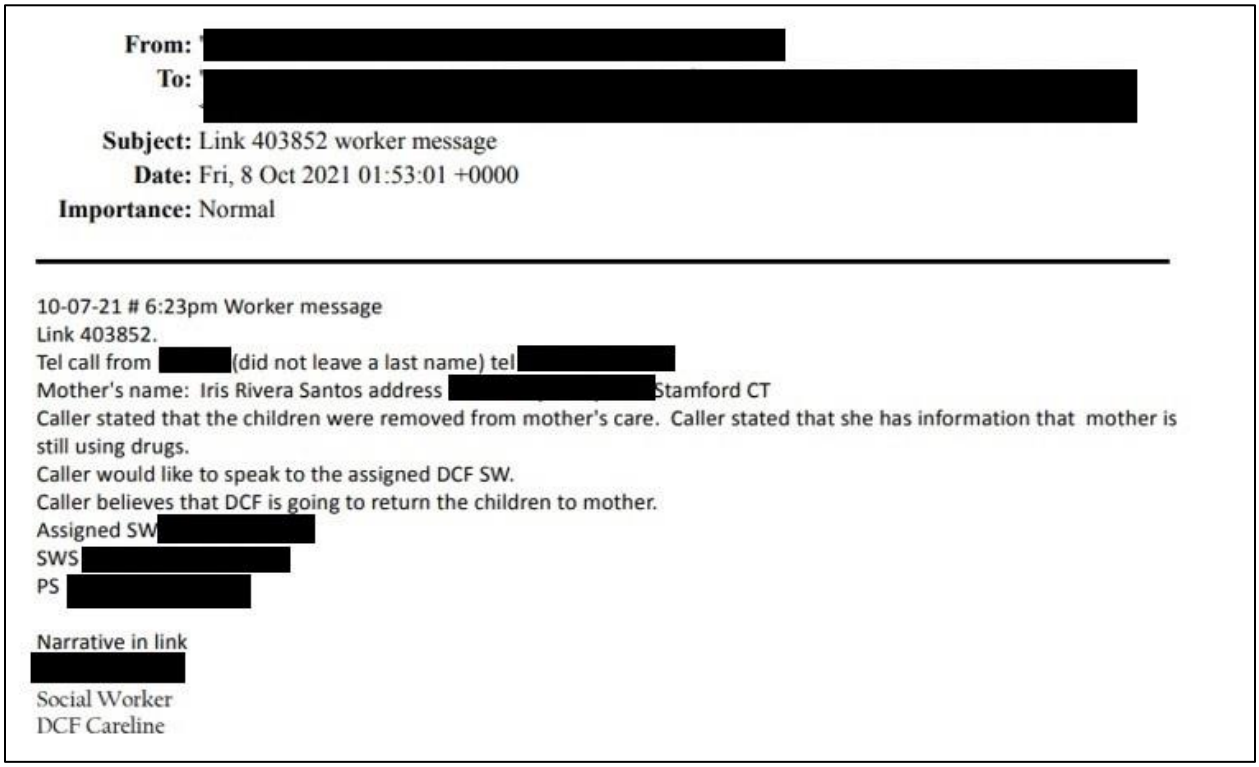
work with parent(s) on parenting skills, improve parent-child interactions and promote attachments (2-3 months).

Ms. Rivera was referred by DCF to RTFT and engaged in the program from September 14, 2021, until October 21, 2021, during which time three supervised visits occurred between Liam's sibling and Ms. Rivera. The service ended shortly thereafter, with only the Readiness Assessment having taken place.

October 2021

A concern was called in to the DCF Careline stating concerns about potential reunification of children with Ms. Rivera.

On October 7, 2021, a call was made to the DCF Careline requesting to speak to the assigned caseworker as the caller had concerns that Ms. Rivera was using drugs and that DCF was considering returning the children to Ms. Rivera's care. A report was not created at this time; however, a case record entry was generated, and an email was forwarded to the assigned caseworker, social work supervisor, and program supervisor with the details of the call. A first name and contact number were left by the caller.



From: [redacted]
To: [redacted]
Subject: Link 403852 worker message
Date: Fri, 8 Oct 2021 01:53:01 +0000
Importance: Normal

10-07-21 # 6:23pm Worker message
Link 403852.
Tel call from [redacted](did not leave a last name) tel [redacted]
Mother's name: Iris Rivera Santos address [redacted]Stamford CT
Caller stated that the children were removed from mother's care. Caller stated that she has information that mother is still using drugs.
Caller would like to speak to the assigned DCF SW.
Caller believes that DCF is going to return the children to mother.
Assigned SW [redacted]
SWS [redacted]
PS [redacted]

Narrative in link
[redacted]
Social Worker
DCF Careline

There is no documentation in the case record that DCF followed up on this concern, discussed a response within the chain of command, or communicated the concerns to the RTFT reunification service provider. There is no documentation that the allegations were shared with the child's attorney, GAL, or the Court.

DCF placed Liam's sibling home with Ms. Rivera under DCF "Commitment" (Guardianship)—no prior notice given to the Court.

In mid-October 2021, following the three supervised visits by the RTFT provider, the provider recommended reunification of Liam's sibling with Ms. Rivera. There were no unsupervised visits, no overnight visits, and no post reunification services requested of the RTFT agency. Despite the opportunity for continued service with this provider as outlined above, the service was ended. At closing, the RTFT program reported to DCF that interventions were needed to support the sibling's reunification:

- It is important that Ms. Rivera continue to address her parenting and why DCF became involved through therapy services.
- It is important that Ms. Rivera remain compliant and follow suggestions/recommendations made by DCF, RTFT, and other service providers.
- It is important that Ms. Rivera continue to utilize positive and appropriate parenting skills with her daughter in order to maintain a positive parent-child relationship.
- It is recommended that Ms. Rivera continue to work with DCF and RTFT services to ensure a good transition and successful reunification with her daughter.

DCF records indicate that DCF, the children's attorney, and GAL were "in support of the children being reunified with their mother since she has been living separately" from Mr. Ismalej-Gomez, who DCF appeared to identify as the offending parent. On October 22, 2021, Liam's sibling was placed informally with Ms. Rivera, with DCF retaining legal guardianship, i.e., commitment. DCF's plan was to see how the home placement went and within 30 days file in the Juvenile Court a Motion to Revoke DCF's Commitment of the child. It is not clear in the DCF record why the RTFT services were ended at this time rather than used to support DCF's plan for the trial reunification period.

OCA finds that DCF's plan to informally reunify the child home was not permitted by state law, which does not grant authority for DCF to place children who are under the state's legal guardianship back into the custody of the parent from whom the child was removed without court approval as the court has exclusive jurisdiction to address custody in child protection proceedings. Additionally, DCF has no written policy or practice guidelines for placing children home "under commitment," as it is frequently called. Such placements are also called "trial home visits."

After reviewing OCA's draft Report, DCF contended that the child protection statutes "authorize[] DCF to place a child in a suitable foster home or with a relative caregiver," noting that "[t]ere are many decisions DCF can make as guardian of a committed child that are not specifically authorized in statute."[13] DCF also asserted that federal law permits the practice "without jeopardizing [federal] funding [for the child's care]." However, federal regulations speak only to possible reimbursement for state-authorized placements, and relevant Connecticut law specifically provides that once committed to DCF, a child may only be placed, amongst other licensed options, with a "relative caregiver" who

[13] DCF Written Response to OCA draft Report, dated September 27, 2023.

is "licensed or approved to provide foster care."[14] Moreover, interpreting "relative caregiver" to include the parent from whom the child was removed, could result in DCF, on its own discretion, immediately reunifying a child that has just been placed in DCF care due to concerns of abuse or neglect. DCF acknowledged in its response to the draft Report that "additional clarity on this authority would be helpful."

February through December 2021

Liam did well physically and developmentally in foster care.

After almost six months in DCF foster care, Liam had gained weight, lost the Failure to Thrive diagnosis, and showed positive developmental gains. His foster mother completed an Ages and Stages screen—a standard brief developmental assessment for children--which found no developmental red flags. State law requires that DCF ensure children under three who are substantiated victims of child abuse or neglect be screened using a standard tool.[15] The foster mother reported to the DCF caseworker that Liam had a healthy appetite and loved to eat. Liam's one year old well-child pediatric visit in July 2021, five months after he was placed in DCF foster care, showed that his weight had moved up to the 20th percentile.

Between October and December 2021, foster mother also brought Liam for sick visits to a local medical provider. All of the visits were due to cough and cold symptoms. Documentation of Liam's weight by the local provider/s indicated he continued to gain weight while in foster care, recording his highest weight of 24 lbs. 8 oz., approximately the 50th percentile, three weeks before he was returned to his mother's care in December 2021. DCF records do not document these visits, other than the foster mother stating that they occurred.

November- December 2021

DCF filed court motions in support of a permanency plan review and a Motion to Revoke Commitment of Liam's sibling.

In November 2021, following DCF's placement of Liam's sibling back home with Ms. Rivera, DCF filed legal motions requesting that the Court approve a **permanency plan of reunification** as to both Liam and his sibling, and that the Court grant **DCF's Motion to Revoke Commitment** (legal guardianship) of Liam's **sibling** and restore Ms. Rivera's guardianship of the sibling. DCF's Motions did not inform the Court that the sibling was already home.

State law provides that, for any child in foster care, DCF must file a proposed Permanency Plan within 9 months of the child coming into state care. The law provides that the Court will then review the

[14] General Statute Section 46b-129(j)(4) provides that once committed, "the [DCF Commissioner] shall be the guardian of such child or youth for the duration of the commitment…The commissioner may place any child or youth so committed to the commissioner in a suitable foster home or in the home of a fictive kin caregiver, *relative caregiver*, or in a licensed child-caring institution or in the care and custody of any accredited, licensed or approved child-caring agency, within or without the state, provided a child shall not be placed outside the state except for good cause…"(emphasis added). "Relative caregiver" is defined in state law as an individual "who is twenty-one years of age or older, related to a child by birth, adoption or marriage and is licensed or approved to provide foster care." 46b129(j)(1) cross-referencing Sec. 17a-126.

[15] Connecticut General Statute 17a-106e.

plan, determine whether the plan is in the best interests of the child, set a timetable for attaining the plan and "determine the services to be provided to the parent if the court approves a permanency plan of reunification and the timetable for such services, and determine whether [DCF] has made reasonable efforts to achieve the goal of the existing permanency plan."[16]

The Court's approval of Permanency Plan of reunification does not by itself return the child to the parent and restore the parent's legal custody. Rather, the Plan, as approved by the Court, sets out the steps and timeline that must be followed to effectuate the permanency goal. When DCF seeks to restore the parent/caregiver's custody and guardianship, DCF must file a Motion to Revoke DCF's Commitment of the child. A hearing date is then set, and the Court will grant the revocation of commitment if such revocation serves the best interests of the child and the cause for commitment no longer exists.[17] There are times when DCF files a Motion to Approve the Permanency Plan (of Reunification) and a Motion to Revoke Commitment at the same time, as it did for Liam's sibling. The responsibilities of the parties and the Court remain the same.

When a Motion to Revoke Commitment is filed and granted, the Court may issue, upon request or upon its own order, a period of Protective Supervision. Connecticut court rules require that "[w]hen protective supervision is ordered, the judicial authority will set forth any conditions of said supervision including duration, specific steps and review dates."[18] The Specific Steps are court orders that delineate expectations for DCF supervision and service delivery during the Protective Supervision period as well as expectations for the parent/caregiver.[19] Notice of the orders is given to all parties and all parties have a right to be heard as part of the proceeding. The lawyer for the child is required to file a formal position on the state's proposed permanency plan.[20]

DCF's Motions, which recommended a Permanency Plan of Reunification and included a Motion to Revoke DCF's Commitment (as to Liam's sibling), did not tell the Court that DCF had already placed the sibling back into Ms. Rivera's custody.[21] DCF's legal filing as to Liam's sibling stated:

> Respondent mother has been compliant her [sic] court ordered Specific Steps counseling and gained insight into the child's emotional and behavioral needs [sic] mother has been engaged in parenting, counseling services and reunification services and it is recommended by the providers that the child should be to return [sic] to her care. The cause for commitment no longer exists and revocation of commitment is in the best interest of the minor child.

[16] Connecticut General Statute Section 46b-129.

[17] Connecticut General Statute Section 46b-129(k). These findings are also required because "whenever the judicial authority orders a child or youth to be removed from the home, the judicial authority shall make written findings [that] … continuation in the home is contrary to the welfare of the child or youth" and that "DCF has made reasonable efforts to prevent removal," or "such efforts were not possible." 42 U.S.C. § 672

[18] Connecticut Practice Book Section 35a-12.

[19] Connecticut Practice Book Section 26-1.

[20] Connecticut Practice Book Sections 32a-5; 35a-14.

[21] OCA reviewed a transcript of this hearing to determine if the Court was orally informed that SIBLING was already returned home. The GAL orally informed the Court that Liam's sibling was already placed home with Ms. Rivera.

The Court was also not informed of the October 2021 call to the DCF Careline and the expressed concern regarding the children's reunification, or how such allegations were addressed. Although all parties supported DCF's Motion to Revoke Commitment as to Liam's sibling and the Permanency Plans for reunification of the children, the lawyer for the children did not file a written position statement on behalf of either child, as required by Superior Court for Juvenile Matters Standing Orders.[22]

The Court approved the Permanency Plan of reunification for Liam and his sibling and concurrently approved DCF's Motion to Revoke Commitment of Liam's sibling and return sibling to Ms. Rivera's custody. No revised Specific Steps were issued to govern the period of Protective Supervision as required by Connecticut court rules.

DCF also did not inform the Court that it intended to immediately move forward with informal reunification of Liam.[23] Shortly after the December 2021 court hearing, DCF held another internal meeting to plan for Liam's return to Ms. Rivera, picking the date of December 21, 2021, just one week away.[24] On November 12, 2021, DCF made a referral to a new RTFT provider (a different provider than the one that had just provided services to Liam's sibling), to assess the reunification of Liam. Between November and early December, the new provider completed four supervised visits between Ms. Rivera and Liam, with one visit occurring in Ms. Rivera's home (the other three visits took place at the DCF office). During the visits, a translator was used via speaker phone as the RTFT provider did not speak Spanish. Neither of Liam's siblings were present for these visits, so no assessment occurred of Ms. Rivera's ability to manage three children in her home environment. The Reunification Readiness Assessment was completed after one month of service, with recommendations for Liam to return home. The assessment record states that no interventions were required to support the reunification, indicating that per DCF, "reunification will take place immediately. No other services are required." Notably, the DCF referral to the provider contained no information about Liam's unaccounted for injuries at the time he was placed in foster care or his previous Failure to Thrive diagnosis.

Like Liam's sibling, no unsupervised visits or overnights were provided, and no aftercare was scheduled. After reviewing OCA's draft Report, DCF commented that its decision to place Liam home under commitment, referred to by DCF as a "trial home visit," served this process. As stated above, OCA finds that DCF does not have statutory authority or even a policy regarding informal reunification of a child with a parent/guardian from whom the child was removed per order of a court. The DCF record also reflects that there is no record of a DCF home visit to see Liam or his sibling for three weeks following his return to Ms. Rivera's care.

Although a protective order was still in place and cooperation with DCF remained a condition of Mr. Ismalej-Gomez' release, there is no documentation that DCF alerted JB-CSSD pretrial services that Liam was going home or whether they were having continued successful engagement with him. There

[22] https://www.jud.ct.gov/external/super/standorders/Juvenile/juvenile_childprot.pdf
[23] OCA reviewed the court memorandum in the file and a transcript from the December 2021 hearing.
[24] Although DCF case records indicate that all parties, including the children's attorney and GAL, agreed to Liam and his sibling being individually returned to Ms. Rivera's custody while under DCF commitment, information provided by the attorney and GAL indicate that DCF staff emailed them the day before or the day of Liam's return to Ms. Rivera.

was also no documented safety planning done by DCF with Ms. Rivera regarding the protective order now that Liam was returned to her care under DCF guardianship.

