STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE

CHILD FATALITY INVESTIGATIVE REPORT

MATTHEW TIRADO

DECEMBER 2017

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"Children with disabilities are more likely than their non-disabled peers to experience abuse and neglect. They are more likely to be seriously harmed by child abuse. Children with behavioral health conditions who were maltreated before age 3 were 10 times more likely to be maltreated again…They are often not fully protected by the systems that were created to protect children from abuse/neglect."[1]

[1] Prevent Child Abuse America, Virginia Chapter *Preventing Sexual Abuse of Children with Disabilities*, citing U.S. Dept. of Health & Human Services 2004 study; Sedlick et al, (2010), and Jaudes & Mackey-Bilaver, (2008).

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PREFACE

Matthew Tirado, a teenager diagnosed with Autism and Intellectual Disability, died in February of 2017 from prolonged child abuse and neglect. His death was preventable. The purpose of this report is to 1) answer questions regarding how this child, known to several local and state agencies, died from abuse and neglect, and 2) examine gaps that may exist in the safety net for children with disabilities and recommend improvements in policy and practice to prevent future tragedies. The report is developed consistent with the statutory obligations of the Office of the Child Advocate to investigate and report regarding the efficacy of publicly-funded services for children and the circumstances leading to the preventable death of a child. The publication of the report should not be taken as an indictment of all of the work of the child-serving systems identified herein, including child welfare legal, and education. These systems, along with professionals from the private provider community, are engaged in critical, and at times, very complex work of serving and protecting children. But close examination of the circumstances leading to a child's preventable death is required and will often provide important information regarding aspects of the child safety net that need closer scrutiny or urgent improvement. This report, issued in the wake of the tragic death of a beautiful young person, Matthew Tirado, who was entirely dependent on others to ensure his right to survive and thrive, requires us to examine the need for systemic improvement on behalf of children with disabilities. When a child dies from a preventable harm, a public account of how systems can improve is necessary.[2]

Children with disabilities are at greater risk of abuse and neglect than non-disabled children and are more likely to be seriously harmed by the abuse and neglect they experience.[3] Because of his intellectual and developmental disability, Matthew was unable to protect himself from harm. OCA's review found

[2] The OCA, in consultation with and as part of the state's Child Fatality Review Panel, reviews the circumstances of every child death referred to the state's Office of the Chief Medical Examiner (OCME). In 2016, there were 145 child fatality cases reported to the OCA by OCME. Of those child fatality cases, 81 deaths were determined to be from natural causes and 64 deaths were from unintentional injuries. Infant deaths from a variety of causes, including accidents, homicide, or undetermined, accounted for over a third of all unintentional and intentional fatal injuries. The OCA, in consultation with the CFRP, publishes regular reports regarding child fatalities and recommendations for the prevention of such tragedies. In recent years, the OCA/CFRP has published public health and investigative reports regarding infant deaths attributed to unsafe sleep conditions, infant-toddler deaths across the state, youth suicide, and individual case review. While current resources do not permit in-depth investigative reports for each and every preventable child death, the OCA and CFRP strive to offer relevant and critical information regarding child fatality statistics and trends, and the OCA regularly presents information and recommendations to administrative and legislative bodies for consideration. All OCA reports can be found on the agency's website: http://www.ct.gov/oca/site/default.asp. The OCA can be directed via vote of the CFRP, or through the OCA's own initiation, to investigate and publish findings regarding an individual child's death. In the case of Matthew Tirado, this report addresses several questions regarding Matthew's death presented to the OCA by members of the Connecticut legislature (hearing held February 23, 2017), and the OCA sought to review the circumstances leading to the death of a child with disabilities, a particularly vulnerable cohort of children who are at greater risk of abuse.

[3] United State Dept. of Health & Human Servs., Child Welfare Information Gateway, *The Risk and Prevention of Maltreatment of Children with Disabilities* (Mar. 2012), found on the web: https://www.childwelfare.gov/pubPDFs/focus.pdf.

that all of the systems that served Matthew—education, child welfare, and legal--must improve their ability to support and protect children with disabilities. Nothing speaks more profoundly to the need for systemic improvement than the fact that a child who had already been identified as a victim of abuse and neglect went unseen for almost a year prior to his death from child abuse. While this report outlines what various individuals did or did not do with regard to their interactions with Matthew and his family, OCA finds that the over-arching and urgent concern is the lack of clear capacity within aspects of our child-serving systems for responding to the special needs of children with disabilities.

As recommended by the United States Department of Health and Human Services "[g]iven the unique needs of children with disabilities, professionals should be trained to identify and assess possible maltreatment in this population… Many opportunities exist to improve collaboration between child welfare and developmental disability agencies to respond more effectively to children with disabilities and their families."

This report is offered in honor of Matthew Tirado. Matthew was, according to his records and school providers who met him, a mild-mannered child who, when allowed, enjoyed going to school, liked to use the microwave and cook his food, and enjoyed looking at books. Matthew enjoyed completing art projects, greeting peers and teachers and learning to communicate. He liked participating in group activities and handing out a "Renter's Guide" to community members and delivering items to people on the Oak Hill campus. The goal of this report is to identify how we can improve the safety net for children like Matthew.

INTRODUCTION AND SUMMARY OF FINDINGS/RECOMMENDATIONS

On February 14, 2017, 17 year old Matthew Tirado, a youth with Autism and Intellectual Disability, died from starvation, dehydration, and child abuse. Matthew's mother, Katiria Tirado,[4] has been criminally charged with Manslaughter in the First Degree and Intentional Cruelty to Persons in connection with Matthew's death. Despite previous reports of child abuse, years-long educational neglect, and an open neglect case in the local Juvenile Court, Matthew's mother had not allowed Matthew to be seen by any local or state agency, school personnel, or other professional, for almost a year prior to his death. Ms. Tirado did not appear or respond to the Juvenile Court child protection proceeding. Matthew's younger sister, also the subject of multiple DCF reports for physical abuse and educational neglect, was removed from the Hartford Public Schools a few months prior to her brother's death by Ms. Tirado, for the purpose of being "home-schooled." Neither child was attending school when Matthew died. This report will examine how Matthew, and then his sister, came to be hidden or invisible in the months prior to Matthew's death.

In the early morning hours of February 14, 2017, Ms. Tirado called for medical help for her son, stating he was sick and vomiting. Emergency personnel responded to the family's home and rushed Matthew to the hospital. He was pronounced dead two hours later. Officials at the Office of the Chief State Medical Examiner quickly reported that Matthew showed signs of significant physical abuse and severe malnutrition. Ms. Tirado was arrested in connection with Matthew's death.

Reports filed with the Juvenile Court in the immediate days and weeks following Matthew's death indicated that Matthew was emaciated at death, weighing only 84 pounds.[5] The Office of the Chief State's Medical Examiner found that Matthew had "numerous injuries in various stages of healing," including multiple "broken ribs, a laceration to the head, several bruises and contusions on his upper body, a pattern type injury to the upper back and bed sore type injuries to the buttocks."[6] The Medical Examiner's office reported that the injuries "appeared to be the result of long term abuse and neglect."[7] Pictures obtained from Ms. Tirado's cell phone confirmed that she had locked and shuttered her refrigerator and kitchen cabinets, restricting Matthew's access to food.[8] Text messages obtained by police investigators allegedly reflected Ms. Tirado's knowledge that her son was starving and the criminal warrant alleged that Ms. Tirado "intentionally prevented [Matthew's] access to food," with Ms. Tirado reporting to a relative that Matthew was forced to seek food "from the garbage and [he] would drink cooking oil, ketchup, and syrup if these items were accessible."[9]

Criminal investigation led to Ms. Tirado's confirmation that she was the sole caretaker for Matthew in the months leading to his death. In mid-2016, DCF learned that Matthew's grandmother, a key

[4] Katiria Tirado is identified in various child welfare records as Katiria, Katrina or Vannessa Tirado. Judicial Branch records refer to her as Katiria.
[5] A September 2015 medical record documents that Matthew was 5'7 and weighed approximately 100 lbs.
[6] Warrant, dated May 12, 2017 citing information from the Office of the Chief Medical Examiner.
[7] Id.
[8] Id.
[9] Id.

caregiver for him, may have recently died.[10] State officials and police learned that Matthew's access to food was severely restricted following his grandmother's death, and that he was allegedly beaten if he attempted to sneak food.[11]

Matthew was reportedly very ill in the days leading to his death, deteriorating and vomiting frequently, but his mother allegedly delayed seeking medical attention for fear that Matthew's appearance would lead DCF to "get involved" with the family.[12] Ms. Tirado called 911 at 2:40 a.m. on February 14, texting a relative that "I'm going to have to take him. He looks like he's dying." Subsequent statements from Matthew's younger sister to forensic interviewers were, according to the criminal warrant against Ms. Tirado, "consistent with the Medical Examiner's assessment of Matthew's long term abuse and neglect." The Medical Examiner classified Matthew's death as a Homicide. Friends and family members that knew Ms. Tirado reported to DCF after Matthew's death that they rarely saw Matthew, if ever. Matthew's father had not seen him regularly in several years.[13] A family party was held at Ms. Tirado's home the Friday before Matthew died, with one relative describing Matthew as very thin and another stating that Matthew was not able to attend the party but stayed in his room. Ms. Tirado reportedly assured relatives who were startled by Matthew's appearance that he had a "fast metabolism," and that she fed him but he would not gain weight. Relatives denied suspecting physical abuse.[14]

This report examines how Matthew and his family intersected with state-funded child-serving systems to determine whether and how his death could have been prevented and what steps should be taken to improve the safety net for children with disabilities.

OCA's investigative process encompassed extensive record reviews, interviews and correspondence with multiple stakeholders, including DCF personnel, Hartford Public Schools officials, the Judicial Branch, Oak Hill School, and the Office of the Chief Public Defender. Since Matthew's death, state and local officials, and community providers have examined their own involvement with Matthew and his family. DCF has initiated efforts to ensure all children who are the subject of an abuse/neglect referral and any siblings in the home must be seen prior to case closure, unless prior approval is secured from a DCF office director. DCF now requires that the DCF legal director or designee approve the withdrawal of any pending neglect petition. Hartford Public Schools continues to review

[10] A court transcript from September, 2016 contains statements from the DCF caseworker that Ms. Tirado had contacted a DCF manager to report that she was dealing with her mother's recent death.
[11] Affidavit in Support of DCF's Order of Temporary Custody, filed with the Juvenile Court in February 2017.
[12] Warrant citing Ms. Tirado's text messages:
Tirado: "Cuz of the way he looks they gonna get DCF involved and shit gonna escalate."
Relative: "He need medical attention cause he gonna get worse."
Tirado: "Idk what to do cuz of the way he looks… they gonna be questioning."
[13] A family friend who reportedly saw Ms. Tirado and her daughter on a regular basis told DCF investigators that she had not seen Matthew "in a few years," and that when she asked Ms. Tirado why Matthew was not in school she was told that Ms. Tirado was homeschooling him. Ms. Tirado reportedly told her that Matthew was often being looked after by a friend or relative. The family friend reported that she never visited in Ms. Tirado's home, they always visited in the friend's home.
[14] Multiple individuals were interviewed by DCF following Matthew's death in February, 2017. OCA reviewed the DCF records which included statements referenced herein.

and reform its approach to mandated reporting of abuse and neglect of children and students who are chronically absent.

Summary of Findings and Recommendations

Factual Findings

1. Matthew was born in August 1999 to Katiria Tirado, then 16 years old. Matthew's father is more than 30 years older than Matthew's mother.

2. Matthew was diagnosed with Autism at age two and referred for early intervention services. When he entered school he was found eligible for special education services.

3. Matthew had a history with DCF as an alleged victim of abuse and neglect dating back to 2005, when he was six years old. Alleged concerns between 2005 and 2009 included educational neglect, physical abuse, and physical neglect. Investigation in 2007 revealed that Ms. Tirado was being treated by a therapist for agoraphobia and panic disorder. Ms. Tirado had her own extensive history with DCF as a child due to Matthew's grandmother's persistent struggles with alcoholism, educational neglect, and mental health challenges.

4. There are no records of reports to DCF regarding Matthew and his family between 2010 and 2014, but OCA found that during this time, Matthew missed extensive periods of school and was seen by his pediatrician only once, in 2011. Ms. Tirado removed Matthew from the Hartford Public Schools on two occasions, for months and then over two years, without enrolling him elsewhere.

5. In August 2013, Ms. Tirado enrolled Matthew's younger sister in kindergarten with the Hartford Public Schools. The kindergarten enrollment form's request for information regarding "siblings" was left blank. Ms. Tirado did not permit Matthew to attend school at this time and there was no inquiry from the school district.

6. In October, 2014, Hartford Public Schools reported concerns to DCF that Ms. Tirado's younger child came to school with signs of physical abuse. Despite the child telling the DCF investigator that her brother was also hit, only the little girl was evaluated by a doctor for signs of physical abuse. Matthew was not seen or assessed at the time by DCF. No evaluation of Matthew or forensic interview with his sister was conducted--though Matthew's inability to communicate, and lack of visibility (DCF soon learned he had not been in school for over two years) in particular dictated a thorough response.

7. In November 2014, Hartford Public Schools called DCF alleging long-term educational neglect of Matthew by Ms. Tirado as he was not enrolled in school and may not have been in school for a long time. Records show that Matthew remained out of school for most of his life between June 2012 through his death in February, 2017 without adequate intervention or response by state or local authorities, and, for multiple years, without anyone noticing.

8. DCF maintained an open case on the Tirado family from October, 2014 until January, 2017, and the agency placed Ms. Tirado on the state's Central Registry due to her "pos[ing] a risk to her children and other children in the community." DCF did not file a neglect petition in the Juvenile Court until July, 2016.

9. In December 2014, Matthew began attending Oak Hill School. Oak Hill is a private, state-approved special education program that delivers services to children pursuant to contract with a local school district. Oak Hill persistently provided information to the DCF social worker and HPS that Matthew was not attending school. Though Matthew remained enrolled at Oak Hill from December, 2014 through his death in 2017, Ms. Tirado frequently did not allow him to attend. After January 2016, Matthew did not attend school again.

10. Between June 2012, and February 2017, despite his significant disabilities and need for support, Matthew attended less than 100 days of school.

11. Matthew's mother minimally cooperated with DCF and persistently failed to send her children to school. HPS made three additional reports to DCF in in 2015 and 2016. HPS made a total of 5 reports to DCF between October, 2014 and May, 2016.

12. After March 2016, Ms. Tirado stopped cooperating with DCF and did not allow DCF to see her children. In July 2016, DCF filed a neglect petition with the Juvenile Court.

13. At various points in time Ms. Tirado both sought and rejected help for her family and for Matthew. In 2015, for example, after Ms. Tirado was referred by a pediatrician to a community agency for services, it appears she waited several months before contacting the agency and then declined the agency's offer for an urgent appointment. There is no record that Ms. Tirado was ever offered in-home therapeutic supports, nor is there documentation that Matthew was ever referred to the Department of Developmental Services.

14. After April, 2016, when Hartford Public Schools (HPS) was told by DCF that it intended to file a neglect petition on Matthew's behalf, there is no documentation that HPS continued to follow up on Matthew's non-attendance in school. There is no documented communication between DCF and HPS from May 2016 through Matthew's death in February 2017.

15. In May 2016, HPS filed a Family With Service Needs (FWSN) Petition regarding Matthew's sister with the state's Judicial Branch due to her persistent non-attendance in school. The FWSN Petition was rejected due to the child's young age, and DCF was notified of the filing.

16. Though Ms. Tirado was served with a copy of DCF's July 2016 neglect petition and a notice to respond, she never appeared in Court or responded to DCF's petition.

17. The Juvenile Court held six short hearings on the Tirado family's case between July and December 8, 2016.

18. Given the unresolved neglect of her children, DCF sought and obtained from the Juvenile Court a default judgment of neglect and a disposition of Protective Supervision for six months, scheduled to end in April 2017. In absentia, Ms. Tirado was ordered to comply with DCF and meet her children's needs.

19. Ms. Tirado continued to refuse access to Matthew, would not allow DCF in her home, and would not send Matthew to school. In early October 2016, DCF called Matthew's sister's school and learned that she had been attending in the weeks since the school year began.

20. In November 2016, HPS failed to contact DCF when Ms. Tirado withdrew Matthew's sister from school for the purpose of home-schooling, despite the district having filed multiple child protection reports between 2014 and May 2016 regarding both children.[15]

21. Several supervisory directives to the DCF caseworker were not followed between July and December 2016, including to conduct a case consult with the Attorney General's Office, confirm the family's whereabouts through their landlord, follow-up with the school system, or request a police well-child safety check.

22. In December 2016, the day before a court hearing and after nine months of not being allowed to see Matthew or verify his whereabouts, DCF submitted a written recommendation to the Juvenile Court requesting that the Court terminate the case and end Protective Supervision early. The paperwork did not spell out what efforts had been sought or made to find the children and ensure their safety. DCF did not allege that closing the court case served the best interests of the children.

23. No orders were sought from the Juvenile Court by DCF or the children's attorney to keep the case open until Matthew was found, compel production of the children, permit visitation of Matthew's sister in school, or seek commitment of either child to state custody—despite grounds for such orders.

24. The Juvenile Court, after several judge-led efforts to bring the parties together and an effort to compel Ms. Tirado to appear and respond to the state's neglect petition, granted DCF's December 2016 request to vacate the Court's order for Protective Supervision over Matthew and his family despite DCF failing to allege, as required, that vacating or modifying the court's orders served the best interests of the children.[16] Transcripts indicate the hearing lasted less than a minute.