A DCF case note states that DCF planned to file a Motion to Revoke Commitment of Liam two weeks after he went home.[25] However, DCF did not file a Motion to Revoke Commitment of Liam for another six months, in part because of a serious incident involving Liam that occurred a month later in January 2022.

January- March 2022

Serious incident occurs one month after Liam returned to Ms. Rivera's care.

On January 19, 2022, Ms. Rivera and Mr. Ismalej-Gomez violated the criminal court-issued Protective Order. On that date, Ms. Rivera called police and reported that Liam had been kidnapped by a paternal relative. Police responded and quickly located Liam with his father walking outside a few blocks away. Police records documented that Liam was wrapped in a towel, wearing no jacket and no shoes. Liam was returned to Ms. Rivera's care, and Mr. Ismalej-Gomez was arrested and detained. One week later, on January 26, 2022, Ms. Rivera gave a statement to police wherein she recanted her accusation against Liam's uncle and stated she had voluntarily given Liam to Mr. Ismalej-Gomez, and that she had lied to police because she was scared that DCF would remove her children. Ms. Rivera was arrested for making a false report- a Class D Felony. DCF was not aware of this recanted statement until sometime in March 2022.

Mr. Ismalej-Gomez was arrested and arraigned on 2nd degree Kidnapping, Violation of Protective Order, 1st degree Custodial Interference, Risk of Injury, and 2nd degree Burglary. He was incarcerated until April 2022.

DCF investigation of alleged kidnapping incident did not include an adequate safety assessment or a documented legal consult, and statement discrepancies were not addressed.

DCF investigated the January 19, 2022, incident and substantiated Mr. Ismalej-Gomez for physical neglect due to the violation of the protective order. DCF's investigation,[26] closed on February 17, 2022, did not reference Ms. Rivera's January 26, 2022 statement to police recanting her kidnapping accusation, and the investigation did not address discrepant reports of what occurred between Ms. Rivera, the paternal relative, and Mr. Ismalej-Gomez. While subsequent DCF case notes after the close of the investigation indicate that the caseworker eventually became aware of Ms. Rivera's recanted statement, there is no documentation in the case record as to how and when DCF learned of Ms. Rivera's actions.[27] There is no documentation that Ms. Rivera recanted her initial kidnapping allegation to the DCF investigator. There was no documentation in the record that all of Liam's siblings were seen and interviewed about the January incident or any other concerns in the home that may have

[25] There is no record of a DCF home visit with the children and Ms. Rivera between December 21, 2021, and January 12, 2022, when a visit by the case worker took place.
[26] Investigations are conducted by the Intake Unit, and results are then shared with the caseworker/supervisor in the Ongoing Services Unit.
[27] OCA's review of caseworker emails not contained in the DCF case file indicate that the DCF investigator eventually became aware of the revised police statement and forwarded the information to the assigned caseworker.

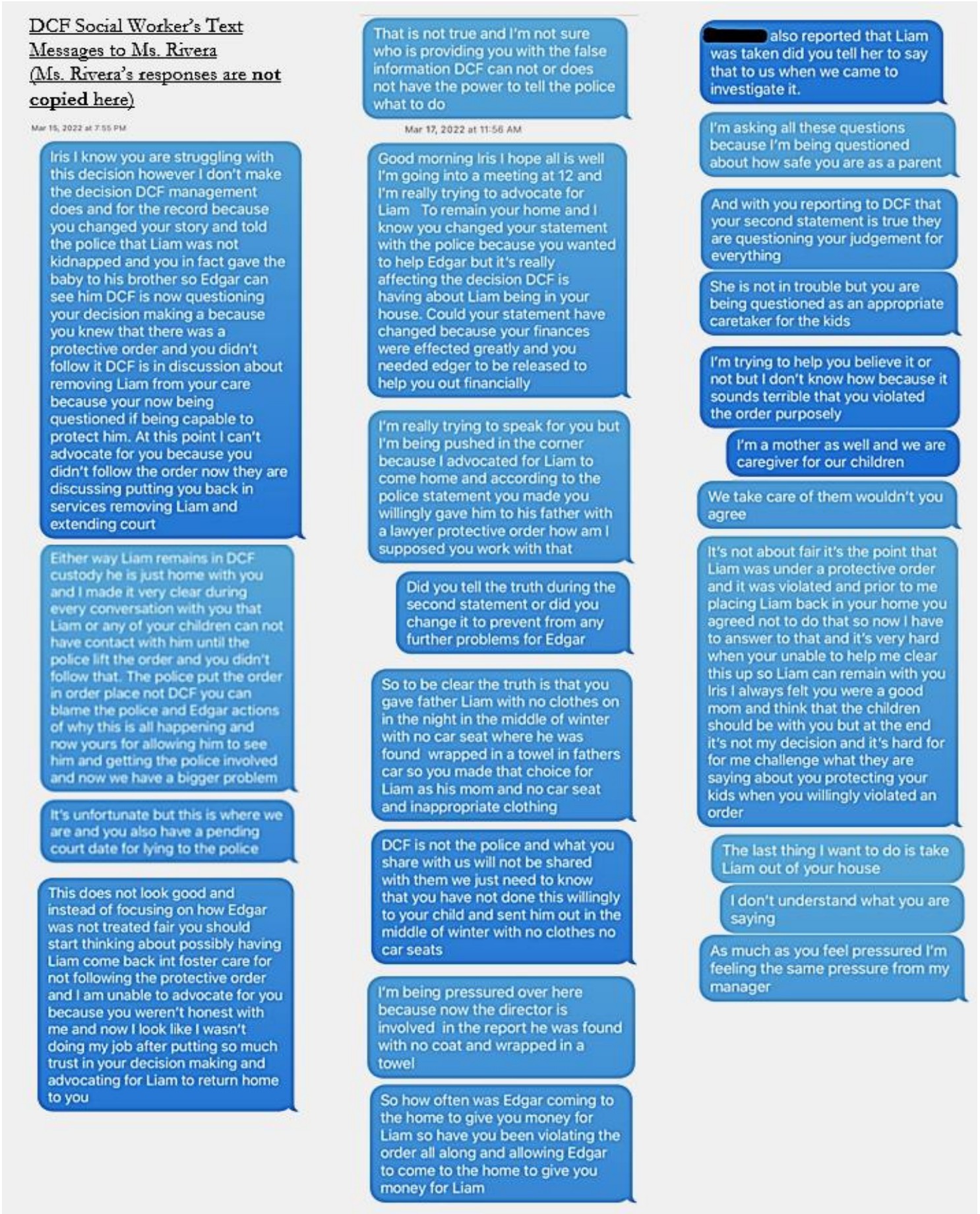
contributed to the incident. With no safety factors identified during DCF's investigation, no safety plan was developed by DCF. Texts by the case worker in March reflect DCF's awareness of Ms. Rivera's inconsistent statements to police and staff's concern about Ms. Rivera's behavior and the implications for Liam's safety.

March 2022 text messages from the DCF worker acknowledge agency's concerns, but there is no documentation in the case record, and no information was shared with the Court, Liam's lawyer or GAL.

There are text messages in March 2022 revealing that the DCF caseworker and the DCF supervisor/s were considering bringing Liam back into DCF custody (see below). However, despite text message that referenced internal discussions and meetings that went up to the Office Director regarding Liam's safety and Ms. Rivera's protective capacity, there are no DCF record entries, including no supervisory case notes or meeting notes, documenting these meetings and case decisions (to leave Liam in Ms. Rivera's care), nor is there documentation in the case record of a plan on how to address any concerns about the children. There was no internal legal consult documented despite Liam being home under DCF guardianship. DCF told OCA that it had confidential discussions with the Attorney General's Office during this time, though the fact of or outcome of these conversations is not documented in the case record either, as required by agency policy[28]. OCA reviewed an internal email indicating that DCF's plan to file a Motion to Revoke Commitment of Liam was delayed due to the incident and DCF's discovery that Ms. Rivera made a "false report to the police about Liam's kidnapping."[29] The same email indicated that there had been a "back and forth with [DCF] and [the assigned Assistant Attorney General] in regards to filing the revocation and the recommendations and [The Motion] didn't get filed until May 6, 2022."

Emails reviewed by OCA did include emails exchanged between DCF staff and the Attorney General's office. However, given the redaction of emails (due to attorney-client privilege), OCA cannot determine what issues were discussed. There is no documentation in the electronic case record or hard copy case records that a safety plan was developed, inclusive of a purposeful visitation plan and other monitoring strategies.

[28] DCF Policy 8-2.
[29] DCF internal email, dated January 3, 2023.


DCF Social Worker's Text Messages to Ms. Rivera
(Ms. Rivera's responses are not copied here)
Mar 15, 2022 at 7:55 PM
Iris I know you are struggling with this decision however I don't make the decision DCF management does and for the record because you changed your story and told the police that Liam was not kidnapped and you in fact gave the baby to his brother so Edgar can see him DCF is now questioning your decision making a because you knew that there was a protective order and you didn't follow it DCF is in discussion about removing Liam from your care because your now being questioned if being capable to protect him. At this point I can't advocate for you because you didn't follow the order now they are discussing putting you back in services removing Liam and extending court
Either way Liam remains in DCF custody he is just home with you and I made it very clear during every conversation with you that Liam or any of your children can not have contact with him until the police lift the order and you didn't follow that. The police put the order in order place not DCF you can blame the police and Edgar actions of why this is all happening and now yours for allowing him to see him and getting the police involved and now we have a bigger problem
It's unfortunate but this is where we are and you also have a pending court date for lying to the police
This does not look good and instead of focusing on how Edgar was not treated fair you should start thinking about possibly having Liam come back int foster care for not following the protective order and I am unable to advocate for you because you weren't honest with me and now I look like I wasn't doing my job after putting so much trust in your decision making and advocating for Liam to return home to you
That is not true and I'm not sure who is providing you with the false information DCF can not or does not have the power to tell the police what to do
Mar 17, 2022 at 11:56 AM
Good morning Iris I hope all is well I'm going into a meeting at 12 and I'm really trying to advocate for Liam To remain your home and I know you changed your statement with the police because you wanted to help Edgar but it's really affecting the decision DCF is having about Liam being in your house. Could your statement have changed because your finances were effected greatly and you needed edger to be released to help you out financially
I'm really trying to speak for you but I'm being pushed in the corner because I advocated for Liam to come home and according to the police statement you made you willingly gave him to his father with a lawyer protective order how am I supposed you work with that
Did you tell the truth during the second statement or did you change it to prevent from any further problems for Edgar
So to be clear the truth is that you gave father Liam with no clothes on in the night in the middle of winter with no car seat where he was found wrapped in a towel in fathers car so you made that choice for Liam as his mom and no car seat and inappropriate clothing
DCF is not the police and what you share with us will not be shared with them we just need to know that you have not done this willingly to your child and sent him out in the middle of winter with no clothes no car seats
I'm being pressured over here because now the director is involved in the report he was found with no coat and wrapped in a towel
So how often was Edgar coming to the home to give you money for Liam so have you been violating the order all along and allowing Edgar to come to the home to give you money for Liam
[redacted] also reported that Liam was taken did you tell her to say that to us when we came to investigate it.
I'm asking all these questions because I'm being questioned about how safe you are as a parent
And with you reporting to DCF that your second statement is true they are questioning your judgement for everything
She is not in trouble but you are being questioned as an appropriate caretaker for the kids
I'm trying to help you believe it or not but I don't know how because it sounds terrible that you violated the order purposely
I'm a mother as well and we are caregiver for our children
We take care of them wouldn't you agree
It's not about fair it's the point that Liam was under a protective order and it was violated and prior to me placing Liam back in your home you agreed not to do that so now I have to answer to that and it's very hard when your unable to help me clear this up so Liam can remain with you Iris I always felt you were a good mom and think that the children should be with you but at the end it's not my decision and it's hard for for me challenge what they are saying about you protecting your kids when you willingly violated an order
The last thing I want to do is take Liam out of your house
I don't understand what you are saying
As much as you feel pressured I'm feeling the same pressure from my manager

In March 2022, DCF conducted an unannounced home visit with Ms. Rivera and the children, the only unannounced visit that occurred prior to Liam's death nine months later. Ms. Rivera insisted to DCF that Mr. Ismalej-Gomez was a good father and she made just one mistake by allowing him access. Ms. Rivera told the case worker that DCF is "cruel," and the protective order is an "injustice." She reported that the paternal relatives are very upset with DCF and are no longer supporting her financially.

The DCF caseworker told Ms. Rivera that she would be expected to reengage in parenting support services and that Protective Supervision would be extended. Notably, Protective Supervision, which is an order that can only be issued by the Juvenile Court as part of the restoration or maintenance of the parent's legal guardianship, was not in place because Liam was with Ms. Rivera informally, and as far as the Court knew Liam was still in foster care.

DCF did not inform Liam's GAL or counsel about the alleged kidnapping incident, the violation of the protective order, DCF's investigation, the police involvement, or subsequent criminal charges for both parents. Neither Liam's GAL nor his counsel requested records from DCF pertaining to Liam's case plan, or reunification home, nor did either visit with Liam during this period, and both lawyers were therefore unaware of any incidents until further legal motions were filed by DCF several months later in May 2022.

DCF did not seek additional RTFT services to support the reunification process, as had been recommended by Liam's sibling's service provider. DCF case records do not describe or address the dynamic of Ms. Rivera's financial dependency and alignment with Mr. Ismalej-Gomez, and how it may impact her parenting decisions and candor with the Department. While OCA makes no finding as to who the perpetrator of Liam's previous and later fatal injuries is, DCF's case record indicates that DCF generally assumed Mr. Ismalej-Gomez to be the perpetrator of Liam's 2021 child abuse injuries. Given that assumption, DCF's record and case plan should have more thoroughly addressed the dynamics of dependency and engagement between the parents, the need for additional therapeutic and in-home support for Ms. Rivera, and implications for safety planning on behalf of Liam and his sibling. At a minimum, DCF should have conducted periodic unannounced visits to the family following the violation of the protective order and the concern implicit in the text messages that the parents remained in regular contact.

April 2022

Mr. Ismalej-Gomez was released from prison in April with probation conditions.

Mr. Ismalej-Gomez was incarcerated until his trial date on April 25, 2022, at which time he pled guilty to Risk of Injury and Assault 3, and was sentenced to 3 years' Probation, with 60 days of time served. His probation conditions required him to obey the court-issued protective order, provide a DNA sample, attend parenting classes, and comply with DCF. Although Adult Probation and DCF policies call for monthly collateral contacts with service providers and other supervising agencies, there was only one contact between CSSD Adult Probation and DCF when it became apparent that Mr. Ismalej-Gomez had absconded from probation supervision.

Additional case concerns and complications developed after Liam was informally reunified with Ms. Rivera.

Complications continued during Liam's informal reunification with Ms. Rivera. Though Ms. Rivera needed child-care due to her participation in parenting classes and house cleaning work, Liam was not connected to a licensed and background checked childcare provider. While Liam was cared for during these times by various adults known to Ms. Rivera, DCF's record documents staff's concern about not having information about the caregivers to complete background checks and the caseworker's directed Ms. Rivera to find a licensed setting for Liam—though this did not occur. For children in the state's care, DCF policy requires childcare providers to be licensed by the state or be a person exempt from such licensure but "who has been approved by DCF."[30] Liam was legally in DCF care, and therefore childcare providers should have been approved by DCF.

Ms. Rivera repeatedly told DCF of her financial struggles, and she stated that she could not obtain benefits, such as nutrition assistance, for Liam as she was still not his legal guardian. While the caseworker told Ms. Rivera she would work with her supervisor to address this concern, there is no documented follow up in the case record. Additionally, Liam missed his 18-month well child doctor's appointment (which should have occurred in January 2022), one of the routine visits for a toddler.

Liam lost weight and pediatrician noted developmental concerns.

In April 2022, Liam—now 21 months old--was brought to his home pediatrician by Ms. Rivera for a well-child check. The pediatrician found that Liam's weight was in the 12th percentile. Because DCF did not have Liam's medical records from the previous October/November doctor's visits while Liam was in foster care, DCF and the home pediatrician did not know that Liam had lost weight in the four months he had been home with his mother.

Liam also failed the M-CHAT autism screen—a standard developmental screen that was administered to Liam during his doctor's appointment. DCF made a Birth to Three (early intervention services) referral on his behalf. However, Liam was never connected to services as Birth to Three made several unsuccessful outreaches to Ms. Rivera and closed the family's case in June 2022 due to Ms. Rivera's non-responsiveness. There is no documentation regarding Birth to Three's discharge of the family in the DCF record.[31]

[30] DCF Policy Sec. 24-1.

[31]The Connecticut Birth to Three coordinator stated that a discharge letter was sent to DCF and Ms. Rivera in June 2022 that Liam's case would be closing due to lack of engagement from the family.

DCF did not conduct an April 2022 administrative case review, required for all committed children every six months.

DCF Policy 5-2 provides:

> Consistent with federal law, the Department of Children and Families shall implement an Administrative Case Review (ACR) process for all children under the care of DCF and their families, including youth over age 18 and children placed through the Voluntary Services Program.

DCF policy mirrors state law requirements[32] that DCF shall:

> [P]repare and maintain a written case plan for care, treatment and permanent placement of every child under the commissioner's supervision, which shall include, but not be limited to, a diagnosis of the problems of each child, the proposed plan of treatment services and temporary placement and a goal for permanent placement of the child, which may include reunification with the parent, transfer of guardianship, adoption or, for a child sixteen years of age or older, another planned permanent living arrangement. The child's health and safety shall be the paramount concern in formulating the plan.
>
> The commissioner shall at least every six months, review the written case plan of each child under the commissioner's supervision for the purpose of determining whether such plan is appropriate and make any appropriate modifications to such plan. If the child is represented by an attorney or guardian ad litem, the commissioner shall notify the child's attorney or guardian ad litem in writing not less than twenty-one days prior to the date of any administrative meeting to review the plan.

ACRs are held every six months and children's lawyers, GALs, parents, and parents' attorneys, as well as service provides should be invited to participate. DCF's ACR Unit— a quality assurance unit-- is responsible for reviewing relevant records regarding the child's care and treatment during the previous six months and ensuring that there is an adequate plan to support the child's health, safety, permanency, and wellbeing.

No ACR was convened for Liam in April 2022. Accordingly, there was no convening of the parties and lawyers, no structured review and formal plan regarding the concerns and complications arising during Liam's informal return home, and no review of Liam's safety, health, or wellbeing by the ACR Unit reviewer.

[32] Connecticut General Statute Section 17a-15.

May-June 2022

May 6, 2022, DCF filed a Motion to Revoke Commitment of Liam and reunify Liam with his mother—court hearing held June 16, 2022

DCF's May 2022 legal filings in the Juvenile Court sought to revoke DCF's guardianship of Liam and formally reunify him with Ms. Rivera. DCF's legal filing informed the Court that Liam had already been living in Ms. Rivera's custody for several months. The filing included information about the January 2022 protective order violation by Ms. Rivera and Mr. Ismalej-Gomez. The filing did not include information regarding DCF's February 2022 investigation and its decision to substantiate Mr. Ismalej-Gomez for physical neglect of Liam due to the violation of the protective order, or the felony charge pending against Ms. Rivera for allegedly making a false complaint of kidnapping to the police. A court filing regarding Liam's sibling was also submitted in May 2022, and had no mention of the January incident, or its subsequent substantiations or arrests.

The DCF court filing erroneously reported that Liam was in the 50th percentile for height and weight, information not supported by his medical record. DCF's filing inaccurately listed the injuries that led to Liam's placement in foster care, offering information about his previous broken arm and omitting information about his tibia fracture and torso bruising and the Failure to Thrive diagnosis. Despite a DCF Program Supervisor case note, entered on February 2, 2022,[33] that acknowledged there are "still concerns/questions surrounding Liam's unexplained injuries as neither parent have given explanation as to how they may have occurred," DCF's May 2022 court paperwork incorrectly asserted that Mr. Ismalej-Gomez's previous arrest incorporated all of Liam's child abuse injuries.[34]

Based on the information provided to it, the Court granted DCF's Motion to Revoke Commitment, restored Ms. Rivera's legal custody of Liam, and ordered nine months of Protective Supervision. The Court records provided to OCA contain no new Court-ordered Specific Steps to govern the period of Protective Supervision, as required by Connecticut court rules.

Liam's lawyer and GAL visited Liam in his home in June 2022, prior to the court hearing. This was their first visit to see him since he was placed back with Ms. Rivera. Neither requested any case records regarding Liam from DCF, his medical provider/s, or Birth to Three, nor did they request such third-party records from DCF.

Thereafter DCF conducted twice monthly announced visits to Liam's home through December 2022. The lawyer and GAL did not visit again prior to Liam's death.

[33] DCF Policy 8-2 "Case Narratives" provides that narratives must be entered into the computer system within five (5) business days of the occurrence.

[34] A review of the arrest warrant reveals that the charge related only to the arm fracture that Mr. Ismalej-Gomez claimed was accidental, and that Mr. Ismalej-Gomez made no statements regarding Liam's other injuries, leaving the circumstances surrounding those injuries unresolved.

June – Liam's Death on/about December 28th, 2022

All of DCF visits to Liam's home were announced.

DCF policy calls for visits with children in open cases like Liam's to occur twice per month.[35] DCF's Purposeful Visitation Practice Guide provides that "[t]he decision to make unannounced visits should be determined **in supervision.**"[36]

All but one (March 2022) of DCF's visits to assess the safety and wellbeing of Liam and his sibling were announced, including after Mr. Ismalej-Gomez was released from prison in April 2022. DCF supervisor case notes are silent as to how home visits should have been conducted, or how Mr. Ismalej-Gomez' release from prison in April 2022 should have affected the supervision of the case. DCF's home visit plan was not revisited after Mr. Ismalej-Gomez absconded from Probation Supervision in June 2022.

DCF reported to OCA that visits to Liam's home did not raise any concern that Liam's father had rejoined the household. The DCF caseworker had spoken to Mr. Ismalej-Gomez in early May, following his release from prison, at which time, he provided an address and contact information, including email. DCF records document no further efforts to maintain contact with Mr. Ismalej-Gomez between May 10, 2022, and Liam's death in December.

DCF did not consistently use an interpreter to communicate with Ms. Rivera or conduct visits.

DCF policy requires that parents, guardians, caregivers, and children who are not English speaking or who speak only marginal English be "permitted to communicate together and with DCF staff using their preferred language or other method of communication during an investigation or when receiving services from DCF … [including] … during supervised visits."[37] DCF policy requires that whenever "reasonably possible," cases "shall be assigned to DCF staff who can communicate in the same language or by the same method as the clients (parents, guardians, caregivers, and children). When this is not possible, reasonable efforts to obtain a competent, authorized interpreter shall be initiated."[38]

Federal civil rights law requires that:

> All recipients of federal financial assistance, including child welfare agencies and state court systems, must comply with Title VI [of the U.S. Civil Rights Act] and its implementing regulations. Title VI states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity

[35] DCF Policy 20-1-1.
[36] DCF: A Practice Guide for Purposeful Visitation (2012), found on the web at: https://portal.ct.gov/-/media/DCF/Policy/BPGuides/20-1-1-PG.pdf
[37] DCF Policy 21-3.
[38] Id.

> receiving [f]ederal financial assistance." Discrimination under Title VI includes both intentional discrimination and disparate impact discrimination.
>
> Title VI's prohibition against national origin discrimination includes discrimination based on a person's birthplace, ethnicity, ancestry, culture related to national origin, or ability to speak English.
>
> To comply with Title VI, federally funded child welfare agencies are also required to take reasonable steps to provide meaningful access to each [Limited English Proficient] individual eligible to be served or likely to be encountered in their programs or activities.[39]

The DCF and Juvenile Court records indicate that both Ms. Rivera and Mr. Ismalej-Gomez were primarily non-English speaking,[40] and that their court proceedings and services required interpreter services. While Juvenile Court records indicate that translation services were consistently utilized during child protection proceedings, OCA found that certain supervised visits for Liam with his parents, while he was in foster care, did not utilize translation services (one DCF case note describes positive interactions between family members during a supervised visit, while also stating "the family is Spanish speaking and [undersigned Social Worker] is unable to understand the language"). Based on OCA's examination of billing records, several home visits conducted by DCF in the last months of Liam's life did not include translation services. DCF conducted twice-monthly home visits with Ms. Rivera after the return of her children between October 2021 and December 2022 (Liam's sibling was reunified with Ms. Rivera in October 2021 and Liam was returned in December 2021). DCF records indicate that the agency did not generate an invoice for translation services between August 16, 2022, and November 8, 2022.[41] During that time, four home visits took place. No translation services were invoiced between November 18, 2022 and Liam's death.[42]

The reunification assessment and support service that DCF put into place for Liam in December 2021 also did not utilize a Spanish-speaking provider. During the supervised visits conducted by the provider, records indicate that a translator was utilized on speaker phone.

Upon review of the OCA's draft report, DCF provided information that it used text translation, presumably for text communications between the assigned caseworker and Ms. Rivera. DCF indicated that it is "exploring other options."

DCF did not provide in-home services to support reunification.

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[39] U.S. Department of Health and Human Services Office for Civil Rights and U.S. Justice Department Civil Rights Division Joint Dear Colleague Letter outlining state child welfare agency obligations pursuant to Title VI of the 1964 Civil Rights Act, issued October 2016, and found on the web at: https://www.justice.gov/crt/title-vi-child-welfare-guidance.

[40] During the March 2021 DCF case conference to transition Liam's case from Investigations to Ongoing Services a notation was made in the DCF record that the family was Spanish speaking only. This fact is confirmed in court documents as well.

[41] Most home visits corresponded to an invoice for translation services through August 2022.

[42] Translation services corresponding to home visits were billed for 19 minutes on November 8, 2022, and 9 minutes on November 17, 2022. Translation services were frequently invoiced for 30 minutes or more for earlier home visits in 2021 and 2022. There were two home visits in December 2022.

Ms. Rivera completed the Hope, Educate, Love, Protect (HELP) program as part of the Court ordered Specific Steps entered in February 2021. While the HELP program website site indicates that this is an in-home parenting service, the case record reflects that Ms. Rivera was participating in office-based services, and at no time did a provider come to the family's home following reunification of the children—possibly due to the COVID-19 pandemic. Ms. Rivera attended seventeen sessions over the next few months, with the program closing on August 26, 2021. Records indicate that Ms. Rivera did not attend any sessions between June 2, 2021, and the date of her case closing, twelve weeks later. Notes from the sessions indicate discussions of basic parenting responsibilities, including nutrition, child development, and access to community supports.

As outlined above, DCF subsequently referred Ms. Rivera to Reunification and Therapeutic Family Time (RTFT) to facilitate Liam's sibling's return home and then Liam's return. Though the RTFT services can last for up to six months, in this case each child received approximately 1 month of supervised visits by the RTFT provider, with no ongoing role identified by DCF for the RTFT provider following reunification. No other childcare supports, financial supports, or in-home services were provided to the family, including home visiting or Birth to Three.[43] Upon the allegation that Liam was kidnapped and Ms. Rivera's false statements to the police regarding that incident that led to her arrest, Ms. Rivera was referred to a "General Parenting Program" class in the community, similar to the HELP program she had previously completed.

<u>There was inadequate follow up on Liam's health and wellbeing following his reunification with his mother—DCF policies not followed.</u>

Federal child welfare law requires that state child protection agencies have:

> a case review system for assuring that … a child's health and education record is reviewed **and updated**, and a copy of the record is supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care and is supplied to the child at no cost at the time the child leaves foster care if the child is leaving foster care by reason of having attained the age of majority.[44]

DCF Policy[45] provides:

> The Social Worker shall contact each service provider, including any professional who is assisting with assessment services, at least once per month in person or by telephone. Documented written reports and emails are also acceptable forms of provider contact.

DCF staff did not follow expectations regarding collateral contacts and acquisition of records. Medical and developmental records were not obtained and/or not updated. Providers for Liam were not contacted. As a result, there was inadequate monitoring of Liam's health and development to ensure his needs were met and address concerns adequately when they arose. It is not clear why these issues

[43] While DCF made referral/s to Birth to Three, successful engagement with the family was never accomplished and Liam did not receive services prior to his death.
[44] 42 U.S.C. 675(5)
[45] 20-1-1 DCF Purposeful Visitation and Contact Standards

were not identified or addressed by case supervisors. As outlined above, they were not addressed during the DCF Administrative Case Review meeting because this meeting was not held while Liam was home "under commitment."

September 2022- Liam observed by DCF to be thin and unable to verbalize.

DCF visitation records include the caseworker's observation that Liam appeared thin, and that Ms. Rivera stated that this was due to family genetics. During a home visit in October, the DCF record indicates that Liam was not able to verbally express himself and appeared to need intervention to assess his development.

October 2022- Liam seen by pediatrician and re-diagnosed as Failure to Thrive. Pediatrician called DCF.

At the age of 2 years and 3 months, Liam was seen again by his pediatrician. The medical record indicates that Liam, now 22 pounds, 4 ounces, had lost weight between the April and October 2022 appointments, and his pediatrician re-diagnosed him with Failure to Thrive. Unbeknownst to the pediatrician, Liam had been losing weight since his return to Ms. Rivera in December 2021. This visit occurred 8 weeks prior to Liam's death. The medical record documents that on October 28, 2022, the same day as Liam's appointment, the pediatrician called the DCF worker about Liam's weight decline. The medical record regarding this call reads as follows:

> I spoke to the DCF social worker of [Liam's] case and raised my concerns about his weight. He had normal weight gain while he was in the foster parent's [care] last year [sic].

The DCF record initially did not document the October 2022 call from the pediatrician, however a note about the call was entered into the DCF case record several weeks after Liam's death and following a meeting of the Child Fatality Review Panel[46] where the doctor's call to DCF was discussed.

Upon review of OCA's draft Report, DCF responded:

> The 10/28/22 narrative (entered 1/30/23) documents that the pediatrician called to report a weight concern but never reflects usage of the phrase "failure to thrive." The pediatrician ***raised no concerns regarding neglect or abuse.*** Prescribed Pediasure and changes in diet. (Emphasis added.)

The pediatrician made a same-day call to the assigned DCF caseworker regarding a potentially serious change in Liam's presentation since his return home from foster care. The medical record reflects the use of the word "concern," and during an interview with OCA, the doctor could not recall what terminology was used during the call. Consequently, OCA can make no conclusive finding as to the precise language used by the doctor in describing Liam's declining weight. OCA respectfully disagrees

[46] DCF is a statutory member of the Child Fatality Review Panel. The discussion about the doctor's call to DCF took place during Executive Session/non-public portion of the meeting. OCA is releasing that information pursuant to its authority to access and disclose otherwise confidential information necessary to conduct the activities of the office. Connecticut General Statute Section 46a-13n.

with DCF's reliance on a belated addition to the record made by the assigned caseworker after Liam's death.