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[15] OCA does not find that a typical request to home-school would require notification to any state agency under current law. However, in the case of the Tirado family, the frequency of concerns HPS officials reported to DCF regarding suspected abuse or neglect of the Tirado children rendered the mother's notification of school withdrawal reasonably suspicious for ongoing neglect, thereby warranting a mandated report to DCF.

[16] Practice Book Section 35a-16 provides that "motions to modify dispositions are dispositional in nature based on the prior adjudication, and the judicial authority shall determine whether a modification is in the best interests of the child or youth upon a fair preponderance of the evidence."

25. In January 2017, DCF administratively closed its own case on the family. No legal consults were sought prior to DCF recommending the case end, and no lawyer assisted in the drafting or development of this recommendation.

26. DCF's risk,[17] safety, and needs assessments completed on Matthew and his family between 2014 and 2016 were inconsistent and inaccurate, resulting in a lower assessment of risk to the children than actually existed. The erroneous assessment of Matthew's risk of harm and his *vulnerability* to harm, affected the trajectory of his case until it closed.

27. The Tirado family's DCF case was handled by multiple workers and supervisors as caseloads transferred and transitioned, negatively affecting the flow of critical information about the family including the history of abuse/neglect concerns, Ms. Tirado's history of mental health struggles, and Ms. Tirado's own extensive history with DCF as a child.

Child Welfare System Findings and Recommendations

1. The child welfare safety net for children with developmental disabilities is inadequate.

    - DCF lacks specific policies and case practice guidance for its staff regarding investigation of alleged abuse and neglect of children with developmental disabilities.

    - DCF does not currently provide specific training for its staff regarding investigation and case planning for children with developmental disabilities. Staff urgently need training and support regarding how to interview and accommodate children with disabilities, and how to access technical support and resources to assist with such cases. From the DCF Careline to the DCF ongoing treatment units, practices and procedures must reflect understanding of the risk of harm to children with disabilities, and resources that can strengthen families and reduce risk.

    - DCF has not had readily enforceable training requirements for staff, and individuals who spoke to or were interviewed by OCA provided varying and inconsistent information regarding the existence of ongoing training requirements for staff.

2. DCF has not had an effective system for assessing risk and child safety, and its use of assessment tools remains inconsistent.[18] In June 2017, a 2016 federal audit of DCF found, based on review of case files, that DCF was "inconsistent in assessing safety and risk in the child's living environment," and the "lack of accurate ongoing assessment of risk and safety

[17] The Risk tool assesses the child's risk of future abuse and neglect and whether DCF should open the family's case for treatment supervision. The Safety tool assesses whether the child is safe or unsafe in their current situation and whether the child needs to be removed from his or her home.
[18] See Section IV, System Issues and Recommendations, pg. x.

factors contributed to the agency's lower performance."[19] DCF recently submitted a Performance Improvement Plan to the federal government[21] identifying the improvement of its risk/safety assessment processes as a priority initiative.

3. OCA finds that DCF's current information management system does not support consistent high quality case management. OCA finds that at least *some* of the reason for assigned staff's lack of awareness of critical information about the Tirado family otherwise contained in the child welfare record is due to the unwieldy DCF case management system. This system is outdated, and it can be very time consuming for line-staff to review and extract information that may be critical to assessment and case planning.[22] Staff may also be hampered by caseloads[23] and shifting responsibilities as cases move from one social work team to another, as was the case here. DCF is actively engaged in an effort to upgrade its information management system, and OCA agrees that this as an urgent issue for completion. The ability to quickly retrieve critical and material information from the child welfare record is essential for accurate risk and safety assessment and case planning, particularly when families have extensive histories with DCF.

Recommendations

- Improving reliability of DCF risk, safety, and needs assessments is an urgent priority—and assessments must give appropriate weight to a child's vulnerability, whether due to age or disability.

- When a family is repeatedly brought to the attention of DCF for concerns of child abuse or neglect over a short period of time, as the Tirado children were on 5 occasions over an 18 month period of time, a thorough review that includes managerial and/or internal consultant support, should be undertaken to determine unidentified risk or safety concerns and unmet needs in the family.

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[19] U.S. Department of Health and Human Services' Administration for Children and Families, Children's Bureau, *Final Report: Connecticut Child and Family Services Review*, at 3, available on the web: http://www.ctnewsjunkie.com/upload/2017/04/children-and-families-CT_FinalReport_2016.pdf

[21] DCF's Performance Improvement Plan (PIP) was filed in June, 2017 with the U.S. Department of Health and Human Services' Administration for Children and Families, Children's Bureau. Report not yet available on HHS website.

[22] For example, there is no consistent method to determine or evaluate 1) a parent's prior mental health diagnoses, 2) services a family has received and been referred for, including discharge summaries and recommendations, or 3) a parent's trauma history as a child involved with DCF.

[23] The Juan F. federal court monitor has repeatedly published concerns regarding the "insufficiency and instability of staffing along with the lack of readily available critical and essential services [that] have resulted in unmet needs for children and families." See *Juan F. v. Malloy* Exit Plan Status Report, February 2017, at 3, found on the web at http://www.childrensrights.org/wp-content/uploads/2017/02/Status-Report-2nd-and-3rd-Quarter-2016-final.pdf

- DCF's effort to rebuild its case management database must be supported as an urgent priority for the agency.

- DCF must develop specific policies, practices, and training curriculum to support investigation and case planning for abused/neglected children with developmental disabilities.

- DCF should collect and report data regarding incidents of abuse, neglect, and critical injuries/fatalities, involving children with disabilities.

- DCF should work with partners from the Office of Early Childhood and the Department of Developmental Services to develop common goals and strategies in serving and protecting children with disabilities and supporting their families' need for services.

Legal System Findings

1. DCF policies and training regarding the appropriate and required utilization of legal resources by social work staff are inadequate. Multiple experienced DCF staff provided inconsistent information to OCA that reflects a lack of uniform understanding regarding the role of lawyers in the development of case strategies and solutions. Multiple staff reported to OCA that there are no "mandates" when it comes to consulting with the agency's lawyers, and that social work staff can recommend case closure to the Court even without prior legal consultation—as was the case here.[24]

2. Matthew was not adequately represented by his appointed lawyer during the Juvenile Court's neglect proceeding. Though Matthew was a child with significant disabilities (i.e. diminished capacity) who had been and was at risk of substantial harms, and though he had not been seen for months due to his mother's active efforts to hide him from the community, Matthew's appointed lawyer did not take protective action on his behalf or act in his best interests as contemplated by the Rules of Professional Conduct, the state's Professional Guidelines for assigned counsel for children, and state statutory requirements.

3. State law does not currently provide clear and unambiguous authority for a DCF social worker to interview or meet with a child who is a suspected or documented victim of maltreatment (in all cases) over a parent's objection, or without a court order or active court proceeding.[25]

[24] Records and interviews indicate that no legal consults took place between the caseworkers and DCF internal legal affairs department or the Attorney General's office to assist in the preparation of DCF's recommendation to the Court that it terminate the Tirado family's neglect proceeding, or subsequently to close the agency's administrative case. Going forward there must be clear protocols for legal consultation in the commencement *and* termination of court cases with processes for court closure that require submission or documentation of efforts made to ensure the safety of a child.

[25] State law was recently amended to authorize a child's appointed counsel to have immediate access to consult with a child privately where a "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." See Conn. Gen. Stat. § 46b-129a as amended by Public Act No. 17-119.

There is a limited statutory exception that permits DCF to interview a child without the consent of a parent/guardian in the case of allegations of physical abuse; but this exception is narrowly drawn and does not expressly allow DCF to interview or assess a child who is the subject of certain types of maltreatment but who may also be highly vulnerable to harm due to age or disability.

Recommendations

- State law should be amended to strengthen protections for children who may be hidden from DCF or the Court system. State law should expressly allow for DCF to assess the safety and well-being of very young children or children with disabilities where there are credible allegations of abuse or neglect and where the child's ability to communicate concerns about his or her own safety is compromised.

- No recommendation to end a child protection proceeding should be submitted by DCF without legal consultation and ensuring the safety of child. The agency, in partnership with the Attorney General's Office, should clarify requirements for staff regarding the use of internal and external agency legal resources to support child welfare oversight activities.

- No disposition of a child protection case in the Juvenile Court should be modified or vacated without an offering and judicial finding that such modification serves the best interests of the child.

- Lawyers for abused and neglected children with disabilities must be trained and well-prepared to take protective action on behalf of child clients with diminished capacity.

- Juvenile Court judges should receive information/training regarding the unique needs of children with disabilities who are victims of abuse or neglect.

- Juvenile Court judges should canvas attorneys for children with diminished capacity at critical points in litigation as to whether the lawyer has been able to obtain adequate information necessary to inform the need for protective action.

- Juvenile Court judges should require DCF to submit documentation regarding its risk/safety assessments regarding a child prior to case closure.

- Barring emergency hearings, all paperwork should be submitted to the Juvenile Court and the parties for review at least 5 days prior a judicial proceeding.

- There should be a clear protocol in child protection proceedings regarding when a capias warrant should issue to compel a parent/guardian to appear in court. Such protocols should address when the capias effort should be made, what efforts should be made to serve the parent, and how long such efforts must persist.

Education System Findings

1. OCA found many other children with complex disabilities who are chronically absent from the Hartford Public Schools. HPS reported to OCA in April 2017 that there were hundreds of children with disabilities who are chronically absent from school, including over 150 children with significant (e.g., Autism, Intellectual Disability) or multiple disabilities, signaling another systemic concern about the safety net for children with disabilities.

2. OCA finds that there is an inadequate framework in Hartford, and statewide, for ensuring the safety of and education for children who are withdrawn from school to be home-schooled. Over the last three school years, more than one-third of the children withdrawn from Matthew's school district for the purpose of "home-schooling" were found by OCA to have lived in homes with prior histories of abuse/neglect concerns. OCA learned that the district does not require its personnel to conduct any follow up to ensure that children are actually receiving instruction as required by district policy and recommended by State Department of Education guidance.[26] OCA's ongoing investigation of this issue has revealed similar concerns in other Connecticut school districts. Home-schooling information clearinghouses identify Connecticut as a state with scant regulation of home-schooling compared to neighboring states.

Recommendations

- Hartford Public Schools (and all school districts) should examine their policies and practices with regard to the withdrawal/transfer of children from and into their schools to ensure that appropriate education records are sought and received, thereby helping to identify children who are withdrawn from school and failing to attend anywhere.

- State and local frameworks for responding to chronic absenteeism must be well-informed regarding the specialized needs of children with disabilities, their unique vulnerability to abuse or neglect, families' fears and concerns about how their children may be served in school, and include strategies to positively engage families and ensure delivery of high quality instruction.

- Whenever there are child welfare concerns concurrent to or recently preceding a parent's notification of intent to withdraw a child from school, district officials should internally assess whether, based on other information known to the district, such withdrawal gives rise to a reasonable suspicion that a child is abused or neglected, and such concerns should be reported to DCF.

- The safety net for children who are withdrawn from school for the purpose of home-schooling must be improved. Connecticut should review approaches taken by other states and revise the

[26] OCA is engaged in an ongoing review of these issues and has been obtaining home-schooling information from other school districts (7 in total). Thus far OCA has found that the issues identified herein are *not* unique to Hartford Public Schools, and OCA has made similar findings with regard to the home-school data from the other school districts.

current home-schooling framework to minimally ensure a child withdrawn from school is receiving an education and is making progress in instructed areas.

AGENCY RESPONSES

The OCA shared a draft of this report with all of the state, local and community agencies identified herein, including: The Department of Children and Families, the Office of the Chief Public Defender, Hartford Public Schools, Oak Hill School, the Connecticut Judicial Branch, and the Attorney General's Office. All agencies were given the opportunity to share with OCA any comments or concerns regarding the draft findings and recommendations. The final report incorporates or references such feedback. Multiple agencies affirmed their commitment to ongoing assessment of internal policies and procedures necessary, as the Public Defenders' Office stated, to make sure we "do all we are able to protect the rights and ensure the wellbeing of children involved" with publicly-funded systems. Specifically agencies responded to OCA as follows:

- Oak Hill School committed to ongoing examination of its efforts to advocate on behalf of vulnerable children in their school, including its protocols for communicating child protection concerns on "open DCF cases" with DCF.

- Hartford Public Schools acknowledged "serious failings" in the District's "policies, procedures and practices regarding chronic absenteeism as well as intra-and inter-agency follow-up, communication, collaboration and response to parental notice of intent to home-school or withdraw children from the District." HPS stated its commitment to addressing these failings and has already begun work implementing new protocols to ensure it "does its part to fill the gaps in the safety net as swiftly and securely as possible." HPS affirmed its commitment to ongoing reforms consistent with its work on an Action Plan developed in response to a February, 2017 report by the OCA regarding its compliance with state and federal child abuse/sexual harassment reporting laws. HPS recently engaged outside experts to, as HPS wrote, "assist in identifying and remedying programmatic deficiencies that contribute to, or fail to protect children [with disabilities] against, abuse and neglect." The Board of Education is actively addressing policies regarding attendance; abuse and neglect; home-schooling; and school transfer/withdrawal, and the District is already engaged in a more robust response to concerns related to chronic absenteeism. HPS leadership also reports meeting regularly with DCF Regional Administration (Hartford) to facilitate communication, and the agencies will be partnering to facilitate professional development for HPS staff regarding mandated reporting of child abuse and neglect.

- The Office of the Chief Public Defender reported to OCA regarding its updates to its Performance Guidelines for assigned counsel for children, which Guidelines recommend regular records procurement by lawyers. The OCPD also referenced its commitment to ongoing ethics trainings for lawyers, and acknowledged the need for more training on issues "relating to the care and representation of children with all types of disabilities." The OCPD reported it would facilitate training for lawyers on working with clients who have intellectual

disabilities,[28] and the OCPD will "continue to look for opportunities to provide specific training related to the needs of children with complex disabilities."

- The Office of the Attorney General expressed its ongoing commitment to working with the OCA to address any policy or legislative issues within its jurisdiction to improve the safety net and protections for vulnerable children, including children who are hidden from DCF or the Court.

- The Judicial Branch stated its willingness to work with other stakeholders to address the "challenging" problem created by the refusal to appear or cooperate by a custodial parent suspected of abusing or neglecting a child subject to a court's jurisdiction.

- The Department of Children and Families did not provide OCA with a written response or any correction to this report, though leadership indicated that a response would be developed and published concurrent to the release of the OCA report.[29]

METHODOLOGY

The Office of the Child Advocate is an independent state oversight agency directed by law to investigate and report on the efficacy of child-serving systems, to investigate unexplained and unexpected child fatalities or critical injuries to a child, and to review complaints of persons concerning the actions of any state or municipal agency, or publicly funded agency providing services to children.[30] The Child Advocate is a permanent member and current co-chair of the State Child Fatality Review Panel. The OCA was created in 1995 in response to the death of an infant involved with DCF.[31] OCA's investigation of the circumstances leading to the death of Matthew Tirado included the following:

- Review of Matthew's medical records dating back more than 10 years;

[28] The OCPD reported to OCA that such training will begin in the Spring, 2018.

[29] Prior to completion of the draft report in July 2017, the OCA met with DCF Hartford-office leadership, the DCF legal director and the DCF ombudsman to discuss OCA's investigation and preliminary findings about case practice. Upon completion on July 26, 2017, OCA provided a copy of the draft report to DCF Commissioner, Joette Katz, offering to meet and requesting any formal comment or agency response within two weeks. The OCA did not receive any response to this communication. The OCA's draft report was also shared and discussed with the state's Child Fatality Review Panel, which Panel includes a designee from DCF—the Ombudsman. The OCA shared a final draft of this report with DCF leadership (and other agencies) on December 5, 2017, offering opportunity for final comment or correction, at which time the DCF Commissioner responded by email to OCA that a response would be developed and published simultaneous to the release of the OCA report.

[30] Conn. Gen. Stat. § 46a-13*k et seq*.

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

- Review of all child welfare records pertaining to Matthew and his family;
- Review of all court records pertaining to Matthew and his family, including all filings, transcripts, court forms, and court memorandum;
- Review of all educational records pertaining to Matthew and his sister;
- Review of all developmental records pertaining to Matthew and his sister;
- Review of police warrants and records from the Office of the Chief Medical Examiner;
- Meeting and discussion with representatives from DCF,[32] Oak Hill School, Hartford Public Schools, and the Office of the Chief Public Defender;
- Review of state law, regulations, and procedures relevant to the educational and child welfare safety net for abused and neglected children;
- Research regarding effective risk and safety assessment and case planning for children with disabilities.

The OCA gratefully acknowledges consultation in the development of this report by the Child Fatality Review Panel.

[32] OCA met with the leadership from the DCF Hartford office, the DCF legal director and the DCF ombudsman prior to the completion of a draft report. Interviews with assigned DCF staff were arranged by subpoena and staff were individually interviewed, represented during each interview by their Union and the Union's legal support staff.

FINDINGS

Matthew was identified early on as child with specialized needs who was often absent from school.

Matthew was diagnosed with Autism when he was two years old, and in November 2001, he was referred by a developmental pediatrician to the state's Birth to Three program. At that time, Matthew lived with his 18 year old mother, Katiria Tirado, his maternal grandmother, and his maternal aunt.[33] Matthew transitioned from Birth to Three into the Hartford public school system, receiving special education services. An educational record from February 2004 states:

> **"The importance of Matthew attending school on a daily basis was discussed [with the family]. To date, Matthew has had 37 absences. Routine and consistency is important for Matthew to progress in school."**

By May of 2004, Matthew had accumulated **55 absences** and though his mother was offered summer programming by the district, she declined.