There were no releases of information in the DCF file for the medical record, which assigned DCF staff never obtained, and the caseworker did not follow up with the pediatrician's office. There is no documentation that the case supervisor and program supervisor were aware of the pediatrician's concern about Liam's weight or helped the caseworker develop a plan for follow up. **The medical records show Liam had in fact been losing weight the entire year, as he weighed 24 pounds, 8 ounces at a medical visit while in foster care on November 30, 2021—a 2.5-pound weight loss following reunification.**

Child abuse and pediatric emergency doctors who treated Liam when he first came into foster care and who were consulted on this death review stated their opinion that given Liam's history of having been abused and needing foster care services, urgent follow up to the weight loss and re-diagnosis of Failure to Thrive was warranted, including consideration of hospitalization and immediate assessment of his physical health and possible causes of the weight loss, including child abuse and neglect. Other pediatric providers opined that certainly close follow up by the pediatrician and DCF was indicated.

Liam's lawyer and GAL did not seek or review primary records regarding Liam's health and development, and they did not conduct any visits with Liam during this timeframe.

November 2022- Ms. Rivera Falsely Reported to DCF that She Followed up with Liam's Doctor**.**

In November the DCF caseworker conducted announced home visits with Ms. Rivera and asked about Liam's weight. Ms. Rivera reported that various family members had been sick. She falsely reported that she had taken him back to the doctor and that Liam's weight was improving. The medical record reviewed by OCA shows that Ms. Rivera did not attend the scheduled doctor's visit in November and the doctor had no further contact with the family after the October appointment. The pediatrician acknowledged to OCA that she did not notify DCF of the missed appointment. The DCF record does not contain any documentation that staff followed up with the doctor.

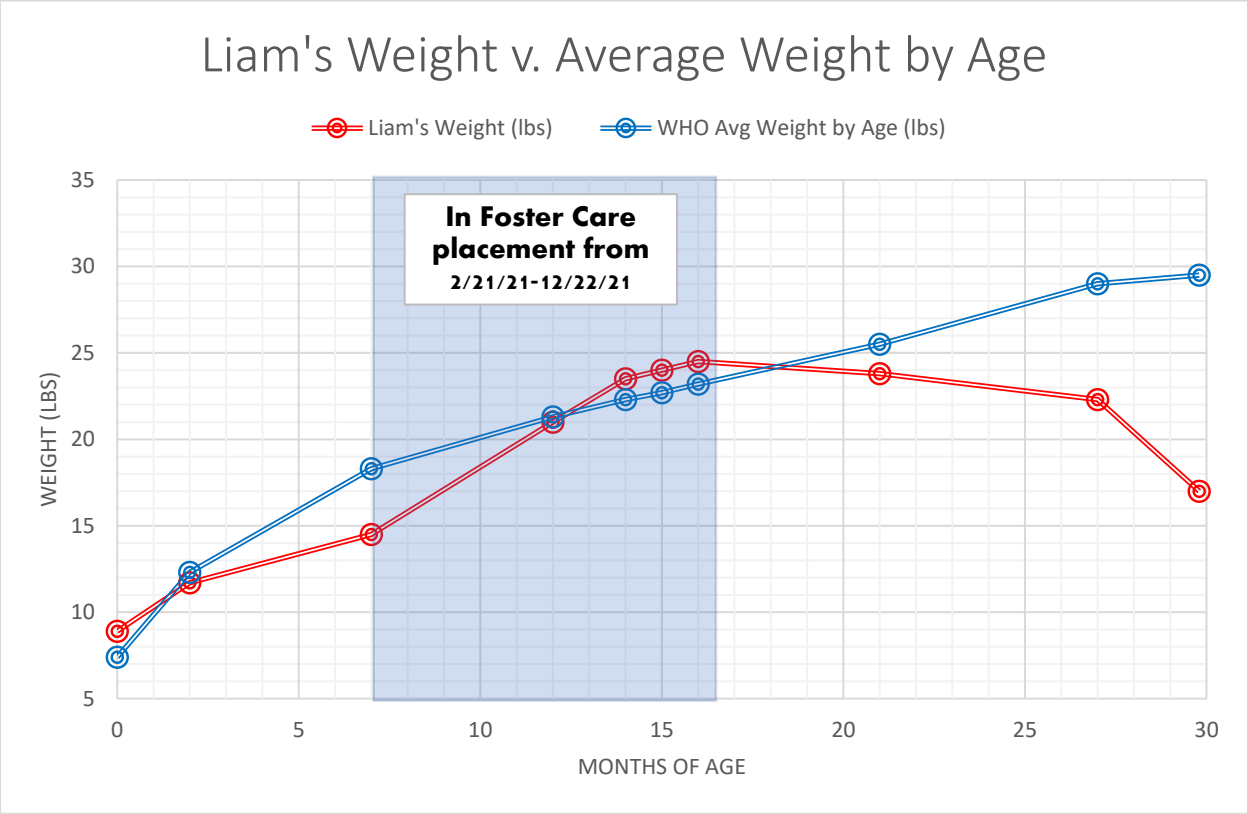
December 2022- Liam observed by DCF to be thin, sick.

DCF conducted two announced home visits with Liam and his family in December. DCF's notes from the first visit indicated Liam looked "well nourished," and healthy, but a December 20th visit note included observations that Liam looked like had lost weight again, and that he appeared tired and sleepy, and that he looked sick. Ms. Rivera reported that he had been sick on and off and did not have an appetite. The DCF caseworker encouraged Ms. Rivera to seek a weight check for Liam in January 2023. Liam died by homicide at the end of December.

LIAM'S DEATH WAS REPORTED ON JANUARY 2, 2023, AND DETERMINED TO BE A HOMICIDE.

On January 2, 2023, two-year-old Liam's body was discovered in a park in Stamford CT, after a report of his injuries and death were made to police. The Medical Examiner ruled Liam's death a homicide due to blunt force injuries to his head. While both of Liam's parents have criminal charges pending, neither has been charged with responsibility for his homicide.

The Medical Examiner reported that after Liam died, his weight upon post-mortem exam, conducted January 3, 2023, was 17 pounds, five pounds less than he weighed during his last doctor's appointment at the end of October, and seven pounds less than he weighed when he left his foster home. He was 2.5 years old at the time of his death. Liam died from blunt impact injury to the head with subdural hematoma.



ADDITIONAL CASE FINDINGS

Critical information was missing from the DCF record or belatedly entered. Certain information about DCF child interviews was entered after Liam's death and contradicted by police record.

DCF policy provides that case record entries must be made within 5 days of the event recorded. There is no agency policy regarding corrections to the record following critical events such as a child fatality or near-fatality. The DCF Area Office Director and the DCF Commissioner told OCA that, following Liam's death, the case worker was directed to enter additional relevant details into the record. Corrections are stamped with the name of the entrant and the date of the entry.

OCA noted throughout this Report that emails or text messages authored by DCF staff reflected case activity that was not captured in the case record at critical decision points. There are also multiple instances of notes entered very belatedly into the case record, weeks and even months after the recorded activity. Despite the executive directive referenced above that Liam's assigned caseworker should complete the record after Liam's death, several gaps in the record remained. Notably, the DCF

case record was amended to insert the following information into most of the home visitation records, with all amendments entered on January 18, 2023, weeks after Liam's death.

> LIAM'S SIBLING was interviewed away from mother in bedroom with the door closed.

The case record corresponding to the last DCF visit prior to Liam's death, December 20, 2022, was also amended following Liam's death to add:

> SIBLING denied any form of contact with Mr. Ismalej [Gomez]… During home visit SW did not visually see any signs of Edgar nor did the SW observe any items in the home that would indicate that an adult male was residing in the home.

The amended statement contradicts a police report which documents the caseworker's statement on January 6, 2023, that during her December 20th visit she did not speak to the children alone as she "normally would do," as the visit was "celebratory for the Christmas holiday." The DCF case worker told police that she observed Liam to be very tired and sleepy, explained by Ms. Rivera as a result of him not napping yet that day. The caseworker told police that she witnessed no visible injuries to Liam, and that whenever he incurred visible injuries such as a bump on his forehead or a mark, Ms. Rivera would send her a picture of the injury on the day it occurred.

Forensic interviews conducted with Liam's siblings after Liam's death indicate that Mr. Ismalej-Gomez was living with or frequently visiting with the family during the time-period prior to Liam's death.

<u>DCF did not timely pursue a Human Resource (HR) inquiry following Liam's death.</u>

As outlined above, a review of DCF records show that in handling Liam's case, assigned staff did not follow DCF policies in several critical aspects, including but not limited to the following: 1) they did not consistently contact collateral sources regarding Liam's health and wellbeing; 2) they did not acquire and review Liam's medical records; 3) they did not maintain contact with Adult Probation regarding Mr. Ismalej-Gomez; 4) they did not conduct the DCF six-month case review required in April 2022; 5) they did not consistently conduct home visits using interpreter/translation services; and 6) they did not document all pertinent activities into the DCF record, including meetings and decisions about Liam's custody and safety following his return home to his mother.

While OCA takes no position on what HR conclusions should have been made regarding assigned staff, we do find that an HR review should have been promptly initiated given the case circumstances. On April 5, 2023, more than 3 months after Liam's death, OCA requested from DCF all HR "communications and/or documentation" regarding Liam's case and/or death review.[47] DCF responded that there was nothing to provide.[48] Shortly thereafter, on April 11, 2023, the DCF legal director contacted OCA to follow up on OCA's meeting with the Attorney General's Office regarding

[47] OCA email to DCF legal director.
[48] Email from DCF legal director.

OCA's concerns about "misrepresentations" by DCF staff to the Juvenile Court in Liam's case.[49] The DCF legal director asked to be directed to "those statements so that it can be investigated whether DCF misrepresented anything to the Court." OCA then provided DCF counsel with specific information about such statements, and several are referenced in this Report. On May 1, 2023, the legal director, during an investigative interview, informed OCA that due to the concerns around staff documentation, an HR inquiry had recently been initiated.[50] In response to OCA's draft Report, DCF stated: "The OCA report did not prompt the internal HR investigation." However, no documentation was provided to amplify or clarify the matter. Following revisions to OCA's draft and provision of a "near final" report to DCF, OCA was again informed that DCF disagreed with our conclusions, that an "HR investigation was initiated in a timely manner, and [the Office of Labor Relations] found no 'just cause' for discipline." OCA was not provided any documentation related to the HR review, or any qualitative findings from DCF's internal death review.

Liam's lawyer and GAL did not meet the standards established by federal law, state law, and the Public Defender's Office for representing children in child protection proceedings.

Federal law requires that states ensure children in child protection proceedings are represented by an individual who may be a lawyer and who obtains a "first-hand, clear understanding of the situation and needs of the child."[51] State law codifies this provision by requiring the appointment of "counsel knowledgeable about representing such children," and who shall be "granted immediate access to (i) records relating to the child, including, but not limited to, Department of Social Services records and medical, mental health and substance abuse treatment, law enforcement and educational records without the necessity of securing further releases, and (ii) the child, for the purpose of consulting with the child privately."[52] The OCPD Performance Guidelines for Counsel for Children, referenced in the state contracts for assigned counsel, provide that lawyers will obtain records, consult with service providers, and assess whether the child is receiving the supports and services they need.

The requirements embedded in federal and state law as well as the state Performance Guidelines were not followed in Liam's case. Liam was minimally visited by his lawyer and GAL. From the time of his appointment in February 2021 until Liam's death nearly two years later, Liam's attorney saw him only two times, once on March 20, 2021, and once on June 1, 2022, the latter visit conducted shortly before the hearing on the state's Motion to Revoke Commitment of Liam. The GAL also saw Liam on two occasions, once on December 14, 2021, and once on June 1, 2022.[53] In the six months after DCF's Motion to Revoke Commitment was granted and Court-ordered Protective Supervision put in place, neither the GAL nor the lawyer visited with Liam.

Liam's attorney requested the DCF case narratives in March 2021, shortly after his appointment, but did not subsequently request DCF records for the remainder of the case. The attorney did not obtain any other records, such as medical records, or communicate with service providers. The GAL obtained

[49] Email from DCF legal director.
[50] May 1, 2023 interview, conducted by OCA, of a DCF regional office director, and attended by Deputy Commissioner Michael Williams and the DCF legal director.
[51] Child Abuse Prevention and Treatment Act, 42 U.S.C. 5106a(b)(2)(B)(xiii).
[52] Connecticut General Statute Section 46b-129a.
[53] The GAL also visited Ms. Rivera's home, where Liam's sibling was living, on December 1, 2021.

the March 2021 DCF case narratives from Liam's attorney. The GAL did not make any subsequent request for DCF records, requests for any other service provider records, or communicate directly with any service providers.

DCF Administrative Case Reviews (treatment plan meetings) occurred on April 16, 2021, and October 7, 2021.[54] Neither the attorney nor the GAL attended the meetings. There is no evidence in the DCF record that the attorney and GAL were provided with written notice of the ACRs in accordance with DCF policy. DCF internal permanency team meetings were held on August 11, 2021, October 21, 2021, and December 17, 2021. The attorney and GAL attended the meeting in August 2021, but did not attend those that occurred in October or December. The GAL stated that he was not invited to the permanency meeting that occurred on December 17, 2021.

Given that Ms. Rivera did not speak English, OCA inquired as to whether the attorney or GAL spoke Spanish or used interpreter services. Neither the attorney nor the GAL speak Spanish and neither submitted expense requests for the use of an interpreter. The attorney indicated that he utilized a Spanish speaking staff person to interpret for him.

Given Liam's age and inability to communicate, his attorney's lack of participation in case planning and failure to obtain records may run afoul of ethical obligations contained in the Rules of Professional Responsibility, particularly those that require lawyers to provide "competent representation"[55] and take "protective action" on behalf of a client with diminished capacity when necessary to prevent harm to the client.[56]

The GAL similarly did not obtain independent, first-hand information regarding Liam's needs and living situation throughout the duration of the child protection case.

JB-CSSD did not follow agency policies regarding pretrial or probation supervision of Mr. Ismalej-Gomez.

[54] An ACR was scheduled to occur in April 2022, and is checked off as completed, but there is no completed ACRI as would be expected if an ACR was completed or documentation in the record verifying it occurred.

[55] Rule 1.1 of the Connecticut Rules of Professional Conduct provide that "a lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness, and preparation reasonably necessary for the representation." The Commentary to Rule 1.1 provides, in part, "Competent handling of a particular matter includes inquiry into and analysis of the factual and legal elements of the problem, and use of methods and procedures meeting the standards of competent practitioners. It also includes adequate preparation."

[56] Rule 1.14 of the Connecticut Rules of Professional Responsibility provides, in part: "Client with Impaired Capacity (Amended June 26, 2006, to take effect Jan. 1, 2007; amended June 30, 2008, to take effect Jan. 1, 2009.) (a) When a client's capacity to make or communicate adequately considered decisions in connection with a representation is impaired, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client. (b) When the lawyer reasonably believes that the client is unable to make or communicate adequately considered decisions, is likely to suffer substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a legal representative."

On August 26, 2021, six months after Liam came into foster care, Mr. Ismalej-Gomez was arrested on charges of Risk of Injury and Assault 3, and he was arraigned the following day. These charges corresponded to Liam's broken arm, which incident occurred in January 2021. At the time of the arraignment, a full protective order was issued with Liam as the protected party. Mr. Ismalej-Gomez was also ordered to comply with DCF services and to surrender his passport, while awaiting trial. Despite JB-CSSD policies requiring documentation and frequent monitoring of individuals during the pretrial supervision period, there is no record of contact with Mr. Ismalej-Gomez by JB-CSSD between his arraignment and second arrest on January 19, 2022, following the alleged kidnapping/violation of the protective order incident.