For the next several years HPS continued to document concerns about Matthew's excessive absenteeism. Ms. Tirado often did not participate in Planning and Placement Team meetings (PPTs),[34] and records indicate that Matthew's **"sporadic"** attendance impeded his ability to learn. The school district provided Matthew's family door-to-door transportation, special education services, speech and language therapy, and occupational therapy. Matthew also received a 1:1 paraprofessional aide while in school.

DCF Policy Regarding Educational Neglect

DCF policy provides that Educational Neglect "may be found in those cases in which a child who is enrolled in school has a pattern of unexcused absences or fails to attend or if the person responsible for the child's health, welfare, or care fails or refuses to meet the child's educational needs." DCF Policy § 34-12-5

Policy guidance further provides that "for children age 12 through 15… there is a greater possibility that a pattern of unexcused absences is due to truancy rather than parental neglect."

DCF guidance states that "reports concerning a dispute between parents and the school system regarding home education shall not be substantiated unless the parents have refused to comply with statutorily mandated requirements."

2005-HPS' First Call to DCF

In December 2005 when Matthew was 6 years old, HPS called the DCF Careline to report that Matthew had missed more than 30 days of school since the school year began. HPS officials told DCF they were concerned that multiple letters and calls home had not helped improve Matthew's attendance, and that when

[33] Records provide little mention of Matthew's biological father. Ms. Tirado was 15 when she became pregnant with Matthew. Matthew's biological father is more than 30 years older than Ms. Tirado.

[34] In Connecticut, educational planning meetings for a child receiving special education are called Planning and Placement Team Meetings. These meetings discuss various aspects of the child's Individualized Education Program.

school staff conducted home visits, **no one answered the door**. School authorities were particularly concerned given Matthew's level of disability. DCF investigated and substantiated Ms. Tirado for neglect, but DCF closed the case at the end of the investigation phase, seven weeks later, because Matthew's attendance improved during DCF's brief involvement.[35] Medical information regarding Matthew that DCF had requested as part of its investigation was not received prior to case closure.

2006-HPS Calls DCF to Report Neglect Concerns

In December 2006, Hartford school officials again contacted the DCF Careline to report that Matthew, age 7, missed almost **50 days of school that school year**. Ms. Tirado explained to DCF that he missed so much school because she was ill and suffered from anxiety. DCF investigators learned that Ms. Tirado reportedly suffered from a panic disorder and agoraphobia, and was receiving support from a therapist.[36] Ms. Tirado told DCF that her mother was moving in with her to help take care of the family. DCF did not substantiate neglect, and closed the case six weeks after the report came in.[37] DCF records indicate that other than not going to school, Matthew appeared cared for and bonded with his mother.

There is no mention in the record of Matthew's grandmother's extensive history with DCF or her history of alcohol abuse and mental health treatment needs, though this information was available in the DCF record. Only months later, in 2007, Matthew's grandmother was again investigated by DCF for medical and physical neglect of one of her other children, Ms. Tirado's sibling.[38] During this investigation, the grandmother did not allow DCF into her and Ms. Tirado's apartment, and the grandmother would meet with DCF in the community, stating that the apartment belonged to Matthew's mother who did "not want DCF in the home."

In 2008, when Matthew was in third grade, an evaluation documented that "Matthew has come a long way this year due in part to much improved attendance." The same report did note Matthew's mother's concern that he had fits at home, including yelling and shrieking, and that the team was not sure what was setting him off other than "frustration at not being able to communicate his needs." *There is no documentation that the family was offered referrals to community-based services or provided an avenue of how to seek additional in-home help for the family.*

[35] A school record from April 2006 noted that Matthew was making improvement both at home and at school.
[36] Per report of Ms. Tirado's therapist to DCF. Additionally, developmental evaluations for both of Ms. Tirado's children (Matthew and his sister), completed in 2007 and 2009 respectively, include information that, per report of Ms. Tirado, she had a history of panic disorder and anxiety, and a family history of depression and anxiety.
[37] A note in the DCF electronic record from March 2006 indicates that the case was unsubstantiated in error, but could not be corrected for technical reasons.
[38] The grandmother was again investigated for neglect in 2007, only months following the closure of Matthew's case. The grandmother's August 2007 case involved her care of one of Ms. Tirado's siblings who had unmet medical needs that resulted in hospitalization. During the 2007 investigation by DCF, the grandmother acknowledged her history of anxiety, depression and excessive drinking, but noted that she was taking medication for anxiety and that only drank occasionally.

2009-HPS Calls DCF to Report Concern that Matthew was Physically Abused

In 2009, when Matthew was 10 years old, Hartford school officials again called DCF, this time to report concerns that Matthew had come to school with bruising on his face, covered up with make-up. School employees reported to DCF that they had observed "**prior [unreported to DCF] marks and bruises**," on the child but that when they called Matthew's mother she would state that Matthew's sister, then two years old, inflicted the bruises.[39] During the investigation, Ms. Tirado denied abusing Matthew.

Mss. Tirado further reported to DCF that her mother had a lot of medical problems and that she was exhibiting signs of Alzheimer's. Matthew's child welfare record shows no assessment of how or whether the grandmother's extensive history with DCF, her own struggles with mental health disorders and alcohol abuse, affected her ability to care for Matthew and assist the family. It appears that investigators were not aware of this history. **Repeated risk assessment tools completed by DCF erroneously noted that Matthew's mother had no history of having been abused or neglected as a child—despite contradictory information available in the DCF database.**[40]

Furthermore**,** interviews conducted by OCA as part of this investigation revealed that staff working on Matthew's case in 2015 and 2016 were not aware of the grandmother's extensive DCF history. Interviews also revealed that the grandmother was primarily Spanish-speaking, though the ongoing DCF worker throughout much of this time period did not speak Spanish.

The 2009 allegation of physical abuse reported by HPS was not substantiated by DCF due to lack of evidence, and the case was closed. Medical records requested by DCF were not received prior to case closure.

Children with developmental disabilities are uniquely vulnerable to abuse and neglect.
One literature review concluded that children with communication or sensory impairments and learning disabilities were at increased risk for abuse. (See Stalker & McArthur, 2010; www.childwelfare.gov/pubPDFs/focus.pdf.) Children with developmental disabilities face other risk factors for abuse and neglect, including the "belief that caregivers would never harm [such] children," (Sobsey, 1994), and a "lack of training [that] impacts the ability of social workers, teachers, and other professionals to identify and report suspected maltreatment of children with disabilities." Id. A parent's lack of skills, resources, or supports to respond to a child's special needs and provide adequate care are serious risk factors for child abuse and neglect, as well as the parent's greater likelihood of exerting control or using physical punishment for a child who exhibits challenging behaviors. Id. Researchers have also found that boys with disabilities are more likely than children without disabilities to be abused. Id.

[39] There is no information in the DCF investigation record as to how often Matthew came to school with bruises or where the bruises were, e.g., on his face, legs, arms.
[40] DCF's case management system is outdated and can be difficult for case workers to quickly navigate. The database does provide information regarding the existence of a child protective service history for Matthew's grandmother, but only a review of the actual investigation records themselves speak to the extent of DCF's prior involvement with her and Matthew's mother and siblings. It appears from a review of these records that concerns of educational and physical neglect, along with concerns related to mental health treatment needs were multi-generational in the family. DCF has identified the need to update its case management system as a

In 2010, Matthew was again noted to be making progress in school, and at the end of fifth grade, when Matthew was 12 years old, the school team reported:

> **[Matthew is making] progress in all areas…Matthew [is] now able to independently write both first and last names. Knows site [sic] words, numbers to 100. Lately he has been observed talking back spontaneously, [a] significant breakthrough. He is also attempting to communicate his feelings and incidents that he has been involved in.**

2010-Ms. Tirado Withdraws Matthew from HPS Schools.

In 2010, Ms. Tirado told HPS officials she was moving from Hartford to New Britain, and that she would be enrolling Matthew in New Britain Public Schools. However, New Britain Public Schools informed OCA that Matthew was never enrolled in their district.

In response to questions from OCA, HPS officials reported that their database shows that Ms. Tirado withdrew Matthew from school on December 6 2010, and re-enrolled him in HPS on June 18, 2011. HPS acknowledged that "[t]ypically, once a student is withdrawn and enrolls in a new district the student's new district will send a request for records to Hartford to obtain the student's educational records." HPS acknowledged that it never received a request for records from New Britain Public Schools[41] and that "it is unclear whether HPS attempted to obtain records from New Britain [after Matthew later re-enrolled in HPS]. There is no such request in Matthew's educational record and HPS did not receive any records from New Britain Public Schools."

June 2011-Matthew Returns to Hartford Public Schools

Matthew returned to Hartford Public Schools in June 2011 with school records stating that "information regarding [Matthew's] progress [in New Britain] is not available." OCA inquired with HPS as to Matthew's attendance for the 2011-12 school year, and HPS reported that Matthew missed 35 school days after his return to the district. There is no record of a call to DCF regarding Matthew's excessive absenteeism.

2012-Ms. Tirado Withdraws Matthew from Hartford Public Schools again and Matthew Does Not Attend School for the Next Two and Half Years. He Is Never Permitted To Attend School Regularly Again.

In June 2012, Ms. Tirado reported to HPS that she was moving the family to New Haven. HPS confirmed for OCA that Matthew was withdrawn from its district on August 28, 2012. HPS "processed the withdrawal as requested by the parent but did not otherwise take additional action," and HPS never received a request for records from New Haven Public Schools. In response to an inquiry from OCA, New Haven Public Schools reported that Matthew was never enrolled in their

high priority action step. Providing easier access to comprehensive and important information to caseworkers and supervisors is a critical need to improve social work practice.

[41] HPS letter to OCA, Apr. 25, 2017.

district. HPS had no documentation that it ever sought records from New Haven Public Schools after Matthew returned to the district more than two years later.

Matthew was not re-enrolled in HPS until November 6, 2014, ten months after his sister had already begun kindergarten in the district. An HPS kindergarten enrollment form submitted by Ms. Tirado in 2013 at the time of Matthew's sister's enrollment contained a blank space next to the request for information regarding siblings.[42] District officials reported to OCA that they would have no way of knowing that the child had an older brother who was not in school, despite the children having the same parent and Matthew having been previously enrolled in the district.

October 2014--HPS Calls DCF to Report Concerns of Physical Abuse of Matthew's Sister

On October 17, 2014, staff from a Hartford elementary school contacted the DCF Careline to report that Matthew's younger sister—a first grader--came to school with marks on her face and that she admitted her mother hits her. According to DCF records:

> **"Child initially refused to tell what happened to her, but later said that mother hit her last night. Child said that mother hit her in the past. Child said that she was scared to go home. Child reluctantly admitted mother hit her." When interviewed alone by the DCF social worker, the child reported "that her brother [Matthew] gets hit also… Child would not answer when asked what happens when she misbehaves."[43]**

A visit to the pediatrician by DCF, the child and Ms. Tirado conducted the same day as the interview confirmed that the child was intentionally struck. Though Ms. Tirado was overheard directing her daughter to lie to the doctor, the pediatrician concluded that the child presented with inflicted injury, the result of "significant force," given the appearance of blood vessels on the child's face. DCF records indicate that the child "presented as on the verge of wanting to tell the doctor what happened but [she] would not articulate it. She just stared at [the investigator] and the doctor as if she could not speak."

At the same time, Ms. Tirado told the DCF investigator that Matthew, then age 15, was "staying with an aunt for a couple of days." Unlike his sister, Matthew was not seen by DCF at that time, nor was he taken by DCF to a pediatrician, and there was no attempt to have him immediately evaluated for signs of physical abuse. Matthew was not seen by a DCF investigator until November 7th, three weeks later, when a report came to DCF that Matthew was not registered in school and had not been in school for two years. There was no physical assessment or evaluation that took place to determine whether Matthew was being abused. The only note in the DCF record regarding contact with Matthew is as follows:

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[42] HPS reported to OCA that when a new student enrolls at a school, the parent fills out the form, and HPS staff input the enrollment data into PowerSchool. At this point, district staff "are only able to see information about that individual student. Mother did not report any siblings when she filled out the form." Id.

[43] DCF Investigation Protocol.

Responding to Child Abuse Victims With Disabilities—California Training for Law Enforcement and Child Protective Service Workers

"To be effective, first responders [including law enforcement and child protection investigators] must be knowledgeable of the most common disabilities [and] what individuals with disabilities can and cannot do. With this information, first responders will conduct better investigations, identify additional sources of information, interview more effectively, and improve their fact finding…. *First responders can make or break cases and their role is critical*! If these cases are not handled correctly liability issues may result, and offenders may continue to abuse."

Curriculum authors: Baladerian, N., Heisler, C., Hertica, M.,— A project of the California Governor's Office of Emergency Services.

"[On November 7, 2014] ISW[44] was able to observe Matthew in the home. He was dressed appropriately and did not appear to have any visible marks or bruises. ISW attempted to speak with the child but he did not respond. He is a 15 year old nonverbal Autistic."[45]

OCA's interviews with DCF staff and supervisors who were assigned to the case from 2015 through the case closure in 2017 stated that they did not know that Matthew's sister had previously disclosed to a DCF investigations worker that her brother was hit by Ms. Tirado. OCA's review of the record indicates that this information, obtained by the DCF investigator during the only interview with Matthew's sister conducted outside of the close proximity of her mother, was never referenced again in the DCF record. The failure at the investigation stage to adequately follow up on the information was a critical error and allowed the information to essentially fade away.

Guidance[46] from a national organization regarding the investigation of and subsequent response to abuse and neglect of children with autism notes that special considerations should be taken to interview and support children with disabilities such as:

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[44] Investigative Social Worker.

[45] In response to questions from OCA to DCF as to why additional steps were not taken in October 2014 to physically assess Matthew, bring Matthew to his pediatrician along with his sister, or otherwise take steps to engage and assess Matthew, the DCF legal director responded that "the immediate need [was] to assess the safety of [Matthew's sister]… During this investigation an educational neglect report was received on 11/4/14 regarding Matthew. The [investigating social worker] did observe [Matthew at that time] and noted he was dressed appropriately [and] had no visible marks or bruises. *He could not be interviewed due to being non-verbal*." (Emphasis added).

[46] Safe & Sound Autism Society, Serving Victims of Crime Series, *Autism, Information for Child Abuse Counselors* (2014), publication found on the web at https://www.autism-society.org/wp-content/uploads/2014/04/Child_Abuse_Counselors.pdf; see also CARES Northwest, *Project Ability*, *Demystifying Disability in Child Abuse Interviewing*, a project funded by Oregon's Children's Justice Act Taskforce, available on the web: http://www.oregon.gov/DHS/CHILDREN/ADVISORY/CJA/Documents/project-ability.pdf (July, 25, 2017); Virginia Commonwealth University, Center for Family Involvement, *Abuse and Neglect of Children with Disabilities: A Collaborative Response*, a one-day training offered by the Partnership for People with Disabilities.

- Use of forensic interviewers, trained to assist individuals with disabilities;

- Consultation with family members or professionals in child's life regarding behavioral changes that may be associated with trauma exposure: such as exacerbation of social anxiety, increased anxiety or phobias, depression, irritability, withdrawal, changes in normal behavior, sleep disturbance or self-injury;

- Use of abuse-screening tools;

- Ongoing communication and relationships with community disability service providers;[47]

- Collaboration with a disability professional, as some signs of abuse and neglect can be "confused with symptoms of a child's disability;"[48]

- "Determine issues that may affect the assessment, such as communication limitations or behavioral challenges. Adapt the structure or location of the interview and equip yourself with appropriate tools and strategies to address the issue;"[49]

The child welfare record does not include information that any of the above steps were taken to engage with or assess Matthew despite the assertion from his sister that he was physically hit by their mother and despite a prior investigation by DCF into allegations that Matthew was physically abused.

People with Disabilities

- **Are abused more frequently**
- **Are abused for longer periods of time**
- **Are less likely to escape the abuse**
- **Less likely to access the justice system**
- **More likely to remain in situations that increase their vulnerability and risk of repeated abuse**

Source: Prevent Child Abuse America/Virginia. http://pcav.org/wp-content/uploads/2013/05/Kids-With-Disabilities.pdf

[47] Id.

[48] United State Dept. of Health & Human Servs., Child Welfare Information Gateway, *The Risk and Prevention of Maltreatment of Children with Disabilities (*Mar. 2012), found on the web: https://www.childwelfare.gov/pubPDFs/focus.pdf, at 12.

[49] Id.

DCF substantiated Ms. Tirado for physical abuse of Matthew's sister and placed her on the state's Central Registry. DCF opened the case for ongoing treatment and supervision and told Ms. Tirado that it was considering whether the children needed to be placed into foster care.[50]

November 2014--HPS Calls DCF to Report Educational Neglect of Matthew by Ms. Tirado

While the October 2014 physical abuse investigation was pending as to Matthew's sister, DCF received another concern in November from Hartford schools stating that Matthew had not been coming to school and may not have been in school for a long time.

The DCF records at this time noted a "pattern of educational neglect… and two physical abuse referrals." The investigator from DCF informed Ms. Tirado that the neglect of Matthew was "egregious" and that DCF had "significant concerns regarding her parenting" and DCF would be filing a neglect petition with the Juvenile Court. Records indicate, however, that a neglect petition was *not* filed for another 18 months -- July 2016.[51] However, the two reports in October and November 2014 did result in DCF opening the case for ongoing agency supervision.