On January 19, 2022, Mr. Ismalej-Gomez was arraigned on 2nd degree Kidnapping, Violation of Protective Order, 1st degree Custodial Interference, Risk of Injury, and 2nd degree Burglary. Mr. Ismalej-Gomez was incarcerated until his trial date on April 25, 2022, at which time he pled guilty to the initial Risk of Injury and Assault charges, and he was sentenced to 3 years' Probation, with 60 days served. His probation conditions required him to obey the protective order, provide a DNA sample, attend parenting classes, and comply with DCF.

Shortly after Mr. Ismalej-Gomez's release from prison on April 26, 2022, Ms. Rivera provided Probation with his cell phone number, and she advised the probation officer that she and Mr. Ismalej-Gomez were no longer a couple. On May 6, 2022, initial contact was made by Probation, and Mr. Ismalej-Gomez confirmed he would report the following week. On May 10, 2022, Mr. Ismalej-Gomez failed to report as required, and Probation reached out to him by phone. Mr. Ismalej-Gomez did present on May 17th, at which time Probation staff administered a risk/need assessment (LSI-R).[57] Probation notes indicate that there was a language barrier as Mr. Ismalej-Gomez did not speak English- however an interpreter was not used.

Mr. Ismalej-Gomez provided the probation officer with an address in Stamford, though the address was not verified per JB-CSSD policy. Mr. Ismalej-Gomez's assessment was scored for "administrative" supervision, but overridden without documented explanation, to "medium" supervision, likely due to the underlying charges and age of the victim. Subsequent review by JB-CSSD administrators after Liam's death revealed that there were also errors in the administration of the LSI-R. Additionally, given the family violence related charges, JB-CSSD review found that a separate screen, the Domestic Violence Screening Instrument-Revised (DVSI-R) should have been completed to inform the risk and supervision level, which given the facts of the case, would have resulted in a High supervision level, increasing the expectations and contacts with JB-CSSD significantly.

Mr. Ismalej-Gomez was texted by the probation officer to report by June 15, 2022. Mr. Ismalej-Gomez again did not report as scheduled. There are no case notes for the next three weeks. Probation made efforts to contact Mr. Ismalej-Gomez on July 8th via phone, but his provided number was out of

[57] The LSI-R is an objective, quantifiable, 54-item risk/need classification instrument. The instrument is composed of ten subscales that contain both "static," (e.g., Criminal History) and "dynamic," (e.g., Alcohol/Drug Problems, Companions, and Family/Marital) risk factors. Although the static risk factors generally cannot be changed, they are still predictive of re-offending. The dynamic risk factors are changeable and provide direction for focusing the intervention or change process.
https://portal.ct.gov/-/media/DCF/Policy/BPGuides/20-1-1-PG.pdf

service. Probation then texted Stamford Police inquiring if they had any contact with Mr. Ismalej-Gomez. On July 15, 2022, a letter was sent to the provided address by Probation, advising that Mr. Ismalej-Gomez was now in "violation status" and to contact Probation as soon as possible. On July 25th a second effort was made to contact Mr. Ismalej-Gomez via the provided phone number, and again this number was out of service. Probation notes indicate that the Violation of Probation started on this date.

On July 27, 2022, Probation contacted DCF for the first time since Mr. Ismalej-Gomez's initial arraignment on the Risk of Injury Charge (almost a year earlier in August 2021) and the DCF case worker reported that Mr. Ismalej-Gomez had been attending parenting classes (at the same provider as Ms. Rivera) but had missed the last two sessions. The DCF worker told Probation staff that she would have Ms. Rivera urge Mr. Ismalej-Gomez to contact the Probation officer. This is the only documented contact between DCF and JB-CSSD regarding Mr. Ismalej-Gomez prior to Liam's death despite policies of both agencies to conduct "collateral contacts" monthly as part of the case management process.

On August 2, 2022, Probation's letter to Mr. Ismalej-Gomez was returned due to listing an incorrect address. On August 4, 2022, Probation visited the provided address to find that no such address exists, which was then confirmed by Stamford Police.

On August 12, 2022, a Warrant for Violation of Probation was signed by the Court. Probation did not follow its policy in attempting to serve the violation of probation warrant. The probation officer did, on August 29, 2022, send information about Mr. Ismalej-Gomez to the Connecticut Intelligence Center (a criminal justice entity that facilitates the sharing of criminal related information) to be included in its weekly bulletin.

OCA reviewed JB-CSSD Pretrial Supervision and Adult Probation policies and met with JB-CSSD administration on three occasions. JB-CSSD administrators shared its internal findings with OCA and acknowledged that staff did not adhere to several policies governing supervision of Mr. Ismalej-Gomez:

- Pretrial staff did not enter Mr. Ismalej-Gomez' conditions of release into the case management system as required by agency policy. As a result, the conditions of release, exclusive of the surrendered passport, were not supervised by pretrial services from 8/27/2021 through 1/19/2022.
- Probation staff did not conduct the appropriate assessments on Mr. Ismalej-Gomez.
- Pretrial and probation staff did not follow agency policies for maintaining contact with DCF on a monthly basis, especially relevant given his condition of release included compliance with DCF.
- Staff did not timely verify Mr. Ismalej-Gomez' address and staff did not consistently follow CSSD absconder policies once Mr. Ismalej-Gomez did not report on May 17, 2022.

OCA found that no case plan was developed by probation staff, also in contravention of agency policy. While agency records document that a case plan was created during the May meeting with Mr. Ismalej-Gomez, CSSD officials confirmed that no case plan had in fact been created, and that the document referenced was likely a template.

Finally, records and discussion with JB-CSSD officials confirm that despite documentation that Mr. Ismalej-Gomez only speaks Spanish, an interpreter was not used by agency staff in communicating with Mr. Ismalej-Gomez. OCA finds that the lack of interpreter services may violate agency policy as well as the non-discrimination provisions of Title VI of the U.S. Civil Rights Act of 1964. JB-CSSD administrators averred that Mr. Ismalej-Gomez's conditions of probation were relayed to him in Spanish.

JB-CSSD administration recounted several steps they were taking to address identified case practice deficiencies, including its audit of the assigned probation officer's case load, and these actions are listed in greater detail below.

SYSTEMS ISSUES AND RECOMMENDATIONS

DEPARTMENT OF CHILDREN AND FAMILIES

OCA met with DCF executive leadership and conducted several interviews relevant to individual and systemic issues discussed in this Report. DCF provided data and information relevant to the findings and recommendations contained herein.

I. Urgent Need to Address Deficiencies in DCF Case Practice

OCA's review of DCF's care and protection of Liam Rivera revealed several deficiencies in case practice, including inadequate staff supervision, documentation, and assessment, collectively resulting in a catastrophic failure to ensure Liam's safety. Other critical incident/injury reviews conducted by OCA have revealed persistent variability in the quality of DCF's assessment and case management activities.

As OCA wrote in its February 2022 fatality report regarding the Fentanyl intoxication death of 1 year old Kaylee S.:

> OCA agrees that children should remain in their homes with family whenever possible, necessitating effective management of child protection concerns, including the timely provision of supports and treatment interventions to caregivers. Cases ... that involve findings of parental abuse or neglect of a very young child, and elevated risk or safety factors, are some of the most challenging that DCF manages. Inconsistencies in practice or lack of access to needed services increase the risk for poor, or even catastrophic outcomes, or unnecessary and traumatic removals of children into foster care. Keeping young children safely home with their parents requires vigilant attention to assessments, effective safety planning, and timely service delivery to these high-need families.

At the time of OCA's fatality report regarding baby Kaylee, OCA found that while DCF had undertaken several new policy and training initiatives to promote safety planning, DCF had "not yet demonstrated adequate quality assurance to determine whether identified deficiencies regarding safety planning and service delivery were being remedied."

In April 2023, DCF implemented a new quality assurance tool for reviewing "in-home" cases like baby Kaylee's and Liam's, cases where children are living with or returned to their parents following identified and/or substantiated concerns of abuse and neglect. The tool created by DCF *can* support regular quality improvement activities, such as identifying strong practice areas and areas needing

improvement. The tool complements a quality assurance tool DCF already has in place for reviewing its investigation practice. DCF's statement to OCA in response to this Report and attached at the conclusion of the Findings and Recommendations, speaks to an ongoing process to examine and strengthen the agency's continuous quality improvement framework.

OCA credits DCF's recent efforts to centralize and strengthen internal quality improvement activities, necessary for supporting high quality and consistent child protection work. DCF has been facilitating staff-wide trainings regarding its safety practice (ABCD safety paradigm), and the agency continues to refine its approach to safety-related "family arrangements" and cases involving caregivers with substance use disorder—indications that internal case reviews and data are informing agency efforts to improve practice in real time.

While OCA acknowledges the work being done at DCF, the systemic data regarding critical aspects of DCF case practice continue to reveal urgent concerns about the reliability of the agency's assessment, safety practice, and staff supervision—all issues present in Liam and Kaylee's cases. These practice areas are also a focus of the federal Child and Family Service Reviews (CFSR)—periodic mandatory audits conducted by the U.S. Department of Health and Human Services/Children's Bureau--and which examine states' compliance with federal child welfare laws. In 2016, the most recent CFSR, Connecticut scored poorly on the Child Safety Outcomes due, in part, to reviewers' concerns about the consistency of DCF's risk and safety assessment work.[58] Pursuant to a federally mandated Performance Improvement Plan (PIP) and with attention from the *Juan F.* federal court monitor, DCF demonstrated adequate improvement to complete the PIP in 2021.[59] However, agency data[60] since DCF's March 2022 exit from federal court (*Juan F.)* oversight shows significant concerns in the following critical practice areas:

1. The quality of investigations, including risk and safety assessment, case supervision, and staff contact with children.[61]
2. DCF "safety practice," including case supervision and the monitoring of safety plans.[62]
3. Practice in In-Home cases like Liam's (an ongoing area of review for DCF and OCA), including safety assessment, visitation, and case supervision.[63]

In response to OCA's draft Report, DCF provided OCA a summary of initiatives it has planned and/or underway (attached at the conclusion of this Report), which includes several activities designed to support quality improvement, child safety and child wellbeing. Given the urgency of DCF's work, it is essential that the legislature examine factors that may be contributing to the inconsistencies and/or recent decline in agency practice, and how administrative, operational, and quality improvement

[58] U.S. Department of Health and Human Services/Administration for Children and Families, *Child and Family Services Review, Connecticut Report*, 2016, found on the web at: https://www.acf.hhs.gov/sites/default/files/documents/cb/ct-cfsr-r3-final.pdf.

[59] The PIP standard is lower than the CFSR performance standard.

[60] Internal DCF data regarding supervision and monitoring of safety plans, supervisory support and case oversight, risk assessment, and contact with children are identified as areas needing improvement, and performance has declined in multiple areas over the last 12 months.

[61] Internal investigations (Differential Response) data has shown a steady decline after Quarter 1 2022.

[62] Internal reviews in March and December 2022.

[63] DCF provided OCA a summary of qualitative case review findings but was unable to provide specific data due to technical issues.

resources will be directed to ensure sustained systemic improvement. Given persistent findings of concern regarding practice in open cases like Liam's, and the end of federal court oversight of DCF, meaningful state oversight of DCF operations is warranted.

Recommendations

1. **Strong Quality Improvement Framework Needed for DCF**
    - DCF's Quality Improvement framework needs to be coupled with effective attention to staff performance, ensuring that staff have the training and resources to meet expectations and that there is timely accountability to these expectations.
    - QI efforts need to capture both the effectiveness *and availability* of the services provided to families around the state that address their most urgent needs—both basic service needs and clinical services that strengthen parental capacity and reduce child maltreatment. This information is essential for system design, including investments in family supports and clinical interventions.
    - DCF policy should require that structured family strengths and needs assessments, such as the NCFAS-G,[64] are used to assess family functioning and families' benefit from DCF intervention and service coordination. Such tools are not currently part of DCF's practice but are used by DCF-contracted providers who are working directly with families.

2. **Enhanced Oversight Needed for DCF Work**
    - OCA recommends that a comprehensive data dashboard be developed that speaks to DCF capacity (workforce and workload, internal resources), availability and effectiveness of services for children and families, as well as child safety, permanency, and wellbeing.[65] The dashboard should be developed with input from child welfare stakeholders, including legislators, agency staff, advocates, service providers, and the Statewide Advisory Committee (SAC). DCF has offered OCA the opportunity to offer

[64] North Carolina Family Assessment Scale for General Services (NCFAS-G). In addition to the six domains of the NCFAS (Environment, Parental Capabilities, Family Interactions, Family Safety, Child Well-Being, and Youth Well-Being), the NCFAS-G adds the domains of Social/Community Life, Self-Sufficiency, and Family Health for use with a wide variety of programs and families.

[65] As Casey Family Programs describes: "Nearly all important agency performance questions fall into one of three categories: system capacity, program quality, or child and family outcomes:

1. System Capacity: Does the agency have sufficient resources in place to meet the demand and need for services? Is the agency effectively utilizing and distributing available resources across the jurisdiction?
2. Program Quality: Are agency programs and processes functioning efficiently and effectively? Are services being delivered in high-quality ways that meet child and family needs? Are services effectively reducing racial disproportionality and disparities in the system?
3. Child and Family Outcomes: Is the agency making the right decisions about cases as they progress through the child welfare system? Are the agency's interventions successful in keeping children safe and improving outcomes for families?"

Blancato, L., Kleiman, S., Casey Family Programs Publication, *How can executive performance dashboards support child welfare agency effectiveness*, found on the web at: https://www.casey.org/performance-dashboards-effectiveness/

input into its public-facing webpage.[66] Several states have developed various public-facing child welfare dashboards.

- State law should be amended to strengthen the role of the Statewide Advisory Committee for DCF, enhance membership, align the SAC's duties with federal requirements for state Citizen Review Panels,[67] and include a specific focus on DCF's resources, case practice data, child and family outcomes, and the quality and availability of services to support children and families. Consideration of additional or alternative oversight measures should also be undertaken. Specific reports by DCF to the SAC should be required.
- State law should be amended to require DCF affirmatively report regarding child fatalities and near fatalities consistent with the federal CAPTA provisions, which read:

> States must develop procedures for the release of information including, but not limited to: the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; the result of any such investigations; and the services provided by and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality or near fatality.[68]

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

- The legislature should consider providing OCA with staffing necessary to support monitoring of DCF child welfare performance. OCA was created in 1995 following the death of a child under DCF supervision. While the legislature directed the Office to investigate child fatalities, including those children involved with the state, the Office was also given responsibility and authority to investigate and report regarding a range of publicly funded systems for vulnerable children. Concurrently, for the last 30 years, the *Juan F.* class action-based consent decree provided an adjacent structure for internal and external oversight of DCF, with a federal monitor's office producing regular public reports regarding DCF performance. Since DCFs successful exit from that consent decree in March 2022, the state has been operating its child welfare agency for the first time in three decades without the court-based structure for external review and public reporting. While OCA has worked within existing resources to conduct

[66] In recent months, DCF has begun posting certain Results Oriented Management (ROM) reports to their website--quantitative reports regarding child maltreatment and permanency, several of which correspond to various federally mandated measures. The reports, while informative, do not yet include several important aspects of agency capacity, performance, and service delivery such as: caseloads; safety planning; and meeting children/families' service and support needs. OCA remains in ongoing discussion with DCF regarding the public-facing reports.

[67] Sections 106(c)(4)(A)(i) and (ii) of the Child Abuse Prevention and Treatment Act (CAPTA)

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

additional systemic review of certain child welfare activities since *Juan F.* ended, given the Office's broad responsibilities, additional staffing would be needed to do this work continuously.[69]

II. The Legislature should review the impact of telework and workloads on DCF case practice and supervision, as well as progress towards implementation of a new information management system.

Covid-19/Teleworking

It is important to understand the systemic concerns outlined above with the implications of the recent pandemic in mind. COVID-19 impacted everything about how human service work could be done and introduced widespread teleworking into industries where virtual work had only been sparingly used, if at all. The impacts of the pandemic and resulting changes in how work is done are still unfolding. Emerging from the pandemic, collective bargaining agreement/s[70] permit DCF staff, including the bargaining class that Liam's social worker and social work supervisor are part of, to telework up to 80% of the time, although home visits have continued to be conducted in person per DCF policy. As stated throughout this report, OCA found that basic agency standards for case assessment, supervision, and even case documentation, were not followed in Liam's case. It is essential to understand, from a data-driven and staff/consumer lens, how teleworking at DCF impacts, positively and negatively, the critical functions of the agency, including engagement with children and families as well as recruitment and retention of staff, professional development, and supervision—and whether DCF can meet its mandates with a largely virtual workforce. Legislative inquiry is warranted.

Caseload Trends

Additionally, caseload volumes affect the quality and consistency of child protective service work. Caseloads have consistently been identified in Connecticut and nationally as a key indicator of child welfare performance and staff retention.[71] Accordingly, OCA examined the assigned caseload reports for the worker assigned to Liam and his family. The worker's caseload did not exceed capacity standards set by the agency as measured on the first of each month through 2022. However, the worker's caseload capacity was *near* the maximum (over 90% capacity) for much of the final six months of Liam's life. Child welfare research confirms that maintaining reasonable caseloads for front line child protective service workers and their supervisors is essential for ensuring consistent and effective practice. Notably, a 2018 *Juan F.* DCF Strategic Plan, designed to achieve the state's exit from federal court oversight, included the goal to "Hire and maintain [social worker] and [social work supervisor] staffing levels to consistently achieve caseload standard of 75%."[72]

DCF administrators have recently shared with OCA concerns about workforce recruitment and retention and stated that workforce issues had impacted various aspects of DCF's investigation

[69] OCA has 8 allotted Full Time positions. Current employees cover: 1) Intake and direct child and family advocacy; 2) child fatality review; 3) facility review and conditions of confinement; 4) complaint-based systems investigations; 5) annual reporting; and 6) assignments to state taskforces and working groups.
[70] https://portal.ct.gov/-/media/OPM/OLR/Notices/Telework-Award122721.pdf
[71] https://www.childwelfare.gov/topics/management/workforce/caseload/
[72] *Juan F.* Strategic Plan Data Group, Quality Assurance + Plan Update, found on the web at: https://portal.ct.gov/-/media/DCF/SAC/2019/JuanFstrategicplanfinalpdf-Dec-handout.pdf.

practice in the past two years. While DCF is working to resolve concerns, given fluctuations in the human services/child welfare workforce, it will be imperative for the state ensure a full and well supervised staff at DCF.

Recommendations

1. There must be strategic and ongoing examination of the impact of telework on DCF's core practice expectations as well as staff retention and professional development and quality assurance data should be utilized to shape telework guidelines and expectations.
2. Regular public reporting regarding agency capacity, including workforce retention and recruitment and caseload capacity should be instituted to inform stakeholders and policymakers' investments and supports of agency hiring.
3. To the extent that DCF has identified the agency's information management system (LINK) as a hindrance to internal QI efforts, there must be a timely and resourced plan to address this concern.

III. Consistent Practice with Young Children and Their Caregivers Needed

Liam was diagnosed with Failure to Thrive twice during his short life, once when he was coming into foster care at age 7 months, and later following his return to his mother's custody. Yet DCF records do not speak to knowledge or a comprehensive plan regarding Liam's medical care and development. Medical records were not obtained, medical care was not verified, and though multiple Birth to Three referrals were attempted, Liam was never successfully connected with services. It is essential that there be consistent case practice, inclusive of appropriate collateral contacts, record acquisition, and frequent supervisory review pertaining to the safety and health of very young children like Liam. DCF has a comprehensive practice guide for working with children birth to five, but DCF data regarding case assessment, collateral contacts, and supervision indicate more work is needed to ensure the guide is incorporated into daily case work. As DCF continues to roll out training updates regarding its safety practice, it will be important to include a specific focus on practice and policy expectations for families with very young children and ensure corresponding quality improvement efforts. DCF's response to OCA's draft Report references new initiatives related to identifying and assessing failure to thrive, as well as related training for staff.

Recommendations

1. OCA recommends development of clear protocols, including supervisory checklists, to assist in operationalizing DCF's Birth to Five practice guide, and support consistent practice in cases involving very young children. Caseworkers should be directed to gather information at least monthly regarding the health and development of children zero to twelve months of age, with clear protocols for when to seek internal expert consultation.
2. OCA recommends working with providers, child abuse doctors, family advocates, and members of the DCF Advisory Committee/s to update policy, case management expectations, supervisory protocols and checklists, and QI tools pertaining to cases involving very young children.
3. OCA recommends that a data-driven analysis be developed regarding the available service array for families with young children, to identify areas of the state where families may have unmet needs for treatment, parenting support, childcare, or other services.

IV. Statutory Amendment Needed to Permit Transitional Reunification of Children in Foster Care—DCF Not Currently Authorized to Place Children Home "Under Commitment."

As referenced in the body of this Report, state law prescribes that when a child is adjudicated neglected, the Court orders a disposition from a menu of statutory options,[73] including commitment of the child to DCF foster care, and such disposition must serve the best interests of the child. Accordingly, when Liam and his sibling were adjudicated neglected in February 2021, the Court ordered them committed to DCF custody and determined that commitment served their best interests. State law then required a permanency plan be filed by the state within 9 months.

Legal paperwork filed by DCF in November 2021 asked the Juvenile Court to approve a permanency plan of reunification for Liam with Ms. Rivera, with no proposed timetable for reunification, and no accompanying motion to end DCF's commitment and restore Ms. Rivera as the children's custodian. To effectuate reunification of a child in foster care with a parent, state law requires a party to file a Motion to Revoke Commitment of the Child, and the Court must find that the "cause for commitment no longer exists," and that reunification serves the best interest of the child.[74] Without invoking these procedures and without informing the Court, however, DCF reunified Liam with his mother in December 2021, where he remained for six months prior to DCF requesting the Court restore Ms. Rivera's custodial rights.

During an interview, the DCF Area Office Director represented to OCA that the agency returned Liam and his sibling to their mother pursuant to an extended "trial home visit," and that such placements are proper and documented in the DCF record when utilized. OCA checked Liam's record and it did not reflect that he was sent home pursuant to a trial home visit. However, whether the placement by DCF is retrospectively characterized as a "trial home visit," or "placement home under commitment," state law does not grant DCF unilateral authority to reunify children committed to state custody by order of a court. Further, there is no DCF practice guide or practice-related policy defining the parameters, including the requirement for legal approval, of a child's placement home "under commitment" or an extended "trial home visit."[75]

As outlined earlier in this Report, DCF stated that it is authorized under state law to return a child to a parent without specific court approval, given its authority to place a child with a "relative caregiver." However, "relative caregiver" is defined in state law as an individual who is "licensed or approved to provide foster care."[76] Further, sending a child home "under commitment" pursuant to DCF's discretion, without seeking judicial findings, approval, and accompanying orders, circumvents the statutory requirements for child protection proceedings. Such informal custodial arrangements also complicate supervision of the child, custodial decisions, a parent's access to public benefits, and liability for children's safety. There is also risk of confusion or disagreement regarding the due process

[73] Connecticut General Statute Section 46b-129(j)(2).
[74] Connecticut Practice Book Section 35a-14.
[75] DCF produced a policy, 2-2-1.2, regarding "trial home visits," but this policy is a revenue-enhancement policy regarding conditions under which DCF can seek federal reimbursement for children's board and care. The policy includes no information that would guide caseworkers and supervisors regarding the utilization of such visits.
[76] Connecticut General Statute Section 46b129(j)(1) cross-referencing Section 17a-126.

rights of parents should DCF subsequently decide the child should not remain informally with the parent, or if one of the other parties, such as the child's attorney, should grow concerned about the child's tentative living situation.

Following the investigative interview wherein DCF asserted that Liam was placed home under a "trial home visit," OCA reviewed data in the DCF system and determined 1) that there were several children currently home on such a status, some for multiple months, and 2) that not all children home under commitment were in fact tracked as being home under a "trial home visit." As stated above, Liam and his sibling were not marked in the DCF system as being home "on a trial home visit." Accordingly, OCA cannot determine how often similarly situated children—children in DCF foster care living under DCF guardianship—are returned home for an extended and informal trial period without judicial notice or approval.

Trial home visits, or gradual reunification plans, may be a useful tool to support safe and developmentally appropriate transition of children from DCF guardianship to their parent/caregiver's custody. However, agency guidelines and state law amendments are needed to create standards and guardrails for this practice and avoid the dangerous and chaotic chain of events that unfolded in Liam's case.

Recommendation

State law should be amended to permit a process for notice and Court approval of a trial home period, inclusive of a process for setting expectations regarding duration of a trial home period, service delivery, case supervision, and safety planning, where applicable.

V. Statutory Amendment Needed to Ensure Foster parents Are Consistently Notified of Juvenile Court Hearings and the Right to Be Heard — As Required by Federal and State Law.

Liam's foster parent was not provided with written notice of her right to be heard in Court regarding Liam's permanency plan, and the case record provided to OCA does not contain a copy of written notice. State law provides:

> A foster parent, prospective adoptive parent or relative caregiver shall receive notice and have the right to be heard ... in any proceeding concerning a foster child living with such foster parent, prospective adoptive parent or relative caregiver. A foster parent, prospective adoptive parent or relative caregiver who has cared for a child or youth shall have the right to be heard and comment on the best interests of such child or youth in any proceeding under this section which is brought not more than one year after the last day the foster parent, prospective adoptive parent or relative caregiver provided such care.[77]

[77] Connecticut General Statute Section 46b-129(p).

Federal law requires that DCF notify the foster parent of the time and date of the hearings regarding the child and specify the foster parent's right to be heard as to the child's wellbeing.[78]

During this investigation, OCA met with foster parents and advocates for foster parents who stated that they do not consistently receive information about their right to be present and provide the Court information on the child in their care. Foster parent advocates/representatives also told OCA that at times they are actively discouraged from attending by caseworkers. DCF's response to this Report includes its commitment to a foster parent "Bill of Rights," and ensuring consistent communication and partnership between foster parents and the state.

Recommendation

OCA recommends that there be a system of accountability for ensuring appropriate notice to foster parents as required by state and federal law. Given that federal law provides that the state agency receiving Title IV-E funds (DCF) must provide notice, OCA recommends that state law or Connecticut Practice Book rules be amended to require DCF to provide the Juvenile Court with a copy of the written notice sent to the foster parent.

VI. Reliable Notification to Lawyers and GALs of DCF Case Plan Meetings Needed

OCA found that in this review and another recent critical incident review, DCF did not provide the lawyer/GAL for the child consistent written notice of administrative meetings concerning the child, including permanency planning meetings and federally/state required Administrative Case Reviews. Lawyers' participation in these case planning meetings is important to ensure the child is safe, and getting their needs met.

Recommendation

OCA recommends an automated and electronic notification process to attorneys and Guardians Ad Litem for DCF client-centered administrative meetings, with quarterly or bi-yearly reports to the OCPD confirming notice to attorneys of Administrative Case Reviews. DCF permanency plan motions/accompanying studies provided to the Juvenile Court should include information regarding dates of ACRs and permanency planning meetings, any identified case plan concerns, and attach a copy of the notice to the attorney/GAL.

VII. Legal Parties Should Receive Notification of Any New Report of Abuse/Neglect of a Child in a Child Protection Proceeding

When DCF investigated the January 2022 violation of the protective order by Liam's parents, there was no notification to the child's attorney or GAL, and no timely notification to the lawyers that DCF substantiated Liam's father for neglect. Accordingly, there was no inquiry by any of the lawyers into the circumstances surrounding this major case event.

[78] Federal law, Title IV-E, requires that "the foster parents (if any) of a child and any pre-adoptive parent or relative providing care for the child are provided with notice of, and a right to be heard in, any proceeding to be held with respect to the child,..." 42 U.S.C.S. 675(5)(G). Federal regulations require the IV-E fund receiving agency to provide such notice. 45 C.F.R. 1356.21(o).

Recommendation

> OCA recommends that state law be amended to require timely notification to attorneys and GALs of record whenever a new allegation (accepted or non-accepted for investigation) of child abuse or neglect is made to DCF, whether to the Careline or the regional office staff. Lawyers and GALs of record should also be informed of DCF's disposition of the allegation and provided a copy of the investigation.

OFFICE OF THE CHIEF PUBLIC DEFENDER

The OCPD Should Strengthen Legal Representation of Children

OCA discussed issues contained in this Report on multiple occasions with administrator/s from the Office of the Chief Public Defender, and the OCPD shared information and records necessary for this review.

Counsel for children in child protection proceedings are assigned by the Office of the Chief Public Defender of the Division of Public Defender Services (OCPD).[79] While OCPD does have a small number of employees who represent parents or children in a limited number of child welfare cases, most parents and children are represented by private attorneys under individual contract with the OCPD.

As outlined above, OCA found that Liam's lawyer visited with him only once in the 12 months prior to his death in December 2022, and obtained no records regarding his care and treatment by DCF or other providers during this timeframe. Given Liam's age he was entirely dependent on his lawyer to obtain independent information and ensure that state and local agencies were meeting his needs.

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 parties] … the child needs an advocate should the state fail to deliver on necessary services and actions due to fiscal constraints and organizational failures.[80]

As stated above, federal law requires that representatives for children "obtain firsthand, a clear understanding of the situation and needs of the child."[81] In Connecticut, the primary role of counsel for the child is 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

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[79] The OCPD provides for the representation of indigent adults in criminal matters, representation of children in juvenile delinquency matters, and representation of children and parents in child welfare maters. For criminal and delinquency matters, OCPD has employees who represent individuals for whom the court has appointed counsel. In addition, OCPD manages contracts with independent counsel for matters in which the OCPD may have a conflict.

[80] Pitchal, 2006; Taylor, 2009.

[81] 42 U.S.C. § 5106a(b)(2)(B)(xiii).

other incapacity, the counsel for the child shall advocate for the best interests of the child."[82] Where the Court finds that the child "cannot adequately act in his or her own best interests and the child's wishes, as determine by counsel, if followed, could lead to substantial physical, financial or other harm to the child unless protective action is taken, counsel may request, and the court may order that a separate guardian ad litem be assigned for the child . . .."[83] Pursuant to Connecticut law, the Guardian ad Litem (GAL), is to "perform an independent investigation of the case and may present at any hearing information pertinent to the court's determination of the best interests of the child." When a GAL is appointed, the Court should set out the scope of duties of the GAL in the specific case.[84]

State law requires that OCPD "establish training, practice and caseload standards for the representation of children and youths."[85] As outlined in this Report, the OCPD has adopted Performance Guidelines for Counsel in Child Protection Matters. The Guidelines for lawyers representing children provide that lawyers should "visit with the client in person at least four times a year and whenever the placement is changed." The Guidelines advise lawyers for children to "interview the caregiver and other family members or staff in any placement," "independently consult with service providers to assess the child's progress and well-being and to determine if additional services are needed," and regularly "obtain records from the child's medical, educational, and childcare providers to assess the development and well-being of the child client."[86] The Guidelines include additional guidance for lawyers for "very young children."[87] These include guidelines that the lawyer should visit twice per quarter and every time the child changes placement, interviewing caregivers and family members or staff in any placement, independently consult[ing] with service providers to assess the child's progress and well-being and to determine if additional services are needed." Records from the child's medical, educational, and child-care providers should be obtained at least every 120 days.