On November 7, 2014 a follow-up interview with Matthew's sister took place in the family's home. According to the DCF record:

Interview in Home with CHILD, age 6

> **[Investigator] attempted to speak with [child] while she was at the home. She was still dressed in her school uniform and did not appear to have any marks or bruises that were visible. Asked her how she had been doing and CHILD just stared at this worker smiling and did not respond. ISW asked if she was okay, she continued to stare blankly at this worker as if she was scared to open her mouth to speak. It should be noted that the apartment is very small and the children were in the living room of the home. Mother was in the kitchen area which is adjacent to the living room of the home. ISW asked CHILD if she had been physically disciplined since the last time she met with this worker and she just continued to smile. ISW asked CHILD what was wrong and why she was not talking to this worker and she did not respond…ISW was able to observe Matthew in the home. He was dressed appropriately and did not appear to have**

[50] DCF investigation records indicate that a "considered removal meeting" was going to be held to discuss the possible need for foster care, but records indicate that a later decision was made not to have the meeting due to the DCF SDM Safety Assessment scoring the children's safety as "conditionally safe" due to the family's agreement that Matthew would reside with the maternal aunt for the weekend while DCF continued its assessment of the family.

[51] In response to a question from OCA regarding why a neglect petition was not filed with regard to this family in 2014, DCF legal director responded that when Matthew's case was transferred to "on-going services, the assessment of the family's functioning was that it was beginning to improve. In addition Matthew had been enrolled in Oak Hill School resulting [in] his educational needs being met. It is likely that a decision was made not to file but [the decision] was not documented."

visible marks or bruises. ISW attempted to speak with the child but he did not respond. He is a 15 year old nonverbal Autistic.[52]

After the investigation was complete, the DCF case transferred from the Investigations/Intake Unit to the Ongoing Treatment Unit. On multiple occasions during 2015, DCF caseworkers (different workers from the DCF investigator) wrote that they met with Matthew's sister during home visits, often documenting that a caseworker met with the child "alone in the living room" or "alone in the dining room." The case record documents that the little girl reported "no concerns of safety in the home." She was described as "happy" and "upbeat" during at least one visit in 2015. The child made no further disclosures that she or Matthew were hit. Concerns regarding interviewing the child in close physical proximity to her mother were not noted again.

No steps were taken to facilitate a skilled assessment or child abuse assessment of Matthew at any time between October 2014 and the closure of the case in January 2017. As stated above, by the time a new social worker and later a new supervisor were assigned to the case in 2015 and 2016 respectively, the information from Matthew's sister that he was physically hit at home had, for all intents and purposes, faded away.[53] DCF's 2014 investigation also showed that Matthew had not been seen by his primary care physician since March of 2011, three and half years earlier.[54]

Matthew did not return to HPS until later in November 2014, at which time a meeting was held to recommend transferring him to a private, state-approved special education program called Oak Hill. Matthew remained an HPS student, but his education going forward would be provided for by the private program, paid for by his school district.

December 2014--Matthew Transitioned to Oak Hill School[55]

Matthew transitioned to Oak Hill School in December 2014, but concerns about his attendance quickly arose. A note from his January 15, 2015 PPT recommended "**follow up ASAP by [HPS] District case manager with home visit to address attendance and adaptive functioning**

[52] DCF Investigation Protocol.

[53] The information remains in the previous investigator's record of activities. But due to lack of follow up by the initial investigator and the failure to draw a conclusion regarding the younger child's allegation, the information about Matthew did not effectively carry forward in the case record.

[54] Records indicate that Matthew was given a basic health screening by HPS so that he could re-enter school in November, 2014.

[55] A local school district may contract with a private educational program or facility to meet the educational needs of a child who is in need of special education and related services. The type of program required by a child who is receiving special education services is determined by the child's Individual Education Program team/Planning and Placement Team. For children that the PPT recommends an "out-placement," i.e. a privately-run, but publicly-funded, special education program, such programs are subject to the evaluation and approval of the State Department of Education. The SDE has "authority and responsibility to evaluate the suitability and efficacy of such private facilities prior to the disbursement of state funds and grants to local educational agencies utilizing such facilities for special education purposes." *Principles, Procedures and Standards for the Approval of Private Special Education Program*, State of Connecticut, Department of Education (June, 1998), found on the web: http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/PPS.pdf

issues." Matthew was being provided door-to-door transportation by HPS. Oak Hill provided him with 1:1 paraprofessional assistance and intensive special education supports. Matthew's mother did not attend the January PPT, which noted that Matthew had attended only six days of school since transitioning to Oak Hill. Educators expressed their view that, based on their interactions with him, Matthew "wanted to be in school."

DCF Family Protective Factor Worksheet

Matthew's mother sat with a DCF social worker to fill out a work sheet about herself and her family.

Q. What do you think your child/children do best?

A. [Daughter] is good at school, Matthew … loves hugs.
Q. Are there things that worry you about your child/children?
A. Nothing.
Q. What do you hope for your child/ren as they grow up?
A. Daughter—wants the best for her, wants her to make it all the way. Wants son's medical situation to get better.
Q. What helps you cope?
A. Work
Q. What worries you?
A. Mom
Q. What do you do when someone gets sick?
A. Cuddle with daughter. Son does not get sick.
Q. When you are stressed?
A. Nothing. Go on with the day.
Q. Conflict with partner or children?
A. Not in a relationship. No conflict with kids.
Q. Do you have people who can help you?
A. Outside of mother, no one.
Q. Who has helped you in the past?
A. No one.

- Family—none.
- Neighbors—none.
- Community providers—none.

April 2015, HPS Calls DCF Careline to Report Educational Neglect of Matthew's Sister

In April 2015, Harford staff again called DCF's Careline to report that Matthew's younger sister had missed almost 30 days of school. HPS reported that staff had called Ms. Tirado, sent letters, attempted to set up a meeting, all with no effect. When DCF questioned Ms. Tirado about the new report, she claimed that her daughter had Scarlet Fever, but the child told DCF that she had not been to the doctor and that she just stayed home and played.[56] Oak Hill also reported to the DCF social worker that Matthew was not coming to school regularly and had not been in school for two weeks. Throughout the previous months Oak Hill communicated with HPS and Ms. Tirado its concerns regarding Matthew's chronic absenteeism.

Also in April, a different DCF social worker was assigned to Matthew and his family. This individual was the third social worker assigned to the family[57] since the case re-opened in October, 2014. The newly assigned worker later reported that when he took over the case there was no case transfer conference, and that he did not have time "to process or go over all of the cases that were

[56] Records reviewed by OCA indicate that subsequently Ms. Tirado took the child to the doctor to have blood work regarding possible Scarlet Fever, but this visit did not occur until more than 2 weeks after HPS called DCF Careline.

[57] The case transferred from an investigations social worker to a treatment worker in early 2015, and then due to that worker taking medical leave, the case was assigned again in April 2015. In total, three supervisors handled the case from November 2014 through January 2017.

newly assigned to him from the previous social worker's caseload."[58] The case worker stated that he did not review the electronic case record in its entirety.[59] The hard copy record and records related to any of Ms. Tirado's involvement with DCF as a child were not requested.

During an interview with the OCA, the caseworker reported being unaware of several key facts regarding the family members and their history with DCF, including:

- Matthew's grandmother had a significant prior history with DCF;
- Matthew's mother had been involved with DCF when she was a child;
- Matthew's mother had been treated previously for Agoraphobia and Panic Disorder;
- Matthew's mother was 15 at the time she became pregnant with Matthew and Matthew's father was more than 30 years older than his mother.
- Matthew's sister had previously alleged that Matthew was hit by their mother.

Interviews also indicated that a new DCF supervisor, assigned to the case in April of 2016, and the Program Manager (the supervisor's supervisor), were also unaware of the above-referenced case facts as well.

OCA notes that DCF's electronic case management system, the LINK system, is outdated, and it can be very time consuming to review and extract critical information to inform risk, safety and family needs assessments. Staff may also be hampered by shifting responsibilities as cases move from one social work team to another, as was the case here. Though caseload levels have been a persistent concern at DCF in recent years, OCA learned that the assigned caseworker in April 2015 was not over-capacity and did not have a full case load, though he had to assume new cases immediately.

A review of relevant case history is imperative for risk assessment and case planning. DCF's current effort to rebuild its case management database must be supported as an urgent priority, as assessment processes discussed in this report require reliable and efficient mechanisms for the inputting and retrieval of critical information about a family. Such a system *does not exist today*, and social work staff are hampered in their ability to do time-sensitive and comprehensive case reviews regarding families who may have extensive prior involvement with the agency. Interim measures must be taken to support thorough case review by caseworkers and supervisors.

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[58] Human Resources Interview of social worker, February 22, 2017. The caseworker reported to OCA that in April 2015 he "[d]id not have [his] own case load." He had "5 or 6" cases that he inherited from the previous treatment worker. He reported to OCA that he was "coming in fresh with no case load," he "was in a previous unit before getting moved; got [previous treatment worker's] cases and a couple of new cases. He reported to Human Resources that no transfer conference was held.

[59] Id.

July 2015, Oak Hill Contacts the DCF Social Worker to Report Matthew's Continued Absence

In July 2015, staff from Oak Hill responded to a DCF request for information, noting that "Matthew misses several days of school a week;" Ms. Tirado communicates only by text and is hard to get in contact with; she does not attend any of Matthew's meetings, and staff had questions "*as to who is supervising Matthew at home.*"

Oak Hill also created progress notes for Matthew and sent copies to his home, DCF and HPS, a practice Oak Hill continued throughout 2016 even after Ms. Tirado refused to send Matthew to school.

On September 25, 2015, staff from Oak Hill called DCF to report that Matthew was still frequently missing from school. According to records, Oak Hill offered DCF: "if you would like to have a provider meeting with Oak Hill and the parent, let me know." DCF records do not indicate that any such meeting took place.

Oak Hill staff also noted that when he comes to school, Matthew is "awake, alert, and always hungry."

OCA asked DCF whether it sought permission from Matthew's mother to participate in his or his sister's educational planning meetings. DCF's legal director responded that "the record does not reflect that DCF sought Mother's permission… As a general matter, DCF does not usually attend [Planning and Placement Team meetings] in in-home cases because we aren't the legal guardian. We will attend if a parent requests that we do so to assist in advocating for his or her child." It is noted, however, that educational neglect was one of the persistent concerns in this family's case, and there should have been regular efforts at communication and family engagement facilitated by DCF in partnership with the school and the district.

During an interview with OCA, Oak Hill personnel expressed frustration regarding the child welfare system's response to what they considered to be egregious educational neglect of Matthew. Oak Hill noted that in addition to sending regular updates regarding Matthew's progress and attendance to HPS, the family, and DCF, that one of the school's social workers spoke on the phone multiple times with the DCF caseworker. However, they felt that there was no "real plan" to assist Matthew, despite the family's case having been open with DCF since 2014. Program staff expressed frustration that "communicating with DCF is a one-way street," and that it can feel like "calling a black hole." OCA discussed these concerns with Oak Hill administrators and asked if they ever addressed them with DCF regional or agency leadership, or if they had a practice of "calling up the chain" when they felt their concerns were not being heard, or even of making a report to the DCF Careline if they felt underlying abuse/neglect concerns were persistent. Oak Hill staff were reflective during this conversation, but acknowledged that they had not taken those additional steps in Matthew's case. They committed to examining their own practices with regard to effective communication and advocacy with DCF.

DCF's ability to respond to providers is limited by state confidentiality laws and, without a release or court order, the agency may be legally unable to provide certain information to a concerned caller. However, in this case Ms. Tirado had signed releases of information. Best practice would recommend regular engagement between child welfare practitioners and providers who are working with a child and family. Providers should be knowledgeable about common goals for the family, and there should be regular discussion regarding progress towards the goals and how such progress is being measured.

A dictation note from Oak Hill's consulting psychiatrist—also a DCF employee--dated December 2015, notes that Matthew's transition to Oak Hill was positive, but that school attendance was "inconsistent," and that his mother did not "consistently communicate" when Matthew would not come. The note references a concern of sleep disturbance, but that this problem was "reportedly better."[60] A note from May 2015 dictated by the psychiatrist reflects Ms. Tirado's report that Matthew did not attend school because he was "too tired," but that "several attempts had been made to get in touch with mother to explore further but that she has not returned any phone calls or text messages." The same note stated that the issue would be discussed with HPS to seek "guidance" and "explore whether [filing a DCF report] was warranted." No DCF report was filed by Oak Hill staff.

Ms. Tirado explained to DCF that work responsibilities prevented her from participating in Matthew's school meetings, though at other times she reported that she worked third shift and was home during the day. She repeatedly expressed displeasure to DCF about Matthew's school experience and insisted that he was not really getting appropriate help or learning enough.

> In January 2016, an annual review PPT was held for Matthew, with mother attending by phone only after school staff called her to remind her of the meeting. A record of the meeting recommended "**Follow up ASAP by district case manager with home visit to address attendance and adaptive functioning issues."**[61]

A summary of the January meeting included the following:

> **Ms. Tirado said she wanted to have Matthew "removed" from Oak Hill. She "claimed that Matthew was not learning anything e.g., how to read or write, despite being severely autistic… [she] indicated that she was moving out of state with Matthew within a month… [Matthew's] lack of progress due to chronic poor attendance was shared with mother… he missed a total of 119 days of school." Ms. Tirado indicated that Matthew has trouble sleeping, but the school noted that mother did not follow up with a referral to see the Oak Hill consulting doctor to address concerns, despite Oak Hill contacting mother "several times." Hartford school officials also "offered to visit mother but she indicated she did not have time to see the HPS case manager since she works third shift."**

[60] Other dictation notes indicate that Matthew was prescribed Benadryl as a sleep aide.

[61] The language in the education record mirrors language and recommendation from a PPT held a year earlier when attendance issues at Oak Hill first arose.

The record indicated that HPS provided mother with a cell phone number for a case manager who would make himself available 24 hours per day.

During an interview with OCA, Oak Hill staff said that they had multiple conversations with the HPS special education case manager and, via text or phone, with Ms. Tirado, trying to address the lack of engagement by the family and Matthew's persistent lack of school attendance. Oak Hill staff emphasized to OCA their view that the HPS case manager diligently attempted to engage Ms. Tirado and problem-solve with her regarding Matthew's lack of attendance. Staff described the HPS case manager as "very present" with children and families, noting that he will pick up families from their homes, and that he "truly cares" about children. Oak Hill staff recalled Ms. Tirado responding to the case manager's willingness to visit her home by stating "**if you come, I'm not going to let you in**."

HPS, in response to an inquiry from OCA, noted that the district did not offer to hold a PPT for Matthew at his home, but they did offer a home visit, which was refused by Ms. Tirado. The district stated that "typically, a PPT is not held at the parents' home, however parents are informed that they always have the option of calling into a PPT if they are unable to attend in person."[62] HPS reported to OCA that, upon the recollection of the case manager,[63] he did attempt to visit the home on "two or three occasions in 2015 while he was in the community during normal school hours," but that the "parent did not answer the door and that he did not leave a written message for the mother on the door."

Records note that Ms. Tirado had high hopes for Matthew and that she was "depressed" by her inability to communicate with him. She told a DCF caseworker that Matthew could not even tell her when he was hungry, she would just put a plate of food in front of him during meal hours. She said that she was interested in learning sign language to improve communication between her and Matthew and that she felt sad because she felt that she didn't know who he was. She reported to DCF that Matthew was well-behaved and just isolated himself in "his own little world." She did say that she wanted help learning sign language and "finding programs that work with Autistic children and their development."

DCF's record does not indicate that it made referrals on Ms. Tirado's behalf or connected her with DDS.

Despite Ms. Tirado's assertions that she wanted help to interact with Matthew, she inexplicably rejected offers of assistance from other sources.

A medical record from September, 2015 indicates that Ms. Tirado was referred by a doctor to the Village for Children and Families due to her urgently expressed desire for help with Matthew. Ms. Tirado eventually did call the Village, *5 months later*, and though the community agency offered her a same-day appointment, she declined and never followed up.

[62] HPS response to OCA inquiry, April 25, 2017.
[63] HPS did not have documentation of home visits to this family, though district policy requires that "all parent outreach efforts must be documented." Policies of the Hartford Public Schools § 5114(g).

Somewhat contrary to Ms. Tirado's concerns about Matthew's performance at Oak Hill, records from this time period indicate that Matthew was able to read and write a little bit. He was able to write his first and last name and teachers noted that he "took pride in his writing. He enjoyed looking at books independently and was able to read some of the words without support—especially basic sight words." He was also able to count to 15, and enjoyed completing art projects. He would "take time to complete [art projects] independently." He enjoyed greeting peers and teachers in his classroom and was learning to communicate through 1 to 2 word phrases, pictures and basic sign language. Matthew was learning to complete vocational tasks as well, working on a computer for up to five minutes at a time, making copies and wiping down tables for short periods of time. Matthew enjoyed cooking as well. Matthew liked participating in group activities and handing out a "Renter's Guide" to community members and delivering items on the Oak Hill campus.

It is impossible to say what Matthew's developmental trajectory would have been if he had been allowed to be educated, but his records indicate that throughout his life, when he was allowed to attend school, he thrived and improved. Education is not simply a *value* for children it is a *necessity* and the denial of an education to a child, particularly a child with a disability is a significant harm with life-long consequences.

During the time Matthew spent at Oak Hill, the school conducted numerous academic, functional and behavioral assessments, and provided special education supports to him. Oak Hill staff reported to OCA that they never harbored concerns that Matthew was being physically abused, and they were shocked by news reports about his appearance at the time of his death. They reported that though he did not need help with toileting and other personal hygiene habits, they did see him in t-shirts and never saw any visible signs of physical abuse. They did not see him over the summer, as his mother opted out of summer programming, and they never took him swimming as a recreational or community activity.