With respect to GALs, the Guidelines are more limited. The role of the GAL is "to determine and speak on behalf of the best interest of the child in the proceedings that are the subject of the guardian ad litem appointment, without being bound by the child's preferences." GALs are directed to "meet with the child as soon as possible after being appointed by the court" but there are no other articulated requirements to visit the child. The guidelines direct the GAL to "independently gather and review all records and . . . not rely solely on the representations of any party or counsel." Further, "[i]n conducting an independent assessment of the best interest of the child, the guardian ad litem shall, as allowed by counsel, meet with collateral witnesses, including biological parents, foster parents, family

[82] Connecticut General Statute Section 46b-129a(2)(C).
[83] Connecticut General Statute Section 46b-129a(2)(D).
[84] "The duties of the guardian ad litem, however, are contextually specific to the case at hand, and the scope of those duties should be set by the trial court judge and communicated to the guardian ad litem. Because those duties may subsume those traditionally performed by counsel when counsel is the child's sole representative; see Connecticut General Statutes § 46b-54 (c); counsel's duties must be similarly articulated by the court." *In re: Tayquon H.*, 76 Conn.App. 693, 708 (Conn.App. 2003).
[85] Connecticut General Statute Section 51-296.
[86] https://portal.ct.gov/-/media/OCPD/Forms/Assigned-Counsel/CT_Performance_Standards_For_Counsel_In_Child_Protection_Matters_-Rev_1-2017.pdf
[87] The term very young children is not defined in the Guidelines.

members, service providers including but not limited to teachers, medical professionals and DCF contractors."[88]

With regard to training for lawyers, OCPD contracts for pre-service and in-service training of lawyers representing children, covering a range of topics pertinent to the representation of children and adult clients. Lawyers with new contracts to practice in Juvenile Court are required to participate in 4 days of pre-serving training facilitated by experienced practitioners across the state.

Due to the independent contractor system, however, there are no current caseload standards for assigned counsel for children. OCPD does not have the ability to track when cases close, as that occurs through the court process. Given the nature of independent contractor work, OCPD also does not have information about the amount of non-contract legal work an assigned counsel must also be handling, creating additional difficulties in setting caseload/workload standards of expectations. OCPD reported to OCA that they do not have an adequate number of assigned counsel for children, as recruitment and retention of lawyers has become increasingly difficult due to the historical compensation structure in place prior to the newly passed budget. Adequate compensation, administrative support, and other case supports, along with enhanced quality assurance mechanisms are needed to strengthen representation for children in juvenile court proceedings.

From a systems perspective, while lack of adequate payment does not relieve any lawyer from their ethical obligations, compensation for lawyers representing children in these cases has historically been low and stagnant, and the fee schedule heretofore in use has not allowed lawyers to bill for several expectations codified in federal and state law or contained in the OCPD Performance Guidelines, including acquiring and reviewing records, consulting with treatment providers, calling state or local agency providers, or convening with providers or case managers to address unexpected issues or concerns. These activities are particularly critical for children who have complex treatment and developmental needs, and/or children who cannot effectively communicate because of minority, like Liam. The OCPD sought and recently received additional funding from the state to support recruitment and retention of lawyers for children in child protection proceedings, citing the challenges in maintaining an adequate system of legal services for this highly vulnerable population of children. The recently approved state budget increases funding for OCPD "assigned counsel" to address this concern. It will be important for policy makers to ensure that children have well trained and effective counsel to represent them in these sensitive proceedings.

With regard to oversight of the quality of lawyering, the system's reliance on independent contractors throughout the state creates challenges for ensuring the adequacy of representation for children. OCPD administrators reported to OCA that they conduct regular billing audits to review assigned

[88] Connecticut General Statutes 46b-129a(2)(A) states that "[i]f the child's parent or guardian has been accused by a competent witness of abusing the child, or of causing the child to be neglected or uncared for, upon the assignment or appointment of counsel, such counsel shall be granted immediate access to (i) records relating to the child, including, but not limited to, Department of Social Services records and medical, mental health and substance abuse treatment, law enforcement and educational records, without the necessity of securing further releases, and (ii) the child, for the purpose of consulting with the child privately."

counsel's compliance with certain Performance Guidelines, including visits with children.[89] OCPD also conducts informal observations of contract attorneys' in-court performance, where possible. If observations raise concerns or if attorneys are not billing for activities in which they should be engaging, like visiting clients, OCPD staff meet with lawyers who are not meeting standards, and may put them on an improvement plan, or in some cases, will terminate or not renew a contract. Given that requesting records and independently assessing a child's case are not billable activities, they are not subject to audit review by OCPD. Additionally, as independent contractors, assigned counsel are not subject to supervision or qualitative file review by OCPD. It should be noted the tension between holding lawyers accountable to the standards and retaining enough assigned counsel to handle the workflow, an increasing challenge in recent years as attrition rates have accelerated, and according to OCPD, several experienced juvenile court attorneys ended their contracts.

Recommendations

1. While the state agency guidelines and statutory expectations for lawyers who represent children are laudable, resources must support the realization of those requirements. Resources could include federal Title IV-E revenue received by the state and an hourly rate for lawyers that matches the performance guidelines and contractual expectations. Importantly, the recent state budget includes increases for assigned counsel for children, requested by the OCPD.
2. In addition to higher hourly and case rates, OCPD should also explore additional quality assurance measures that may be built into contracts to ensure adequate legal representation is provided to children.
3. OCPD may consider expanding categories for which assigned counsel may bill hourly, to include obtaining and reviewing records and communicating with service providers. It may also be prudent to permit billing for paralegal and/or social workers for tasks like record review and other fact-gathering activities such as meetings with service providers.
4. OCPD should consider additional administrative and practice supports that can be afforded to assigned counsel, including providing access to agency-based investigators, social workers, and other support staff.
5. OCPD should review and strengthen the performance guidelines for appointed Guardians Ad Litem to clarify expectations for these representatives of children.
6. State law should be amended to ensure that during child protection hearings, that the Court canvas the lawyer for the child to ensure that the child has been seen and that the lawyer has independently gathered information necessary to advancement of the client's interests. OCA notes that children are legal parties to these proceedings, as are their parents. Adult parties are often present during hearings, and they are canvassed by the Court at various stages of the case to ensure that they have an opportunity to confer with counsel and that they understand the nature of the proceedings. Children are typically not in the court room, and there is no parallel procedure to ensure the due process/statutory right to counsel for the child.
7. The legislature should create a working group to review the delivery of legal services to children in child protection proceedings and make necessary recommendations to support high quality representation for children.

[89] Audits involve a review of billing information but do not include any qualitative file review. This kind of review would not provide OCPD with information regarding non-billable activities, like contacting the child's pediatrician, talking to the child's school, or requesting and reviewing DCF or other relevant records.

JUDICIAL BRANCH- COURT SUPPORT SERVICES DIVISION

OCA and JB-CSSD met several times during the pendency of this investigation to review aspects of Mr. Ismalej-Gomez's case and the agency's policy and quality assurance framework for ensuring consistent supervision practice. JB-CSSD officials acknowledged that in Mr. Ismalej-Gomez's case, several agency policies regarding pretrial and probation supervision were not followed. JB-CSSD provided OCA with its internal review of Mr. Ismalej-Gomez's case and what action steps the agency has/is undertaking to address system improvement, including revision of several agency policies, enhancement of quality assurance reports, and updated memorandum and training for staff. OCA references some of this information below but includes a full recounting of JB-CSSD action steps in the Agency Responses section below.

JB-CSSD has numerous policy requirements for supervision by pre-trial/probation staff. JB-CSSD has several quality management reports to help administer and review supervision practices and outcomes, including: timeliness of needs/risk assessments; contact (with probationer) standards; and referrals for treatment; case plan timeliness; and violations/re-arrests. The agency supervisors, and at times, regional and central administrators, review the quality of case work to identify areas of strength and areas needing improvement.

During this investigation, JB-CSSD reported to OCA that they are making several revisions to agency policies, including clarifying expectations for quality assurance reports, and providing training and guidance to staff to address deficiencies and areas for improvement identified during OCA and JB-CSSD's concurrent reviews. Such changes include, but are not limited to:

1. Clarifying frequency for review of quality assurance reports;
2. Developing policy memorandum to ensure administration of domestic violence screening is facilitated in non-intimate partner family violence cases such as Liam's;
3. Addressing policy to enhance supervisory oversight of case management practices by probation officers and ensuring that regional management staff review reports measuring compliance with performance standards.

JB-CSSD also stated that it is reviewing the adequacy of agency policies for home visits and home address verifications, as well as use of interpreter services, to see if additional changes are needed.

OCA acknowledges that there are many quality management reports used by JB-CSSD supervisory/regional/administrative staff. OCA finds that additional improvements are needed to ensure consistent supervision of individuals on pretrial and probation status.

Teleworking

The Judicial Branch allows certain JB-CSSD employees to participate in telework, but adult and chief (supervisory) probation officers, like those assigned to Mr. Ismalej-Gomez's case, are exempt from this allowance because of their job responsibilities.

Caseload

JB-CSSD indicated that at the time the Adult Probation Officer was assigned to Mr. Ismalej-Gomez's case, the APO was transitioning to a new role. As such, the APO had a mixed caseload, and because

of this transition exceeded the desired workload size. Due to the varying contact standards per case type, this volume should not have affected meeting the contact standards in this case.

Recommendations

1. Modification of supervision policies and expectation should be considered where a child is a victim, including enhanced home visit/address verification (to take place within 30 days in all cases); explicit requirement for administration of the domestic violence/family violence screening tool; and specific expectations for DCF and service provider contacts. Quality improvement reports, inclusive of record audits, should be aligned with expectations in this policy.
2. JB-CSSD should examine policies regarding engagement and supervision of individuals where there are risk indicators that may impact a child in the individual's household (e.g., individual impaired by substance misuse; individual convicted/charged with violent offenses), including consideration of whether the presence of young children dictates a more frequent contact/supervision schedule or more intensive supervision and service delivery.
3. JB-CSSD should consider protocols for when a joint visit/s with DCF should be conducted when cooperation with DCF is a condition of release/probation. Such a practice would a) ensure connection between the agencies serving/supervising the individual; b) ensure expectations for service participation and other agency expectations are clearly established and communicated; and c) continue to support verification of household and address of supervised individual.
4. Acknowledging JB-CSSD's commitment to enhancing case supervision and practice compliance review, OCA recommends that JB-CSSD have a centralized and consistent methodology for auditing case supervision (both pretrial and probation), to determine the fidelity of practice with agency policies.
5. OCA recommends that JB-CSSD audit the use of interpreters for individuals under supervision that are not English speaking; and develop corresponding quality assurance for ongoing review of this issue; and ensure an update of relevant policies so that practice is consistent with obligations codified in Title VI of the 1964 Civil Rights Act.

JUDICIAL BRANCH- SUPERIOR COURT FOR JUVENILE MATTERS

OCA found that the Juvenile Court was not provided with complete and reliable information regarding Liam's living situation, health, development, or support needs to support his safe reunification with Ms. Rivera.

Recommendations

1. State law should be amended to include inquiry and/or findings by the Court that correspond to children's rights under state and federal law to adequate care. Specifically, the law should require judicial inquiry regarding:
    a. Did the child (if in DCF care) have the 30-day required Multi-Disciplinary Evaluation? Is there a plan to address recommendations? (Reference C.G.S. 46b-129(t)).
    b. Was the child screened for developmental delays and/or referred to Birth to Three (Reference C.G.S. 17a-106(e))?

c. Is the child in a licensed/licensable home? Have appropriate waivers been obtained as applicable? (Reference C.G.S. 46b-129(t)).
d. Is the child up to date medically and are there any concerns identified? (Reference C.G.S. 17a-101).
e. Have counsel for the child, DCF, and where applicable the GAL, seen the child in their living environment, and where appropriate interviewed the child alone? (Reference C.G.S. 46b-129a).
f. Has DCF, as required by federal law, obtained, and updated all necessary and relevant information regarding the child's educational, developmental, medical, and other service needs, and do the case plan and studies provided to the Court reflect that information? (Reference 42 U.S.C. 675(5)).
g. Have there been any new reports and investigations into allegations of abuse or neglect pertaining to the child, or new criminal charges pertaining to the parent/guardian?

2. Require that all DCF narrative submissions to the Court identify the source/s for information submitted regarding the best interests of the child (e.g., pediatric records/information provide... school records indicate...).[90]
3. The Court should continue to ensure that attorneys for children are 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, such as a young child or child with a disability, sought and obtained adequate information to take necessary protective actions and make recommendations consistent with the child's best interests.

AGENCY RESPONSES

OCA met with all of the agencies identified herein. All agencies had the opportunity to respond to the draft Report and provided written feedback, some of which is referenced throughout this Report, including with regard to JB-CSSD, action steps they took in response to ongoing case discussions with OCA. In addition, OCA invited the agencies to submit a document outlining the agency response to the tragedy, and the responses provided are attached.

JUDICIAL BRANCH

OFFICE OF THE CHIEF COURT ADMINISTRATOR

COURT SUPPORT SERVICES DIVISION

455 Winding Brook Drive, Glastonbury, CT 06033

Fax: 860-529-7937

[90] After reviewing OCA's draft Report, the Judicial Branch indicated that this requirement could be accomplished through a standing court order.

Edgar Ottoniel Ismalej-Gomez: Review of Case Management

Adult Probation Services

On 05/17/2022, the probation officer (APO) conducted the Level of Services Inventory-Revised (LSI-R) and Edgar Ottoniel Ismalej-Gomez was assessed administrative; a case classification override was not requested despite the underlying offense involving serious injuries to a six-month-old child. Previous CMIS case notes indicate that Mr. Ismalej-Gomez only speaks Spanish, in the LSI-R notes the APO stated that there was a language barrier, but records do not indicate that interpretive services were utilized. In addition, there was not a corresponding Domestic Violence Screening Instrument-Revised (DVSI-R) conducted as part of the assessment process, although the underlying offense involved family violence. Further, there were errors committed in the administration of the LSI-R.

Not completing the case classification process appropriately was a violation of CSSD Policy 4.57, Assessments, Case Plan, Referral, and Case Management Services.

Not using interpretive services was a violation of CSSD Policy 5.25, Multicultural Standards of Practice.

Not conducting the DVSI-R was a violation of CSSD Policy 4.57.

Not completing the assessment appropriately was a violation of CSSD Policy 4.57.

In response to a review of this case, an audit was conducted of the APO's entire caseload.

A review of records show that interpretive services were not used during the other interactions with Mr. Ismalej-Gomez, although it was determined that the Conditions of Probation were reviewed, by an intake assistant, with the client in Spanish.

Not using interpretive services was a violation of CSSD Policy 5.25.

In response to the review of this case:

1. Since using interpretive services is not addressed in adult services policy, further consideration of the matter is needed, and the response may include specific guidance to APOs.
2. Completing the DVSI-R in non-intimate partner family violence cases has been addressed with senior field office management and a policy memorandum is forthcoming, which will include this issue.
3. Further training and quality assurance of the LSI-R is under consideration.

Family Services

A case management review did not find any policy violations and the casework was appropriate and followed common practice.

Pretrial (Bail) Services

On 08/27/2021, the court imposed three conditions of release, Obey protective order, Cooperate with DCF [Department of Children and Families], and Surrender passport, but the conditions of release were not entered into the JB-CSSD case management system as required.

As a result, the conditions of release, exclusive of the surrendered passport, were not supervised by pretrial services from 08/27/2021 through 01/19/2022.

This was a violation of JB-CSSD Policy and Procedures 4.1, Bail Intake and 4.8, Pretrial Supervision.

In response, pretrial services conducted an audit of all active court-imposed conditions of release to confirm that pretrial services is conducting proper supervision of such conditions, including timely communication with collateral contacts providing direct or indirect supervision of such conditions and submission of current and accurate progress reports to the court.

In addition, guidance was sent to pretrial services staff explaining the communication obstacles with DCF, including a contact list for each DCF office, and reviewing staff responsibilities in the direct and indirect supervision of court-imposed conditions of release. Further, JB-CSSD is considering requesting that DCF provide specific contacts for JB-CSSD in DCF's field offices.

Lastly, effective July 1, 2023, JB-CSSD Policy and Procedures 4.8, Pretrial Supervision, is being revised to specify that cases will be supervised in accordance with any non-court session conditions of release prior to arraignment or in accordance with the conditions of release after arraignment.

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Vannessa L. Dorantes
Commissioner

Ned Lamont
Governor

September 27, 2023

DCF statement in response to child fatality in December 2022

In the aftermath of the tragic death of a two-year-old child whose family the Department was serving, the agency initiated its Continuous Quality Improvement (CQI) review process consistent with our standard practice. The purpose of the process is to review and evaluate the work leading up to the incident and identify areas in which there are opportunities for systems improvements. Continuous quality improvement is a tenet of the Department's core values, as evidenced by the March 2022 court decision to end the Juan F. Consent Decree and remove federal oversight of the Department's practice. CTDCF worked closely with the Court Monitor's Office for over 30 years to ensure that an effective CQI infrastructure was developed to identify, analyze, and refine practice to improve outcomes for children and families. Since the termination of federal oversight and in keeping with a commitment to excellence in child welfare practice, the Department contracted with Chapin Hall, an independent policy center at the University of Chicago, to complete a comprehensive overview of the Bureau of Strategic Planning and its functions to build upon the existing performance management system and propose recommendations to create a holistic CQI Practice Model. This engagement began in January of 2023 and recommendations are currently being reviewed by the DCF Executive Team.

Over the past year, through rigorous review of case work and identification of areas that could be reinforced, the Department has continued efforts to enhance its existing and ongoing work as follows:

Working with undocumented families

- The Department has recognized the need for enhanced engagement with undocumented families who come to our attention, given the increased population in CT and the unique needs of this population. Senior DCF officials met with leaders of Integrated Refugee and Immigration Services (IRIS) and Connecticut Institute of Refugees and Immigrants (CIRI), to collaborate on strategies to engage and better meet the needs of these children and families, particularly in the southern part of the state.

- DCF's Director of Immigration Practice routinely consults on cases in which one or more family members is undocumented in order to assist with culturally competent engagement, identify language and service resources to assist families and assess potential legal barriers.

Identifying and assessing failure to thrive

- DCF's Health Management and Oversight (HMO) Division includes nursing staff in each of DCF's six regions who routinely consult on cases in which a child has medical issues. The HMO Division has drafted a regional nurse standard to incorporate a child's weight and history of failure to thrive in the consult assessment and documentation. This working draft should become finalized guidance by the end of September.

- The HMO Division has partnered with Yale and Connecticut Children's to develop training to increase the awareness of a child's weight and failure to thrive on the health outcome for that child. The training will be given to DCF staff by the child abuse providers in fall 2023.

Partnering with foster parents

- CT DCF has officially become a Quality Parenting Initiative (QPI) jurisdiction. The Youth Law Center, a nationally renowned advocacy group in California whose mission is to advocate to transform foster care and juvenile justice systems, was instrumental in developing QPI. QPI is an effort to transform foster care agencies into relationship-based systems whose primary goal is to ensure that each child develops and maintains strong, positive relationships and has effective parenting while in care. All DCF child protective services and foster care staff have received training on the QPI model.

- DCF is partnering with the Connecticut Association of Foster and Adoptive Families, Fostering Communities, and other foster family advocates throughout the state to develop a Foster Care Bill of Rights legislative proposal for the 2024 Connecticut General Assembly session. The Bill of Rights will require several things, including: ensuring that communication between foster parents and DCF staff is timely and accurate, and allowing foster parent to actively participate and have input into the case planning and decision-making process regarding the foster child.

Reinforcing safety practice and in-person family contact post-pandemic

- During the Covid-19 pandemic, DCF, like all other state agencies, had to adapt its work to meet its mandates, while also adhering to public health requirements. As such, there were times when virtual, rather than in-person visitation, between a social worker and family on their caseload was permitted. In order to conduct a virtual visit, a case-triage was required, and a determination that, due to the medical needs of the family, an in-person visit was not feasible. As we exited the public

health emergency, DCF issued guidance that was clear --virtual visitation is no longer a substitute for seeing a family in-person.

- Further, Commissioner Dorantes issued guidance about expectations regarding announced vs. unannounced home visits and meaningful engagement with families. This memorandum reinforced that family engagement includes conducting quality assessments of safety, risk, strengths and needs. This is to be accomplished through face-to-face contact and direct observation. Child safety must be continuously assessed using the Department's ABCD child safety paradigm and should inform the frequency and purpose of visitation.

- In congruence with the ABCD Child Safety Practice Model, Safety Planning Practice Guidance was developed in August 2022, with facilitated discussions led by the Child Welfare Bureau, Legal Division, and the Academy for Workforce Development in December 2022 following a Statewide Safety Leadership Forum held in November 2022.

Refining trial home visits for committed children and partnering with stakeholders

- DCF has broad statutory authority to place a child under its commitment "... in a suitable foster home or in the home of a fictive kin caregiver, *relative caregiver*, or in a licensed child-caring institution or in the care and custody of any accredited, licensed or approved child-caring agency..." (C.G.S.A. 46B-129 (j)(4) emphasis added). As such, best practice dictates that there are times when a trial home visit period may be in the child's best interest in order to ensure successful reunification. Although trial home visits are described in DCF's policy, the agency is considering additional policy and/or legislation to more clearly delineate the parameters of a trial home visit for a child under commitment.

- The decision to reunify a committed child is never made by DCF in isolation. The agency works with service providers, attorneys for parents and children, foster families and the parents and children themselves on developing a timeframe and thoughtful transition. This work does not look the same for every family. The unique needs of each child and their caregivers must be considered in order to tailor a reunification plan that will ensure the highest likelihood of success.

- The Department undertook revisions of its Permanency Planning Policies and accompanying practice guidance, including new policy on Reunification and Parent/Child Visitation. This policy series will be posted by the end of September 2023.

Developing Post Consent Decree Workgroups

- DCF exited federal judicial oversight pursuant to the Juan F. consent decree in March 2022. In the aftermath, we convened Post Consent Decree Workgroups which focused on four practice areas:
    - Intake (including an analysis of our Differential Response System, commencement, frequency and contact standards, documentation, etc.)
    - Caseload Weighting (evaluating current methodology for assigning point system to different types of cases, identifying maximum caseload standards by type of case, and developing an approach that ensures complexity of cases and caseload requirements are considered upon case assignment)
    - Case Plans (creating a document that reflects our case planning process that ensures family input and voice is represented)
    - In-home/Out-of-home Visitation Standards (including an assessment of frequency of contact, by whom, and contact standards, etc.)

- With technical assistance provided by Casey Family Programs and input from a diverse population of subject matter experts within the Department, a final report with recommendations was made to the Commissioner in July 2023. The following recommendations, which are directly relevant to improving practice areas related to this matter, were approved for implementation in September 2023:
    - Revisions to the ongoing services SDM reunification assessment and risk reassessment tools.
    - Revisions to the early childhood practice guidance and High-Risk Newborn policy emphasizing the ABCD paradigm to strengthen supervision guidance and reinforce Birth to Three referral and assessment expectations.
    - Revisions to the DCF Policy on Visitation and Contact Standards, Purposeful Visitation Practice guidelines and engagement questions.

Promoting Safety Culture within DCF Workforce

- CTDCF is proud to be among 33 state, county and tribal child family serving agencies to participate in the National Partnership for Child Safety (NPCS). Formed in 2018, the mission of NPCS is to improve child safety and prevent child maltreatment and fatalities by strengthening families and promoting innovations in child protection. Supported by Casey Family Programs and the University of Kentucky, NPCS is a quality improvement collaborative formed to further key recommendations and findings of the federal Commission to Eliminate Child Abuse and Neglect Fatalities, which highlighted the importance and impact of safety science and data sharing to system change and reform.
- Safety science provides a framework and processes for child protection agencies to understand the inherently complex nature of the work and the factors that influence decision-making. It also provides a safe and supportive environment for professionals to process, share and learn from critical incidents to prevent additional tragedies. This framework is foundational to the DCF Safe and Sound employee practice model.
- Participation in the partnership allows CT DCF to use data to identify trends and protect children at risk of maltreatment or fatality. The Partnership also strengthens accountability, promotes collaboration to improve child safety outcomes by sharing data and applying a set of strategies, including implementing a standardized platform for critical incident review and reporting of data, comparing critical incident and team culture data and the sharing of cross-jurisdictional messages on practice.

The Department's case records involving families are subject to strict confidentiality laws (C.G.S.A. 17a-28), which limit what we can share publicly without infringing upon the privacy afforded to families by our state legislature. Further, the tragic passing of this young child and the circumstances surrounding his death remain under active investigation by law enforcement. The Department cannot, and will not, release any information to the public that could in any way jeopardize a full and fair investigation into the circumstances of this untimely death.

[redacted]

REPORT OF SUSPECTED CHILD ABUSE OR NEGLECT

DCF-136
04/2015 (Rev.)

Careline
1-800-842-2288

Within forty-eight hours of making an oral report, a mandated reporter shall submit this form (DCF-136) to the relevant Area Office listed below
See the reverse side of this form for a summary of Connecticut law concerning the protection of children.

Please print or type

Child's Name	☒ M ☐ F	Age Or DOB	Race: ☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American (not of Hispanic Origin) ☑ Hispanic ☐ White (not of Hispanic origin) ☐ Unknown ☐ Other
[redacted]		[redacted]	

Child's Address: [redacted]

Name Of Parents Or Other Person Responsible For Child's Care	Address	Phone Number
Iris Joana Livera	SAME	[redacted]

Name Of Caroline Worker To Whom Oral Report Was Made	Date Of Oral Report	Date And Time Of Suspected Abuse/Neglect
[redacted]	7/10/17	

Name Of Suspected Perpetrator, If Known	Address And Phone Number, If Known	Relationship To Child
Iris Rivera	SAME / SAME	Mother

Nature And Extent Of Injury(ies), Maltreatment Or Neglect
Iris supposedly pushed Child muvin out of room roughly.

Describe The Circumstances Under Which The Injury(ies), Maltreatment Or Neglect Came To Be Known
Iris is roomate name [redacted] contacted the Police

Describe the Reasons Such Persons(s) Are Suspected of Causing Such Injuries, Maltreatment of Neglect
[redacted] Stated that Iris pushed [redacted] out of room & has also hit her other Child named [redacted]

Information Concerning Any Previous Injury(ies), Maltreatment Or Neglect Of The Child Or His/Her Siblings
Unk.

Information Concerning Any Prior Cases(s) In Which The Person(s) Have Been Suspected Of Causing An Injury(ies), Maltreatment Or Neglect Of A Child
Unk.

List Names And Ages Of Siblings, If Known
[redacted]

What Action, If Any, Has Been Taken To Treat, Provide Shelter Or Otherwise Assist The Child?
Child was left with mother

REPORTER SECTION

Reporter's Name And Agency	☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American (not of Hispanic Origin) ☐ Hispanic ☐ White (not of Hispanic origin) ☐ Prefer Not to Answer ☒ Other	Address: 805 Bedford St / City: Stamford	Phone Number
[redacted]			[redacted]

Reporter's Signature [redacted] Position: Police Officer Date: 7/10/17

WHITE COPY: TO DCF AREA OFFICE (see below) **IF YOU NEED ADDITIONAL SPACE, YOU MAY ATTACH MORE DOCUMENTATION**

Bridgeport 100 Fairfield Avenue Bridgeport, CT 06604 203-384-5300 TDD: 203-384-5399 Fax: 203-384-5387	**Danbury** 131 West Street Danbury, CT 06810 203-207-5150 TDD: 203-748-8325 Fax: 203-207-5730	**Hartford** 230 Hamilton Street Hartford, CT 06106 860-418-8000 TDD: 860-315-4082 Fax: 860-418-8327	**Manchester** 364 West Middle Tpke Manchester, CT 06040 860-533-3600 TDD: 860-315-4415 Fax: 860-533-3750	**Norwalk** 761 Main Ave Norwalk, CT 06851 203-899-1400 TDD: 203-899-1451 Fax: 203-899-1483, 203-899-1464
Meriden One West Main Street Meriden CT 06451 203-238-6400 TDD: 203-238-6517 Fax: 203-238-6287	**Middletown** 2081 South Main St Middletown, CT 06457 860-638-2100 TDD: 860-638-2195 Fax: 860-346-2585	**Milford** 38 Wellington Road Milford, CT 06457 203-306-5300 TDD: 203-306-5604 Fax: 203-777-4358	**New Britain** One Grove Street, 4th Fl New Britain, CT 06053 860-832-5200 TDD: 860-832-5210 Fax: 860-832-5318	**New Haven** One Long Wharf Drive New Haven, CT 06511 203-786-0500 TDD: 203-786-2209 Fax: 203-786-7457
Norwich Two Courthouse Square Norwich, CT 06360 860-886-2641 TDD: 860-885-2438 Fax: 860-885-1360	**Torrington** 62 Commercial Blvd Torrington, CT 06790 860-496-5700 TDD: 860-496-5799 Fax: 860-496-5746	**Waterbury** 395 West Main Street Waterbury, CT 06702 203-759-7000 TDD: 203-465-7329 Fax: 203-759-7296	**Willimantic** 322 Main Street Willimantic, CT 06226 860-450-2000 TDD: 860-456-6663 Fax: 860-423-9014	

Send to this office

NARRATIVE

Written by: [redacted]

Monday 07/10/2017 Weather- Clear Post- 3C-30

Officer [redacted] and I responded to [redacted] on report of a roommate dispute and one of the parties abusing the children. We arrived and met with [redacted] could not speak English, so Officer [redacted] translated for us over the phone.

[redacted] stated that her roommate named Iris Joanna Rivera continuously has people at their house. [redacted] also stated that I. Rivera abuses her own children. [redacted] stated that I. Rivera became upset with her son [redacted] for coming into her bedroom. [redacted] stated that I. Rivera then forcefully pushed [redacted] out of her bedroom. [redacted] also stated that I. Rivera also hits her daughter named [redacted]

[redacted] stated that I. Rivera was not home and she did not have any contact information for her. We advised [redacted] that I. Rivera is allowed to have people at her apartment and we would contact DCF about her reporting child abuse. We also advised [redacted] that we would check back at the residence to attempt to speak with I. Rivera.

As we left the above residence, we saw I. Rivera with her children [redacted] I. Rivera spoke no English, so her friend named [redacted] translated for her. I. Rivera stated that [redacted] gets upset when she has friends over. We noticed sores on [redacted] and a scratch on his nose. I. Rivera stated that [redacted] had a rash on his legs and she took him to Stamford Hospital for treatment. I. Rivera stated that he received the scratch on his nose from falling. We observed no visible marks on [redacted]

We advised I. Rivera that due to the complaint of suspected child abuse, we had to contact DCF and make a referral. We also advised I. Rivera that she is allowed to have visitors in her own apartment, but to not engage in arguments with [redacted]

I completed a DCF-136 form and submitted it into the Stamford Police Records. I contacted DCF and made a verbal report to [redacted]

Page 1 of 1