Matthew's Independent Living Skills/Adaptive Behavior Assessment (Oak Hill)

Demonstrates the behavior or skill most of the time

- Toileting.
- Dressing.
- Appropriate meal time behavior. (Note: Oak Hill Dining Guidelines and interviews by OCA with Oak Hill administrators indicate that Matthew had no specialized eating support needs, and he demonstrating no inappropriate eating behaviors such as hording or over-eating.)
- Appropriate grooming.
- Appropriate behavior.

Developing Skills/Behavior

- Comprehends typical verbal communication
- Adequately expresses emotion, choice
- Demonstrates knowledge of what activities are necessary to maintain personal safety
- Understands the concept of time
- Takes turns when appropriate.

Not demonstrating Skill/Behavior

- Applies functional academics to his health and safety
- Avoids situations in which he could become the victim of a crime

DCF Case Records Contain Little Information Regarding Matthew during Home Visits Conducted Between 2014 and 2016[64]

Between December 2014 and February 2015, following the investigation into allegations of physical abuse in the home, Matthew was seen only once by DCF workers, though there were multiple home visit attempts. Finally, in March 2015, the DCF worker was able to see Matthew during an announced home visit, but his mother and sister were not present, only his grandmother. Matthew was noted to be "*clean, dressed appropriately and happy*." Subsequent visits, when contact was able to be made, often noted that "*Matthew was in his room*," or "*Matthew ignored [caseworker]*," or *"[Caseworker] observed Matthew in his room, playing on the bed. No concerns. Child is autistic and nonverbal*." Sometimes the case record would say only that "*Matthew observed in the home*." During a visit in May, 2015, the caseworker noted that he attempted to meet with Matthew but that Matthew did not wish to meet with him. "*When asked to do so he waved at [caseworker] from the door of the bedroom and went back inside shaking his head*."

The final DCF case worker assigned to the family[65] reported (during internal interviews with DCF Human Resources) that he had limited interaction with Matthew, but that he would watch Matthew's "body language" to assess his comfort in the environment. The caseworker stated that, per Ms. Tirado's instruction, he was never allowed outside of the family's living room and that he never saw where Matthew slept and spent his time. The few times that the caseworker tried to go into the bedrooms Ms. Tirado yelled "no," and called the children out. These observations and limitations are not documented in the DCF case record. The case worker reported

Purposeful Visitation: Children with Developmental Disabilities

In response to questions from the OCA regarding "what constitutes a high quality home visit and child-contact in the case of a child with a complex disability/developmental disability," DCF responded by referencing a list of agency practice manuals available to caseworkers and indicated that best practice guidance is "woven into the [DCF] practice model in several" ways. Though DCF's manuals have much in the way of helpful guidance and iteration of best practices with regard to children generally, OCA did not find specific guidance regarding what steps a DCF caseworker should follow when attempting to assess the safety and well-being of a child with a developmental or other complex disability who is unable to engage in typical communication. Assigned staff interviewed by OCA confirmed that they have little or no training specific to the needs of children with developmental disabilities, despite noting the ever growing number of children with disabilities coming to DCF's attention.

Child welfare agency workers require specific training regarding 1) the unique vulnerability of children with developmental disabilities to abuse and neglect; 2) assessment and engagement practices for children with disabilities; and 3) agency and community-based resources that can assist child welfare practitioners in assessing and ensuring the safety of children with such disabilities.

[64] DCF's Case Planning Guide (2014) provides that: "[a]ll children and families with whom DCF is involved should be visited based on the case goal and the needs of the family, keeping in mind the minimum visitation standards outlined in policy." Guide at 8.

[65] The case worker who took over the case in April 2015 and handled it through January, 2017.

to Human Resources that he actually never saw Ms. Tirado interact with Matthew other than to tell him "no."[66] The caseworker, similar to other DCF staff who spoke to or were interviewed by OCA, stated that he had never received training regarding how to investigate or conduct case planning for children with developmental disabilities.

As stated earlier in this report, there is guidance from national experts and the federal government regarding prevention, identification, and response to concerns of abuse and neglect of children with disabilities, which guidance addresses how to assist potential victims who may have significant challenges and communication disorders. Current DCF practice does not appear to incorporate this guidance, specifically speak to child safety issues affecting children with disabilities, or provide specific information regarding how to identify or assess child abuse among children with complex disabilities, including intellectual and developmental disabilities.

January 2016--Ms. Tirado Remains Frustrated with DCF Involvement, Denies Any Problems with Her Children

Ms. Tirado repeatedly told DCF that she did not think there were any problems in her family or with her parenting that warranted DCF or other support. She told DCF that she was a good parent and that the Department "should be bothering other people." The caseworker told Ms. Tirado that if she demonstrated that she could meet the children's educational and medical needs, then the agency would close the family's case.

Records do not reflect that DCF staff had any concern regarding Ms. Tirado's mental health or any other psychological impediments that were affecting her ability to meet the needs of her children. Educational neglect, however, particularly chronic and persistent neglect, may be a symptom of underlying pathologies and unmet mental health treatment needs, including parental trauma. In this case, the most important information regarding Ms. Tirado's mental health and parenting capacity was likely the extensive history she had with DCF as a child, including concerns of physical and educational neglect within her own home, her pregnancy with Matthew at age 15 by a man decades older than her, her extensive trauma history, and her 2009 admission to DCF that she struggled with a history of anxiety and depression. DCF records reviewed by OCA show that Ms. Tirado's mother had a history significant for anxiety, depression, excessive drinking, homelessness, and persistent child welfare intervention. Notably, the DCF caseworker who was assigned to the family from April 2015 until January 2017 reported during an internal human resources interview following Matthew's death that he could not visit with or engage with Ms. Tirado's mother because she "spoke very little English."[67]

None of the information about the family's multi-generational history of child maltreatment or mental health disorders are identified, addressed or integrated into the case plan involving Ms. Tirado and her own children. In fact, repeated assessments completed by DCF state that Ms. Tirado *did not* have any

[66] Written report of interview with case worker, conducted by DCF Human Resources Department, February 22, 2017.
[67] Written record of February 22, 2017 interview with case worker conducted by DCF Human Resources Department, pg. 4.

history of child maltreatment and that she had adequate coping skills, parenting abilities, and an adequate support network, all information contradicted by the case record.[68]

January 2016--HPS Calls DCF Careline to Report Educational Neglect of Matthew's Sister—Ms. Tirado Tells DCF She Is Moving out of Connecticut

In January 2016, HPS elementary school staff contacted the DCF Careline to report that Matthew's sister, then in second grade, was still missing school. HPS also reported that Ms. Tirado refused help and referrals to address truancy. The report was not accepted by the DCF Careline because the family's case was already open with the local DCF office for the same issues.

Ms. Tirado stopped allowing Matthew to go to school in January 2016. He did not attend again prior to his death in February 2017.

Ms. Tirado told the DCF caseworker during a home visit that she was planning on removing Matthew from Oak Hill, and that she wanted to move to New York City. Later correspondence between DCF and HPS in April of 2016 indicated that DCF did not believe that mother was moving and that the Department intended to file a neglect petition in the Juvenile Court on behalf of the children. The children's case had now been continuously open with DCF for 18 months.

March 2016--HPS Calls DCF Careline to Again Report Educational Neglect of Matthew's Sister

In March 2016, HPS elementary school staff again contacted DCF to report Matthew's sister was still missing school. DCF declined to accept the new report for a new investigation but sent a letter back to HPS indicating that the family had an "[a]ctive case, ongoing issues."[69]

An internal discussion at DCF regarding the persistent concerns in the family noted:

> "Assessment tool shows minimal concerns however both children continue to miss school and mother has been unwilling to meet and discuss ongoing information with the Social Worker, **thus assessments are only able to be minimal at best.**"

[68] Any findings on the SDM Assessment are supposed to be incorporated into the child and family's case plan. But as stated above, these assessments were repeatedly filled with erroneous findings, resulting in few needs or required services being identified in the case plan. Only the last two assessments found that Ms. Tirado had inadequate parenting and protection skills. But the final assessment filled out on the family in January 2017 continued to state that Ms. Tirado had adequate coping skills and support systems (despite the death of her mother, her only acknowledged resource), and no child maltreatment history. The same assessment stated that Matthew had achieved "satisfactory [educational] achievement and development."

[69] In response to questions from OCA, DCF stated that the new reports from HPS were properly "non-accepted because the only allegations were school attendance concerns which were already the subject of the ongoing case." DCF clarified that "these new allegations were not considered repeat maltreatment."

Despite the Persistent Ongoing Concerns No One Else from DCF Other than the Assigned Caseworker Participated in Assessment or Engagement Efforts with Matthew's Family.

In response to questions from OCA, the DCF legal director reported that "other than the assigned or covering [case workers], no one else from DCF met with the family." There were no consults with internal regional resources (RRGs) at the Department that are available to consult on cases that involve children with medical complexity, special education needs, or parents with significant and unresolved mental health needs. OCA notes however that there are no specific members of the internal resource group at DCF that are designated to be experts on developmental disability. Multiple DCF staff told OCA during the development of this report that such expertise, along with additional training for DCF staff, would be invaluable for child abuse investigation and family case planning. Staff reported to OCA that there is no "go to" expert on children with autism.

Given the persistent nature of the neglect concerns, and the intractable resistance of Matthew's mother to educational/developmental services that would support her child year-round, and DCF's acknowledgement that assessment tools were not useful due to the mother's resistance, a different approach could have utilized other consultation resources within (or external to) the Department to meet with the family, assist with safety and risk assessment, and support more effective case planning and intervention. DCF staff reported to OCA that there is not as much cooperative case planning with outside disability-serving agencies as there could be, including the state's Department of Developmental Services, and that agencies tend to exist in silos that are hard to break out of. If Ms. Tirado could not be engaged despite efforts, then court intervention should have been sought much earlier in the case.[70]

Child welfare caseworkers should be assisted by community-based providers that are experienced in working with families who have children with disabilities and who can fill the role of case manager or care coordinator for the family. A whole-family approach is often necessary to improve outcomes for the child and caregivers, with care coordination and assessment examining the needs of all family members and what interventions and sustained supports may help the family thrive over time. DCF should also examine whether its Community Support for Families' contracts could encompass this type of service for families who have children with complex disabilities.

It is also not clear what the treatment *plan* was for the family over the 27 months the case was open between 2014 and 2017, other than for the mother to meet the *goals* of ensuring the children's medical and educational needs were met, which she was unable to accomplish. The family's DCF case plan from 2015 stated that no services were recommended for the family. There is no record that Matthew was ever referred to DDS by DCF, HPS or any other provider.

[70] No neglect petition was filed until July, 2016, 21 months after the investigations into physical abuse and educational neglect of the children.

Ms. Tirado likely needed help understanding what Matthew's needs were and how best to cope and manage with his life-long disability.[71] Some parents of children with developmental disabilities believe that their child will be cured of or outgrow their disability, and parents may grieve when they realize that their child presents with significant limitations. Case planning for families that have children with complex needs must encourage a different approach to parenting, and support the family with tools that allow them to accept their child's needs while providing strategizes and services that help the child achieve optimal development, and help the family function and thrive together.

After March 2016, Matthew's Mother Stopped Allowing DCF Access to her Children

On March 14, 2016, a DCF caseworker met with Ms. Tirado and her daughter at a local drugstore. Ms. Tirado reported that Matthew was now living with an aunt, but she wouldn't say where or name the relative. The caseworker voiced concern that Ms. Tirado's daughter was not "medically up to date," and that she had not had a physical since January 2013—over three years earlier. Two weeks later, the caseworker visited the home and saw Matthew in the care of his grandmother. The worker noted that, by this time, Matthew had not been attending school for months despite his grandmother telling the DCF worker that he was still attending. There were unsuccessful home visit attempts in April and May by DCF. On June 22, 2016, Ms. Tirado reportedly told DCF that she would call the police if the caseworker came to her house again. Over the next several months DCF records indicate that multiple letters were sent and home visits attempted. **The children were not seen again prior to case closure in January 2017, and there were several months where no visits were attempted.**

In April 2016, a new supervisor was assigned to the case. Changes in personnel can often create challenges for newly-assigned supervisors who are not as familiar with the case history and the family dynamics, particularly where prior risk, safety and family need assessments are completed *incorrectly*, as was the case here.[72] Supervisors necessarily rely heavily on the caseworker's interaction with the family and interpretation of the case record.

During a documented supervisory case conference in May 2016—after the children had not been seen for some time--the DCF caseworker and supervisor discussed the family and the worker's finding that the children, during previous visits, appeared to have a good relationship with their mother. The family

[71] Kandel, I., Merrick, J., *The Child With a Disability: Parental Acceptance, Management and Coping*, The Scientific World Journal (Nov. 12, 2007) (discussing families' needs when coping with and accepting a child's disability: "Families' coping patterns depend on a wide variety of factors, like personality, support system, education, financial situation, spousal relations, family cohesion, and the level of the child's handicap."); Paczkowski, E. and Baker, B., *Parenting Children with Developmental Delays*, J. Mentl. Health. Res. Intellect. Disabil. Vol. 1, Iss. 3 (2008) ("The heightened stress experienced by parents of children with disabilities is a well-documented finding.").

[72] As discussed in other sections of this report, OCA found that initial and ongoing risk assessments conducted in Matthew's case through 2017 were completed incorrectly, thereby erroneously downgrading the risk for future child abuse and neglect. The Family Strength and Needs Assessments completed on the family were also replete with dubious findings such as: Ms. Tirado has an "adequate" support system and displays "adequate" coping skills; Ms. Tirado "adequately parents and protects" her children, and Ms. Tirado has no history of her own child maltreatment. DCF supervisors typically are responsible for 4 to 5 caseworkers, each of whom may have up to approximately 20 families assigned to their caseload. Supervisors rely on the caseworker's interpretation of the child welfare record.

members got along well "despite the ongoing missed school days and concerns about [medical care]. *Matthew spends a lot of time in his bedroom watching TV. He does not often exit his room when [the case worker] visits*. Maternal Grandmother and Matthew seem to have a caring and gentle relationship… Mother and [youngest child] do seem to have a nice, calm relationship. They appear bonded and connected. Mother and Maternal Grandmother seem to have a decent relationship and mother relies on her a lot." OCA notes that the caseworker reported to Human Resources following Matthew's death that he never saw Ms. Tirado and Matthew interact other than observing her telling Matthew "no."

But as time wore on without hearing from Ms. Tirado or seeing the children, and with Matthew still not allowed to attend school, DCF determined that more must be done to ensure the safety and well-being of the children. The new supervisor directed the caseworker to take multiple actions to find and see the children:

- The caseworker was directed to discuss the situation with an Assistant Attorney General. Once the case was actually filed in court, an Assistant Attorney General represented DCF in the child welfare proceeding.

- The caseworker was directed in November 2016 to continue making visitation attempts until "the children are found." There is no documentation that this follow-up occurred between November and January when the case closed.[73]

- Also in November 2016, the DCF caseworker was directed to contact the schools for updates on the children. There is no documentation that this follow-up occurred prior to case closure.[74]

- In November 2016, the DCF caseworker was directed to gain information regarding the family's landlord to confirm if they were still there and paying rent. There is no documentation that this follow up occurred prior to case closure.

[73] Records indicate that an attempt was made by the DCF caseworker in December 2016 to connect with Ms. Tirado during a traffic court appearance. Letters were not responded to, and per the DCF record Ms. Tirado was hostile to the caseworker during the traffic court connection.

[74] In October 2016 the DCF supervisor contacted Matthew's sister's school to confirm her attendance. The front office reported that the child was attending school at that time but the office staff disconnected the supervisor while trying to transfer her to the child's classroom teacher. The supervisor directed the caseworker to complete the contact and follow up with the teacher, but there is no documentation that this occurred prior to case closure.

Caregiver's Refusal to Cooperate and Provide Access to Child is a Significant Safety and Risk Concern per DCF's Risk and Safety Assessment Tools

DCF's Initial Safety Assessment tool, used at the outset of an investigation of abuse or neglect identifies a caregiver's refusal to allow access to a child as a "safety factor" that must be addressed by the agency as part of a child safety plan, either through intervention or, where determined necessary, through removal of the child from the home.

Similarly, DCF's Risk Reassessment Tool, used during active cases, identifies the lack of cooperation or engagement from a parent who has abused or neglected their child as a significant risk factor.

- The caseworker was directed to complete a check with the Department of Motor Vehicles to track down mother's car. Though there is no documentation in the DCF case record that this was completed, a court transcript indicates that a DMV check was sought.

- The caseworker was directed to conduct a well-child visit with police, but there is no documentation that this was sought.

- The caseworker was directed to conduct a Lexis-Nexus search[75] to identify other family members and attempt to connect with them through last known addresses of relatives. But there is no indication that this follow up was completed.[76]

February—April 2016, HPS Communicates Frustration Regarding Matthew's Absenteeism to DCF

On February 19, 2016, HPS communicated ongoing attendance concerns to DCF, noting that from January 2015 to February 16, 2016, Matthew missed 133 days of school. HPS asked for more information from DCF regarding "what course of action [DCF] plans on taking."

Hartford education records for Matthew indicate that Ms. Tirado called the district stating that she wanted to withdraw Matthew from Oak Hill, and that she was moving out of Hartford. She requested a copy of Matthew's records. HPS reported to OCA that it did not receive a withdrawal from mother "or any other information indicating that Matthew had been withdrawn from school," and HPS did not receive a request for records from any other school district indicating that Matthew was enrolled elsewhere.

[75] LexisNexis is a public records data-base available as a fee for service utilized by DCF in searching for known relatives or other information relevant to a child welfare case.

[76] During an interview with DCF internal Human Resources department, the caseworker acknowledged that he did not request the police check, visit Matthew's sister in her school, go to the school at the end of the day to see if he could make contact with Ms. Tirado when she would pick up the younger child from school, attempt to locate Ms. Tirado at her job, contact the landlord to establish residence, contact any other local school systems where relatives lived to see if Matthew was enrolled, or contact other relatives to confirm whether they had seen Matthew or whether Matthew was living with them. Per written record of interview with DCF caseworker conducted by DCF Human Resources Department on February 22, 2017.

A follow up email from HPS to the DCF caseworker on March 21, 2016 indicated that Ms. Tirado was now refusing to speak to the HPS case manager as well.

> **What does DCF plan on doing? I have much concern that there is severe educational neglect going on for a student who due to his autism has significant needs. Could you please get back to me. Thank you!**

On April 11, 2016, HPS sent another email to DCF, copying a supervisor[77] and an educational consultant internal to DCF.

> **I have not heard back from you regarding what the department plans on doing over Matthew Tirado's chronic lack of attendance at Oak Hill and significant truancy. Could you or [supervisor] get back to me ASAP. Has the Department sought to refile or seek other interventions to get his mother to bring him to school? Mother's educational neglect is very concerning given his severe autism. Thank you!**

On April 15, 2016, the DCF caseworker sent a response to HPS echoing the district's concerns:

> **Hello, I was under the impression Mother withdrew him from the school. She informed me also Matthew would be moving to a paternal relative's home in South Windsor but refused to give details. I don't believe her at all though. The Department is filing neglect petitions with the Juvenile Court soon.**

HPS acknowledged receipt of DCF's email and asked to be kept informed of DCF's activities. OCA's review of the record reveals no further communication between HPS officials and DCF until Matthew's death in February 2017, other than the phone call from a DCF supervisor to an HPS elementary school in October 2016 asking about Matthew's sister's school attendance.

Throughout 2016, Oak Hill, who was still waiting for a PPT to be held regarding Matthew's school placement, continued to contact HPS officials regarding Matthew's lack of attendance and the need for follow up. HPS cancelled Matthew's school transportation to Oak Hill in July, 2016, five months after his mother stopped sending him to school. HPS continued to pay Oak Hill through the end of 2016, approximately $11,000 per month.

In September, 2016 Oak Hill sent another email to HPS' special education case manager:

> "**As we spoke last week I wanted to remind you that [ANOTHER STUDENT] and Matthew Tirado continue to be chronically absent in their attendance at Oak Hill School. I know you were in the process of involving DCF on both cases. Please let me know if there is anything we can assist you with on our part."**

[77] It appears the supervisor copied on the email from HPS had been re-assigned, and as of April, 2016 was no longer supervising Matthew's case. A new supervisor was assigned.

HPS reported to OCA that it did not have any written documentation of its response to this email, and that HPS did not have any further contact with DCF regarding Matthew.[78] HPS reported that it did not appear that district administrators consulted with internal or external legal resources regarding how best to respond to the prolonged and persistent concerns regarding Matthew.

Despite Matthew's lack of attendance to the school and HPS's communication to Oak Hill that Matthew would no longer be attending per mother's wish, Oak Hill continued to send progress notes to the district, the family, and DCF, which notes documented Matthew's lack of attendance in school. Oak Hill administrators, interviewed by OCA as part of this investigation, stated their view that they remained responsible for Matthew's education until a formal PPT could be held to transition him appropriately from their program to another educational program.

May 2016--HPS Files Family With Service Needs Petition (Truancy Grounds) with the Judicial Branch Regarding Matthew's Sister.

In May 2016, HPS filed a Family With Service Needs Petition[79] alleging that Matthew's younger sister was chronically absent from school, and that no efforts made by the district had been successful to address the problem. The response received by the district from the Judicial Branch stated that the referral was "not accepted due to the child only being 8 years old."[80]

HPS reported to OCA that "it is not standard protocol for HPS to forward a Family With Service Needs petition to DCF," and that once the petition is filed, "the Court notifies DCF."[81] The DCF legal director acknowledged to OCA that it did receive notice of the filing, but it was "not clear how or if the caseworker followed up on this."

[78] HPS reported that with regard to the other student referenced in Oak Hill's email, the district made a report of suspected child abuse/neglect to DCF on February 16, 2017.

[79] A Family Service Needs Petition is a complaint filed with the Juvenile Court that a child is beyond control, truant, or has run away from home, i.e. engaged in behavior that constitutes an "offense" due to the child's *status* as a minor. The purpose of the complaint is to secure services and supervision from the Judicial Branch and its Court Support Services Division so that the needs of the child and family can be met and the child's safety maintained.

[80] In response to questions from the OCA, the Judicial Branch responded that though the statutory minimum age for such petitions is 7, the over-arching policies of the juvenile justice system are to divert children from the court system, and that "bringing an 8-year-old to court for truancy is often not in the best interest of the child, as the truancy is most likely a result of a parenting issue such as neglect." DCF and the Judicial Branch do have protocols for coordinating information and interventions, and in this case, the Court Support Services Division "did provide a copy of the FWSN referral to DCF for its information and response as DCF was involved with the family."

[81] HPS letter to OCA, dated April 25, 2017.

July 2016--DCF Files a Petition Regarding Matthew and his Sister with the Juvenile Court Alleging Children are Neglected

In July 2016, DCF filed a neglect petition with the Juvenile Court.[82] The petition traced the family's history with DCF and the history of allegations of physical abuse and neglect. The neglect petition noted that as of January 2016, Matthew had missed over 100 days of school the previous year, and that he had not attended school in months. DCF's petition further alleged:

> **"[Matthew's sister] is 8 years old and Matthew is 16 and diagnosed with Autism; he is non-verbal therefore he is unable to express his thoughts and perspective. Both children are completely dependent on competent adults to provide all their needs in order to survive."**

July through December 2016, Matthew's Mother Never Appeared in Court or Responded to DCF's Petition

Court activity following DCF's filing of the neglect petition:

- August 16, 2016

  Initial Plea Date. Ms. Tirado did not appear in court. Court records indicate that DCF was directed by the court "to make best efforts to contact [children's] mother and inform her that a default may enter." Abode service was confirmed with regard to Ms. Tirado on this date. Court orders previously granted to allow for "notice by publication" to the children's fathers, whose whereabouts were unknown to DCF at the time the neglect petitions were filed.

- August 23, 2016

  Plea Date. Ms. Tirado did not appear in court. The Court "defaulted" all parties for Failure to Appear. The Children were adjudicated neglected on the grounds that they were "denied proper care and attention, physically, educationally, emotionally or morally;" and that they were "being permitted to live under conditions, circumstances or associations injurious to [their] well-being."[83] No disposition was ordered at the time.

  Once the Court finds that a child is uncared for, neglected, or abused, the Court may enter a dispositional order that will either 1) commit the child to DCF care/guardianship (i.e. foster care); 2) transfer the child's guardianship to a suitable

[82] Internal DCF records indicate that a neglect petition was recommended for filing in March 2017, but was not actually filed for several months.
[83] Neglect is defined by Conn. Gen. Stat. § 46b-120.

person or agency; or 3) maintain the youth with a parent or guardian with protective supervision by DCF, subject to court orders and conditions.[84]

Because Ms. Tirado had not yet cooperated, the judge continued the dispositional portion of the case to give DCF additional time to locate and engage Ms. Tirado in the court proceeding.

- September 13, 2016

  In Court Judicial Review. Ms. Tirado did not appear. The Court ordered that a summons be issued to the mother and that it be served personally with a note that the mother's continued failure to appear would result in the issuance of a warrant for her arrest.[85]

- September 27, 2016

  In Court Judicial Review. Ms. Tirado did not appear. The children's attorney reported that he went to the home three times and left his business card and notes to call. The Court noted that a capias order and warrant for mother's arrest for failure to appear could only be issued if the court could confirm "in hand" service of a subpoena to appear. The court record reflects that the marshal "couldn't even get in to [the home] to verify the address" despite trying "several times."[86] The Court offered to give DCF orders that would permit it to seek additional information from schools or other providers regarding the children, and the Assistant Attorney General asked for additional time to consider next steps and consult with a DCF manager.

- September 29, 2016

  In Court Judicial Review. Ms. Tirado did not appear. A different Assistant Attorney General was present. The caseworker stated that he did not know if the manager spoke to the other AAG, but he also stated that his manager wanted to engage in more efforts to find relatives of the children. No orders were sought by any party to obtain

[84] Conn. Gen. Stat. § 46b-129(j).

[85] Notice of a juvenile court proceeding may be accomplished through abode service, i.e. a marshal leaving notice of the proceeding and dates to appear at the known address of the respondent. If a court wishes to compel an individual's appearance and hold such individual accountable through possible arrest for non-appearance, the respondent individual must be personally served or must have actual notice of the proceeding, expectation to be present, and consequence for failure to appear--notice may not be presumed.

[86] This reference to the marshal's inability to access the family's home seems to pertain to the Court's subpoena for Ms. Tirado to appear. The OCA confirmed that there was a valid Return of Service on the original neglect petition, and that it was served at Ms. Tirado's "abode," with Return of Service identifying "abode" as Ms. Tirado's specific apartment. State statute setting forth the requirements that must be met for the court to be authorized to issue a capias does not require physical acceptance of the subpoena, if the person is given notice of it and its contents. However, abode service of subpoena authorizes the court to issue a capias only if the party requesting the capias establishes that the absentee witness received the subpoena and knows of the contents of the subpoena. *Moye v. Commissioner of Correction*, 168 Conn. App. 207, *cert denied* 324 Conn. 905 (2016).

education or medical records as previously suggested by the Court, for Ms. Tirado to produce her children for assessment, or for any party to interview Matthew's sister in the school.

- October 6, 2016

  In Court Judicial Review. Ms. Tirado did not appear. DCF informed the court that it had previously contacted Matthew's sibling's school and confirmed that she was attending at that time [in October], but that Matthew had still not been seen.[87] The Court granted DCF a default judgment, and the children were adjudicated neglected.[88] DCF sought and obtained a dispositional order of Protective Supervision for six months, to extend through April 6, 2017. Pursuant to state law, the Court's order for Protective Supervision included judicially-ordered conditions, including the duration of supervision requested by DCF, "specific steps," and in-court review dates.

Per statute, "specific steps" require a parent or guardian to follow certain court orders necessary to "retain or regain custody of [a] child or youth."[89] The specific steps issued in Matthew's case required Ms. Tirado to:

- Keep all appointments set by or with DCF including to cooperate with home visits by DCF and the children's attorneys;
- Let DCF and the attorney for the children know where she and the children are at all times;
- Take part in counseling and make progress towards identified treatment goals;
- Take care of the children's physical, educational, medical, or emotional needs, including keeping the children's appointments with his or her medical, psychological, psychiatric or educational providers;
- Make all necessary child care arrangements to make sure the children are properly supervised and cared for by appropriate caretakers.

When Specific Steps are ordered, DCF is reciprocally ordered to assist the parent in meeting the court-ordered expectations. DCF is also ordered to ensure the safety and well-being of the subject children.

[87] Matthew's sister had been moved into a new elementary school. On October 6, 2017, that school's front office provided information to DCF via phone that the child was currently attending and had missed three days of school so far.

[88] The Judgement File indicates the date of the adjudication and disposition is October 6, 2016. The transcript from the August 23, 2016 hearing indicates that the court defaulted the parties on that date.

[89] Conn. Gen. Stat. § 46b-129.

DCF Status Report Filed with the Court December 6, 2016

Present Situation

"Ms. Tirado and the family have continued to evade the Department despite several attempts to locate them." DCF "has attempted several visits to the home without success." DCF sent certified letters to the home. "On 10/6/2016 DCF learned that [Matthew's younger sister] was no longer attending school at [one Hartford elementary school] and was transferred to [another school] in Hartford… The school reported [child] has maintained satisfactory attendance and *there do not appear to be any safety concerns associated with this family.*[90]"

"Despite the many concerns the Department has had which led to neglect petitions being filed with the court, it has been difficult to work with and assess a family that is essentially whereabouts unknown. The family is unwilling to meet with the Department, they do not answer phone calls, allow visitation to the identified home, nor respond to the requests of the court. Based on the consistent inability to meet with and assess the family, services cannot be identified nor offered. For all of these reasons, the Department recommends the Protective Supervision expire effective today 12/8/16 if Ms. Tirado does not attend the hearing on this date and continues to evade the Department and the Juvenile Court."

- December 8, 2016

  In Court Judicial Review of Protective Supervision.[91] Ms. Tirado did not appear. The Court, based on a new recommendation from DCF to close the case, modified its previous dispositional order and ended supervision and the Court's jurisdiction on this date. The memorandum of hearing indicated that "Mother has never appeared in court. Judgment entered via default. DCF indicated at that time despite being unable to talk to mother that it wanted Protective Supervision. Today [DCF] reported contact with mother who was uncooperative. So they moved to end [Protective Supervision]."

[90] The child welfare record indicates the following: On October 6, 2016, a phone call was made by a DCF supervisor to the child's school; the school's main office "reported that [Matthew's sister] has had one excused absence so far this year and 1 unexcused absence…. From the main office, there are no known issues. Call was disconnected when trying to reach the teacher. [DCF caseworker] will follow up with the teacher." There is no documentation that any follow up occurred over the next two months prior to the December 8th court date, and the only information provided to DCF came from the school's main office.

[91] The Connecticut Practice Book requires that an order for protective supervision must be "[s]cheduled for an in court review and reviewed by the judicial authority at least 30 days prior to its expiration. At said review, an updated social study shall be provided to the judicial authority." Practice Book § 35a-12.

There Are Several Concerns with Regard to the Process Leading to the Termination of the Court Case

1. DCF Did Not Provide a Written Motion to Vacate the Court's October 6, 2016 Order for Protective Supervision and Specific Steps.

   The Court's decision on December 8, 2016 to modify or vacate its previous order for protective supervision and terminate its jurisdiction over the children's case was issued after receipt of a written recommendation from DCF, submitted to the Court in the form of an agency Status Report and dated December 7, 2016. Though the Court's memorandum notes that DCF "moved to end [protective supervision]," no written motion to modify the disposition, inclusive of a clearly articulated legal and factual basis, was offered by DCF.[92] DCF non-legal staff drafted the recommendation and submitted it to the Court clerk's office.[93] The DCF legal department did not participate in the development of the recommendation and status report.

2. DCF's Status Report Did Not Make the Required Offer to the Court that Ending Protective Supervision Served the Best Interests of Matthew and his Sister.

   The grounds for a modification of the juvenile court's dispositional order is whether such modification serves the "best interests of the child or youth upon a fair preponderance of the evidence."[94] DCF's status report contended that despite its "many concerns," it was not able to assess the family due to the mother's evasiveness and unwillingness to meet or confirm the children's whereabouts. Not only is this not a cognizable ground for a motion to modify the Court's order, it is the opposite of an assertion that ending protective supervision serves the best interests of the children, particularly Matthew, who had not been seen by DCF or school personnel for nine months. The status report made no assertion that Matthew was safe and instead acknowledged that Matthew, like his sister, was "completely dependent on competent adults to provide for his needs and survive."

   The DCF staff assigned to Matthew's family acknowledged during interviews with DCF Human Resources (and separately during interviews with OCA) that they had never had a

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[92] Practice Book § 34a-1 provides that a "motion or request, other than a motion made orally during a hearing, shall be in writing. An objection to a request shall also be in writing…The form and manner of notice shall adequately inform the interested parties of the time, place and nature of the hearing. A motion, request, or objection to a request whose form is not therein prescribed shall state in paragraphs successively numbered the specific grounds upon which it is made." Practice Book § 11-10 requires that a "memorandum of law" be filed with regard to certain motions and requests, including motions to modify a judgment pursuant to Practice Book § 17a-4. While the Rules of Practice do not specifically speak to form requirements for motions to modify *and terminate* orders for protective supervision, the Rules do provide that any motions to *extend* the court's order for protective supervision and any objections thereto shall be submitted in writing with the court. § 35a-12.

[93] The caseworker drafted the status report, which was approved by the supervisor and the program manager.

[94] Practice Book § 35a-16: "[m]otions to modify dispositions are dispositional in nature based on the prior adjudication, and the judicial authority shall determine whether a modification is in the best interests of the child or youth upon a fair preponderance of the evidence."

situation where a custodial parent refused to appear in court or where protective supervision was terminated because a parent did not comply with court-ordered expectations. Despite the novel nature of the concern, no additional legal consults took place in the case. OCA finds that DCF policy has not required legal consultation prior to DCF seeking to terminate a child protection proceeding, and generally speaking, the status reports and social studies submitted by DCF social workers to the Juvenile Court during periods of Protection Supervision are not required by agency policy to be reviewed by DCF's internal legal counsel prior to being filed with the Court.

While DCF is represented by the Attorney General's Office in court proceedings, an in-court review of Protective Supervision is conducted during the short-calendar docket-- a day on the court's schedule where brief matters are heard such as initial pleas or motions for various court orders," and depending on case developments, there may be little time for advance consultation with DCF prior to or during such proceedings. In this case, the DCF social worker submitted the status report to the Juvenile Court clerk's office the afternoon prior to the hearing.[95] The subsequent short-calendar hearing occurred the following morning, at which time the status report and its recommendation for case closure was entered into the record. DCF staff assigned to Matthew's case stated that there was no consultation with the Attorney General's Office prior to the development of the status report or its submission to the Court. Staff stated that such consultations do not typically occur during short calendar hearing days due to scheduling and time constraints—but that brief consultations may occur, according to one staff member, "when there is something that really needs to be discussed"[96] or, according to another, when the social work team has a question.

3. DCF Had Not Adequately Complied With its Court-Ordered Obligations to Ensure the Safety and Wellbeing of the Children

Pursuant to the Court's previous order entered on October 6, 2016, DCF was required to "Take all necessary measures to ensure the children's safety and well-being and monitor the welfare of the children and the circumstances surrounding their care by [their mother]." DCF's December 8, 2016 status report did assert that it had been difficult for the caseworker to assess the family given Ms. Tirado's evasiveness, and perhaps DCF was factually contending that it was, through no fault of its own, *unable to obey* the court's order to ensure the safety of the children, but such an argument, even if it could have been adequately demonstrated, was not clearly a basis for ending supervision over these children, nor was the issue of futility or inability to comply adequately alleged in DCF's status report.[97]

[95] Given the timing of the filing, there would have been nothing received in advance of the hearing by the Attorney General's Office.

[96] OCA interview with caseworker, conducted October 31, 2017.

[97] The lack of clarity regarding the legal basis for DCF's position highlights other concerns discussed in this section, and is likely due to the fact that no lawyer participated in the drafting of the status report, though the document was, for all intents and purposes, offered to the Court and treated as a pleading or motion.

As outlined elsewhere in this report, there were other measures that could have been taken to assess the safety of the children—first and foremost moving for permission to see and interview/assess the children, one of whom was thought to be in a neighborhood school, or conducting a well-child visit with police, and confirming the family's residence with their landlord, or meeting with relatives—all steps that were consistent with prior supervisory directives to the caseworker, but which did not occur.

Finally, though DCF's Status Report asserted that Matthew's sister had been attending school, that information was already over two months old by the time of the December 8th hearing and there was no indication in the Status Report that DCF had made efforts to update the information. By the time of the December court hearing, Matthew's sister had actually been withdrawn from school by her mother, and in the weeks preceding her withdrawal she had accumulated almost a dozen absences.[98]

4. There Was No Finding by the Court that Modifying and Ending Protective Supervision Served the Best Interests of the Children

As stated above, where a motion to modify a dispositional order is filed, the "judicial authority shall determine whether a modification is in the best interests of the child or youth upon a fair preponderance of the evidence."[99] No such finding was asserted by DCF in this case and no such finding was made by the court.

5. DCF Did Not Seek Additional and Available Orders to Protect Matthew, Including an Order for Commitment to DCF Care

In response to questions from OCA, the DCF legal director stated that it could not have sought additional orders from the Juvenile Court such as 1) to see Matthew's sister in school; or 2) to obtain records related to the children, such as educational records, because "a court order would not be effective against a non-appearing party since [the mother] would have no

[98] Per Attendance Summary, Hartford Public Schools, 16-17 school year; first quarter report card, 11/11/2016. The child's attendance record indicates that 8 of the 11 absences accumulated by November 28, 2016 were "excused" with a comment that "student was excused from school by her doctor," though no doctors notes are contained in the education record. District policies provide that "physician or other appropriate certification" is required at the discretion of an administrator for absences in excess of 5 consecutive days or of a total of 15 days in a school year. District Policy Section 5114. Again it appears that the rising number of absences may not have triggered alarms at the school because the child was attending a new elementary school in the district that was not aware of the prior concerns regarding educational neglect. But a note in the child welfare record following Matthew's death indicates that a staff member from Matthew's sister's school stated that the child was "abruptly withdrawn from the school by mother in December, 2016… that mother refused phone calls from [the school] on several occasions asking them to stop harassing her and that her daughter [was] going to be home schooled."

[99] Practice Book § 35a-16; *see also In re Diamond J.*, 121 Conn. App. 392 (2010), declining to review the trial court's decision granting DCF's motion to modify the child's disposition from protective supervision to commitment; *In re Stanley D.*, 45 Conn. App. 606 (1997) (upholding the trial court's decision to modify disposition from protective supervision to commitment on the grounds that the parent failed to comply with court ordered specific steps and the best interests of the child required commitment).

notice and it would not be effective as to the school because the school is not a party to the case…. [While] the Assistant Attorney General can subpoena attendance records for an evidentiary hearing in this case, the mother was defaulted [for Failure to Appear] so there was only a pro forma proceeding."

However, a default judgment—due to the mother's non-appearance-- would not limit the superior court's ability to exercise all of its powers in a neglect proceeding where the parent was properly noticed. The court has authority to proceed with a neglect petition, or to grant a petition for termination of parental rights, even in the face of a default judgment against a parent.[100] If a default is properly entered, then the court may proceed to enter any order that a court may enter in any other neglect proceeding, including orders for mental health or educational evaluations and orders concerning custody or guardianship.[101] State law provides that a court may order a local or regional board of education to provide to the court educational records of a child for the purpose of determining the need for services or placement of the child.[102] And the legislature granted broad statutory authority to the Juvenile Court to "make and enforce such orders directed to parents, … guardians, custodians or other adult persons owing some legal duty to a child therein, as the court deems necessary or appropriate to secure the welfare, protection, proper care and suitable support of a child subject to the court's jurisdiction or otherwise committed to or in the custody of the Commissioner of Children and Families."[103]

After the Court adjudicated Matthew and his sister neglected and issued a dispositional order for six months of Protective Supervision, DCF could have recommended that the children be committed to DCF (i.e. transfer of guardianship of the children from the mother to DCF) based on both the original conduct that required DCF intervention and Ms. Tirado's refusal to cooperate in the proceeding or comply with the court-ordered Specific Steps.[104]

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[100] See, e.g., *In re Elijah D.*, 2011 WL 6270523, *In re Kamal R.*, 142 Conn. App. 66, 68 n.3 (2013); *In re Cambrie S.*, 2016 WL 4498209. See also Connecticut Practice Book § 33a-7 which provides that "at the first hearing on a petition for neglect… the judicial authority, [after recording adequate notice to the necessary parties] may proceed with respect to the parties who (i) are present and have been properly served; (ii) are present and waive any defects in service; and (iii) are not present, but have been properly served."

[101] See *In re Stephanie I.,* 2015 WL 5625321 (August 4, 2015, Rubinow, J.), *15 n87 ("As in other civil matters, '[t]he entry of a default constitutes an admission by the defendant of the truth of the facts alleged in the complaint.' *DeBlasio v. Aetna Life & Casualty Co.*, 186 Conn. 398, 400 (1982). See also *Commissioner of Social Services v. Smith*, 265 Conn. 723, 732–33 (2003) (respondent in child support proceeding who fails to respond to pleadings 'is deemed to have judicially admitted the underlying facts of the support petition'); … Thus, even where it is impracticable to require a default in a TPR case to be supported by a Practice Book § 17–21 military affidavit, the non-appearing respondent's absence serves to admit each of the petitioner's adjudicatory and dispositional allegations. See *In re Shonna K.*, 77 Conn.App. 246, 253 (2003). As in other civil matters, it correspondingly follows that a default against a TPR respondent enables a finding that the petitioner has prevailed on all issues, although evidence may be introduced before judgment is rendered, as provided by Practice Book § 35a–8(a). See *In re Kamal K.*, 142 Conn.App. 66, 68 n. 3 (2013) (respondent failed to attend trial, was defaulted, and trial proceeded in his absence).")

[102] Conn. Gen. Stat. § 46b-121.

[103] Id.

[104] *In re Stanley D.*, 45 Conn. App. 606, *cert denied* 243 Conn. 910 (1997).

Ms. Tirado complied with none of the court ordered Specific Steps. Such gross non-compliance with the Court's orders, combined with Matthew's disabilities, his lack of visibility to the community, and the loss of his grandmother, should have led to urgent action by DCF to confirm Matthew's whereabouts, ascertain his well-being and safety, and—without cooperation from the parent—led to a recommendation that the children, or at least Matthew, be committed to DCF custody.[105]

6. No Legal Consult took Place Prior to DCF Submitting Its Request to End Protective Supervision

DCF is supported in its child protection work by both its internal Office of Legal Affairs as well as the Office of the Attorney General. DCF's Legal Affairs division was created in 1998 to "oversee many and varied legal aspects of the Department," and has duties that may include drafting court petitions and motions, "consulting with social work staff regarding the legal sufficiency of decisions to substantiate abuse or neglect," and "consulting with social work staff regarding case work decisions *as requested*."[106]

In Matthew's case, between October 2014 and January 2017, DCF's Legal Affairs division was asked three times by DCF social work staff to consult as to whether neglect petitions should be filed on behalf of Matthew and his sister with the last consult held in March, 2016. DCF social work staff eventually filed a neglect petition in July, 2016. There were no further internal legal consults.

The Attorney General's Office is a separate state agency that provides legal representation to DCF (and other state agencies) in administrative matters and when petitions are filed in the Juvenile Court. State statute requires that assistant attorneys general "diligently prosecute petitions of neglect giving priority to petitions which allege child abuse as the grounds of neglect… [and] shall cooperate [with DCF] in preparation of such cases as shall be necessary to protect the safety and best interest of the child named in the petition."[107]

Once the neglect petition regarding Matthew and his sister was filed with the Court, DCF was represented by the Attorney General's Office's Child Protection Department in all hearings related

[105] OCA cannot speculate as to whether a DCF motion for Commitment would be granted, but Commitment is a viable dispositional option where there is underlying and unresolved concerns of child neglect (or abuse) and commitment to DCF serves the best interests of the child. Conn. Gen. Stat. § 46b-129(j). Practice Book § 35a-12(d) provides that "[p]arental or guardian noncompliance with the order of protective supervision shall be a ground for a motion to modify the disposition. Upon finding that the best interests of the child so warrant, the judicial authority, on its own motion or action on a motion of any party and after notice is given and hearing has been held, may modify a previously entered disposition of protective supervision in accordance with the applicable General Statutes."

[106] DCF Policy § 31-10-2. (Emphasis added).

[107] Conn. Gen. Stat. § 17a-47.

to Matthew's case from July 2016 through December 8, 2016, consisting of short-calendar hearings that grappled with Ms. Tirado's persistent non-appearance and non-cooperation.

Just as there is no record that DCF social work staff sought an internal legal consultation prior to submitting its request to close the Tirado case, DCF's case-closure checklist states that no AAG consult was held prior to case closure either.[108] DCF non-legal staff drafted the recommendation for case closure and filed the recommendation at the close of business on December 7th 2016, the day before the scheduled court hearing, held at 10:06 a.m. The hearing lasted less than a minute.[109] The assigned caseworker reported to OCA that no consult was had with the AAG prior to the submission of the recommendation that morning.[110]

Multiple DCF employees that spoke to or were interviewed by OCA stated that while they often rely on legal counsel to assist them in navigating difficult cases, that there are few, if any mandates, regarding when a social work team has to consult with inside counsel or the Attorney General's Office, and that such consultations are held on a "case by case" basis.[111] Multiple staff stated that once a case is court-involved they will go to the Attorney General's office with any questions or problems prior to a court hearing, but that there are no internal mandates to do so. Even the DCF closing checklist's component regarding whether an AAG has been consulted prior to case-closure, is considered by staff to be "discretionary." When asked who drives the need or request for legal consultation, OCA was told by a DCF staff member that "there is no defined role, sometimes [its] going to be [us], sometimes [legal/AAG] are going to reach out to us." All individuals that were interviewed by OCA stated that during "short-calendar" proceedings there is little time to consult with the assigned AAG given the pace and congestion of the day, but that consultations sometimes take place if, as one staff member stated, there is "something that really needs to be discussed."[112]

OCA finds the lack of legal consultation in the development and submission of DCF's recommendation that the Juvenile Court close Matthew's case to be significant. While state law *permits* DCF social workers to draft and submit certain petitions in child protection matters, documents that commence a child protection proceeding, or seek adjudicative or dispositional orders, or that seek to end an abuse/neglect proceeding *should* be developed with the assistance of counsel. That such a critical request to end a child protection proceeding was developed by non-legal staff and submitted on the eve of the court proceeding with little notice to the court actors,

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[108] A previous state Supreme Court decision held that social workers are entitled to file certain legal papers with the Juvenile Court, pursuant to state statute, and that such activities did not constitute the unauthorized practice of law. *In re Darlene C.*, 247 Conn. 1 (1998), reversing the trial court's decision to enjoin DCF non-lawyers from drafting, signing and filing petitions to terminate parental rights.

[109] Transcript of hearing, December 7, 2016.

[110] OCA interview with assigned caseworker to OCA, October 31, 2017.

[111] One staff member told OCA that the only time a DCF social worker must consult with a lawyer is when the social work team intends to file a petition to terminate an individual's parental rights. DCF policy provides that internal legal consults regarding case work decisions is discretionary; DCF policy provides that in court cases, the Assistant Attorneys General will advise social work staff regarding legal strategy. DCF Policy 31-10-5.

[112] Id.

to be heard during a tightly scheduled short-calendar docket, may offer some explanation as to why, as outlined in this Section, the drafted request was deficient and unsupported, and why other strategies to ensure the safety and well-being of the children were not availed. Legal consultation should have been held to review DCF's child protection case goals and DCF's methods for achieving those goals.

Going forward, consultation should be required before DCF seeks any judicial remedy from the Court and prior to any termination of a child protection proceeding. Consultation should be required whenever a child who is the subject of a child protection proceeding has not been seen during a 30 day period of time due to refusal to cooperate by the parent. DCF should work with the Attorney General's Office to develop a clear framework for consultation and case-specific decision-making during or prior to the onset of a child protection proceeding. All of DCF's requests for judicial remedies to be heard in short calendar hearings must include prior consultation with the Attorney General's Office. Training and support regarding expected use of legal resources, both internal and external, should be provided.

Matthew Was A Child At Risk For Substantial Harm—Though This Risk Was Not Properly Assessed Or Recognized.

Child Safety—Element 1 Threats of Danger

A manual for judges and lawyers produced by the National Resource Center for Child Protective Services and the National Child Resource Center on Legal and Judicial Issues provides important guidance regarding how the safety of children in child protection proceedings should be assessed.[113] The manual's guidance regarding various threats of danger that children may need protection from include:

- Where a caregiver "largely reject[s] [Child Protective Service] intervention; refuse[s] access to a child; and/or there is some indication that the caregivers will flee."[114] The authors elaborate that "[i]n all instances when a family is avoiding any intervention by [Child Protective Services], the current status of the child or the potential consequences for the child must be considered **severe and immediate**. Overt rejection of CPS could be an expression of a caregiver's rights; however, until access to the child can be gained through legal means, the conclusion about the rejection representing a threat of danger remains."[115]

[113] Lund, Therese; Renne, Jennifer, Child Safety, A Guide for Judges and Attorneys, Published by the American Bar Association (2009). Available on the web at http://www.ct.gov/ccpa/ lib /ccpa/ ABA_Child_Safety_Manual_june32009.pdf
[114] Id., Appendix, at. 60.
[115] Id. at 61.

- Where a "caregiver refus[es] and/or fail[s] to meet a child's exceptional needs," as such failure "can result in severe consequences to the child."[116] Authors define "exceptional" to mean a child's condition, such as a developmental disability or special medical need.

- Where "no adult in the home is routinely performing basic and essential parenting duties and responsibilities."

- Where the parent "lacks parenting knowledge, skills, and motivation necessary to assure a child's basic needs are met."[117]

Child Safety—Element 2: Vulnerability

Authors of the Child Safety Manual emphasize that for a child to be deemed "unsafe," there "must be a threat of danger, *and that child must be vulnerable to those threats*.[118] Children are vulnerable because they depend on others for protection and care. Considering a child's vulnerability involves both knowing about the child's ability to protect himself from threats and knowing how the child is able to care for himself…. Criteria to consider include age, physical ability, cognitive ability, developmental status, emotional security, and family loyalty…. ***Vulnerability is presented as a key element of safety assessment because workers, attorneys and judges often skip or oversimplify whether a child is vulnerable to a threat of danger.***"[119]

> From the Child Safety Manual--The following helps determine a child's degree of vulnerability:
>
> - A child lacks capacity to self-protect;
> - A child is susceptible to harm based on size, mobility, social/emotional state;
> - Young children (generally 0-6 years of age);
> - A child has physical or mental developmental disabilities;
> - A child is isolated from the community;
> - A child lacks the ability to anticipate and judge presence of danger;
> - A child consciously or unknowingly provokes or stimulates threats and reactions;
> - A child is in poor physical health, has limited physical capacity, is frail;
> - Emotional vulnerability of the child;
> - Impact of prior maltreatment;
> - Feelings toward the parent – attachment, fear, insecurity or security;

[116] Id.
[117] Manual at 10.
[118] Emphasis added.
[119] Id. at 11. (Emphasis in original.)

- Ability to articulate problems and danger.

Child Safety—Element 3: Protective Capacity

Part of assessing whether a child is safe is determining whether the caregiver has "sufficient protective capacity to manage threats."[120] When a child is at risk and the parent has limited capacity to serve and protect the child, then a Court may direct the child welfare agency to "do what the parent cannot,"[121] up to and including placing the child in another home. "All adults living in the home should be assessed for protective capacity."[122]

Parental protective capacities may be demonstrated when the parent:

- Has a history of protecting others;
- Acts to correct problems or challenges;
- Demonstrates impulse control;
- Demonstrates adequate skill to fulfill caregiving responsibilities;
- Sets aside her/his needs in favor of a child;
- Is adaptive and assertive;
- Uses resources necessary to meet the child's basic needs.[123]

Matthew was at risk of harm given the multiple threats to his well-being, his high degree of vulnerability, and his mother's lack of protective capacity. These risks went unrecognized.

Using either the risk tools that DCF incorporates (Structured Decision-Making) or the guidance from the Child Safety Manual, Matthew was at risk of harm for multiple reasons outlined above: there were threats to his safety and well-being due to his mother's persistent refusal to cooperate with child welfare authorities, Matthew had not been seen, he was not attending school, his need for supports, services and education were not met, and he was a highly vulnerable child who could not advocate for or protect himself. Matthew's mother displayed scant protective qualities given the persistent nature of the concerns regarding Matthew, her years-long inability to meet his needs or seek or respond to resources that would help her meet his needs, and her refusal to engage with any helping system. Accordingly, Matthew's safety likely could only be assured through state supervision and intervention.

Ensuring child safety depends in large-part on the reliability and adequacy of efforts to identify children at higher risk of abuse and neglect and children who are unsafe. Matthew's case was closed because this risk, and the accompanying threat to his safety, were not recognized. The larger system issue is whether the caseworkers and the resources that support and guide them, are adequately trained and prepared to ensure reliable risk and safety assessment and implement effective interventions. As

[120] Manual, at 13.
[121] Id.
[122] Id.
[123] Id. at 14.

will be discussed below, case reviews conducted by OCA as well as audits by the federal government and the Juan F. federal court monitor have led to concerns that risk and safety assessments by the agency are inconsistent and unreliable—an urgent and foundational practice concern.

Compounding concerns regarding risk and safety assessments, as stated above there was also no internal consult with the DCF office director or DCF legal team prior to the closure of Matthew's case, and there *was no clear policy requiring such contact*. After the 2015 homicide deaths of two children, allegedly at the hands of their mother,[124] it was publicly reported that the children's mother had significant history with DCF. OCA learned that the mother's most recent case in 2014 had closed despite the mother's refusal to allow her children to be interviewed or even seen. In the wake of those deaths, DCF internal directives were revised to ensure that no investigation was closed without seeing children, or without a DCF office director approving the case closure. In the wake of Matthew's death, policies were again revised to extend the requirement for seeing children and reviewing case closures (where children had not been seen) to all cases open with DCF. The state's need to balance the legal interests of parents with its obligation to ensure the safety of abused and neglected children continues to create challenges in the state's child protection activities.

Matthew and His Sister Were Represented by An Attorney In the Juvenile Court Proceeding. The Attorney Was Also Not Able To See The Children and He Did Not Object to the Case Closure.

Connecticut statute provides that "if a child [client] is incapable of expressing the child's wishes to the child's counsel because of age or other incapacity, the counsel for the child shall advocate for the best interests of the child." Conn. Gen. Stat. § 46b-129a.

Matthew and his sister were assigned counsel to represent them in July, 2016 when DCF filed its neglect petition on the children's behalf. The children never met their lawyer. All children removed from their homes due to abuse or neglect and for whom neglect petitions are filed with the Superior Court for Juvenile Matters are automatically appointed counsel to represent them.[125] By statute and ethical rule, the lawyer's job is to investigate, identify and advocate for a child's unmet and/or spoken needs, taking protective action on behalf of an impaired client who cannot competently or reasonably direct the course of the lawyer's representation.[126] The state's contract with the child's "assigned counsel" echoes these expectations. A review of the DCF case records and the court record, including transcripts, reveals that the children's attorney attempted to visit the family on three

[124] Leroya Moore was charged in 2015 with the double-murder of her two children, Aleisha, 6, and Daaron, 7.
[125] Conn. Gen. Stat. § 46b-129a provides that such "child shall be represented by counsel knowledgeable about representing such children…[and] the primary role of any counsel for the child shall be to advocate for the child in accordance with the Rules of Professional Conduct, except that if the child is incapable of expressing the child's wishes to the child's counsel because of age or other incapacity, the counsel for the child shall advocate for the best interests of the child." In Connecticut, it is the State Division of Public Defender Services (The Division) that appoints lawyers to represent children and indigent parents.
[126] See the Division's Performance Guidelines for lawyers representing children. See also Rule 1.14 of the Connecticut Rules of Professional Conduct.

occasions, called Ms. Tirado, left messages and left his contact information, but the attorney did not hear from the mother and was not able to make contact with either child.

DCF records indicate that the attorney did not request case records from DCF about his clients, including any records from DCF's current or previous investigations regarding the family. Court records indicate that the attorney did not file any motions or objections during the proceedings, did not seek court orders to obtain the children's medical or educational records, and did not seek an order of the court to permit access to either child, including an order to see Matthew's sister in school.[127] The attorney did not object to DCF's recommendation that Protective Supervision end in December, 2016.

The Rules of Professional Conduct for lawyers provide that when representing a client with diminished capacity, i.e. that the client's "capacity to make or communicate adequately considered decisions in connection with the representation is impaired, whether because of minority, mental impairment, or for some other reason," the lawyer should maintain, as much as possible, a "normal client-lawyer relationship," but that where a lawyer believes that the client is "likely to suffer substantial physical, financial or other harm unless action is taken, and [the client] cannot adequately act in the client's own interests, the lawyer may take reasonably necessary protective action" on behalf of the client.[128]

Professional guidelines issued by the Public Defender's Office in Connecticut provide that when representing an "impaired child client," the lawyer for the child "shall take protective action as contemplated by Section 1.14 of the Connecticut Rules of Professional Conduct."[129] These guidelines also provide that counsel for the minor child should obtain independent and first-hand information regarding the child's well-being, and should "obtain records from the child's medical, educational, and child care providers to assess the development and well-being of the child" on a regular basis.[130] These professional guidelines echo the requirements contained in federal law, which requires that states appoint and train representatives for children in child protection proceedings, and that such representatives have "first hand" knowledge of the health, well-being and safety of the represented child."[131]

While Matthew's lawyer sought to see him and his sister, he took no legal action, despite persistent neglect concerns pertaining to his client, Matthew and a lack of information about Matthew's sister. The question then becomes whether the ongoing neglect of Matthew, combined with his lack of

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[127] Again, OCA notes the issue of whether the parent has been technically served notice of the proceeding within the meaning of the Connecticut Practice Book, and whether any issues or defects in service would affect or could affect orders available to the parties.

[128] Connecticut Rules of Professional Conduct 1.14.

[129] State of Connecticut, Division of Public Defender Services, *Performance Guidelines for Counsel in Child Protection Matters*, Revised 2017, Guideline 1.7, available on the web at: http://www.ct.gov/ocpd/Lib/ocpd/Child_Protection/CP_Procedures_Assigned_Counsel/CT_Performance_Standards_For_Counsel_In_Child_Protection_Matters_-Rev_1-2017.pdf.

[130] Id. Guideline 3.2

[131] 42 U.S.C. §5106a(b) (2010).

visibility and the history of abuse/neglect concerns created a requirement that the lawyer take "protective action" on Matthew's behalf or created a condition whereby the lawyer could reasonably conclude that allowing the case to close without confirming Matthew's whereabouts and physical/emotional well-being served Matthew's best interests, as required by state statute. OCA concludes that given Matthew's vulnerability, the history of persistent neglect concerns, the historical abuse concerns, and his lack of visibility to the community, combined with his mother's utter failure to cooperate with state, local and court officials, Matthew should have been deemed an impaired client in need of protective action by his lawyer. The neglect petition was filed on his behalf, the issues that led to the petition being filed were unresolved, and he had not been seen by anyone in months—all leading to a reasonable belief that Matthew was at risk of harm and in need of help. Even aside from concerns of physical abuse, the fact that Matthew was a significantly disabled child who was being denied educational support services was an indication in and of itself of substantial harm.

At The Time the Court Case Closed, Unbeknownst to DCF and the Children's Attorney, Ms. Tirado had Also Withdrawn Matthew's Sister from School.

In November 2016, Ms. Tirado notified Hartford Public Schools that she was withdrawing her younger child from school to home-school her. From that time until Matthew's death in February, neither child was seen again by local or state officials. Ms. Tirado's "notice of intent" to home-school her daughter lacked any credibility and was submitted after HPS had filed 5 child protection reports over a recent 18 month period as to both Tirado children. The effort to withdraw the young child from school should have raised immediate alarms.

Connecticut law acknowledges parents' right to home-school their children as an alternative to public school attendance. Connecticut General Statute Section 10-184 provides that parents or persons having control of children from age 7 to 16 shall cause such children "to attend a public day school regularly," but allows the parent or person having control of such child to educate the child at home if they are "… able to show that the child is elsewhere receiving *equivalent instruction* in the studies taught in the public schools." Likewise, local boards of education are required to "cause each child seven years of age and over and under sixteen living in the school district to attend school in accordance with the provisions of Sections 10-184…" Per State Department of Education guidelines, "if parents wish to educate their child in their home, they must show equivalency as described" in the statute and districts must "determine whether or not such child *is receiving* equivalent instruction as required." (Emphasis added).

The district's home-school packet was mailed to Ms. Tirado on November 28 2016, and Ms. Tirado's signed withdrawal form was received by the district on December 8th—the same day the Juvenile Court closed the family's case.

The SDE home-schooling guidelines recommend that districts create a process by which parents file a notice of their intent to home-school with the superintendent, that such notice be effective for up to one school year, that the district maintain such records, that such record include basic program information including the proposed home-school teacher, subjects that will be taught, days of instruction and methods of assessment, *and* that an annual portfolio review be held with the

parent and school officials to review the instruction that has been provided to the child. This guidance is *not* codified in state law.

Ms. Tirado signed a "notice of intent to provide home instruction" for her child (see image below). A letter, dated December 14, 2016, from HPS to Ms. Tirado, acknowledged the intent to home-school and stated that Ms. Tirado was thereby assuming "full responsibility for the education of [her] child in accordance with the requirements of state law." Ms. Tirado was advised in writing that per district policy[132] she was to maintain a portfolio of her child's work and schedule an annual review with the district's designee after May 2017. The form letter from HPS was signed by a district central office Coordinator of Assessment Programs, Office of Data and Accountability.

The only documentation as to Ms. Tirado's reason for home-schooling her child was that she wanted to "focus on child's spelling and pronouncing." (See image below.) The letter of intent/application to home-school is one page and requires minimal parental input. After Matthew's death, DCF investigators documented that Ms. Tirado "had no explanation as to why she withdrew her daughter from school," and that "there was no evidence that mother was home schooling [the child]."

OCA asked the district whether it conducts a review of a child's attendance and any prior concerns regarding a child's safety and well-being before it signs-off on a parent's home-school notification. OCA was concerned that a child who had been the subject of multiple neglect concerns and/or had been chronically missing from school, could be simply withdrawn from the district for the purposes of home-schooling without any additional inquiry from the school system or follow-up.

[132] The December 14, 2016 letter from HPS to Ms. Tirado referenced Hartford Board of Education Policy 6171 which policy requires a parent/guardian who is home-schooling a child to "maintain a portfolio of student work and schedule a portfolio review with the principal or designee at the designated Hartford Home School." Ms. Tirado was further instructed to "maintain a student portfolio that contains dated work samples in chronological order."

HARTFORD
PUBLIC SCHOOLS
Where the future is present.

NOTICE OF INTENT TO PROVIDE INSTRUCTION AT HOME

School Year 2016-17

Please complete this form in its entirety and return to the address below. If this is the first year filing the *Notice of Intent* with Hartford Public Schools, and the child meets mandatory attendance age requirements, this form **must** be accompanied by:

- **evidence of withdrawal from a school, or**
- **a copy of the signed prior year *Notice of Intent*.**

Name of Student: [redacted] Tirado		Grade: 3	Date of Birth: [redacted]
Address: [redacted] Park St	Zip Code: 06106	Home Phone #:	
Name of Teacher: Katrina V. Tirado		Cell Phone #: 860-[redacted]	
Teacher's Address: [redacted] Park St Htfd 06106 CT		Email: [redacted]@Gmail.com	

PLEASE CHECK ONE: For the 2015-16 school year, my child was:
_____HOMESCHOOLED, or _✓_ENROLLED IN SCHOOL Parkville / Htfd CT (School, Town, and State),
or _____NOT APPLICABLE (Child did not meet mandatory attendance age requirements).

Required Subjects	Required Subjects
Reading ✓ Med	Science ✓
Writing ✓ Lows	U.S. History
Spelling ✓ Highs	Citizenship (Including a study of Town, State and Federal Governments) ✓ Lows
English Grammar	
Geography	**List Any Others Below**
Mathematics ✓ Med	

Total number of days scheduled for instruction: 5

Teacher's methods of assessment of student progress:
I'm more focused on [redacted]'s spelling and pronouncing
I want to test her more on pronounce Rather, we will focus ✓
on spelling second.

I acknowledge and accept full responsibility for the education of my child in accordance with the requirements of the law.

[redacted] K. Vanessa Tirado 11-29-16
Parent/Guardian Signature — Printed Name — Date

****************Below Completed By Hartford Public Schools****************

Designated Hartford Home School (Based on Home Address): Sanchez School Address: 176 Babcock St

Name of Principal: [redacted] Phone Number: 860-695-4940

My signature acknowledges receipt of this form and renders no opinion as to the appropriateness of the planned program.

[redacted] 12/12/16
Superintendent (Designee's Signature) — Date

Planning & Partnerships
Office of Engagement & Partnerships

Note: This form will be signed and a copy mailed to you for your records. Appointments for portfolio reviews and any requests for instructional resources should be directed to the designated Hartford Home School listed above.

"Every student and every school thrives"

HPS responded that no internal review took place prior to or following the approval of Ms. Tirado's home-school notification. Ms. Tirado's daughter had begun a new HPS elementary school for the 16-17 school year and the new school "did not have the information regarding former DCF complaints as that information remained at her previous school in a limited access file." The new school did not have concerns regarding abuse/neglect. The child had been present for 61 days, absent for 11 days, of which 8 absences were "excused." HPS stated that it has no policies requiring that district personnel "review the attendance of the student [prior to withdrawal] as it is the parent's right to withdraw and homeschool per state regulations."[133] OCA also learned that HPS, despite the form letter sent to Ms. Tirado, has not been requiring parents do take any steps to demonstrate the child *is receiving* equivalent instruction, and HPS has not been requiring parents to participate in an annual portfolio review.

OCA made subsequent requests for information from HPS and identified other children who had been withdrawn from the district for the purposes of home-schooling and whose families had prior histories with DCF—findings are outlined in the Section below, System Issues and Recommendation. As a result of this investigation, OCA has developed significant concerns regarding the state's current home-schooling framework. There is a dearth of statutory-regulatory requirements regarding the withdrawal of children from school, and districts' practices reviewed by OCA are not consistent with SDE guidance regarding follow-up with families who home-school their children. OCA does not dispute nor is OCA concerned about parents' right to provide equivalent instruction to children in their homes and communities. However, OCA is concerned about children who are withdrawn from school and not provided any education at all and/or may be living in conditions injurious to their well-being.

Through January 2017, Oak Hill School Continuously Notified DCF and HPS Regarding Its Concerns about Matthew's Lack of Educational Program

As stated above, though Matthew was not sent to school after January 2016, and despite Ms. Tirado's assertions to Oak Hill that she wanted them to leave her alone, and despite HPS' notification that Matthew would no longer be coming to their school program, Oak Hill staff continued to send progress reports throughout 2016 to HPS, DCF, and Ms. Tirado documenting Matthew's lack of attendance and requesting follow up.

An email from Oak Hill to Matthew's HPS case manager in May 2016:

> "**We are holding Matthew's placement at Oak Hill; however he has not been coming to the school."**
>
> HPS acknowledged receipt of this email to Oak Hill and stated again that it would "follow up" with DCF.

An email from Oak Hill staff to HPS, dated September 28, 2016:

[133] HPS letter to OCA, April 25, 2017.

Identified Matthew and another HPS student that:

> **"Continue to be chronically absent in their attendance at Oak Hill School. I know that you were in the process of involving DCF on both cases. Please let me know if there is anything we can assist you with on our part."**

On October 28, 2016 Oak Hill sent another report:

> **Matthew has made "no progress," and that goals were "not introduced" given his lack of attendance.**

On December 30, 2016, Oak Hill sent an email to Matthew's HPS case manager:

> **We have a number of PPTs that are in need to be scheduled and/or rescheduled. Would you please be able to reach out to [Oak Hill staff] as she is scheduling PPTs at this time."**
>
> The list of names attached to Oak Hill's email included Matthew.[134]

OCA could find no record of any reply by HPS to Oak Hill about Matthew.

On January 24, 2017, three weeks before Matthew's death, his HPS case manager sent an email to Oak Hill indicating that he had fallen behind with scheduling PPTs and he asked that new dates be offered.

A dictation note from Oak Hill's consulting psychiatrist, dated January 26, 2017, stated the following:

> **Matthew has not been back in school at all since January 2016 and is [sic] mother's number have been disconnected. His mother had stated he will not be returning and he has not. Unclear what the follow up from DCF has been. Plan: Continue to look at family dynamics. Continue to work on behavioral programming. Attempt to follow up with mother. DCF is involved to look at some of the family dynamics as well as school refusal. Consider Educational Neglect.**

The text of the above note is essentially unchanged from other monthly dictation notes entered into Matthew's record for the previous several months.

DCF Submitted Forms Internally to Administratively Close its Case on January 19, 2017

A DCF closing checklist completed in January 2017 indicated that case records were complete and "support the case closing." The same checklist provides that "all visits have been documented and the

[134] HPS, in response to an inquiry from the OCA, noted that the practice was for Oak Hill to alert HPS to a student's annual review, and that HPS received such notice from Oak Hill on December 30, 2016 as indicated by the email quoted above. HPS acknowledged that its case manager was behind in scheduling and that Matthew's PPT annual review was not scheduled.

last visit is within the visitation plan guidelines." The many directives issued by the DCF supervisor to continue to visit, locate, and update information regarding the family were not documented as complete. Case closure must be approved by a supervisor and program manager.

1·18

DCF-2220
10/00 (New)

State of Connecticut
Department of Children and Families

CLOSING CHECKLIST - TREATMENT

Case Name: katrina Tirado LINK #: 214368

DOCUMENTATION

Yes	No	N/A	
☒	☐	☐	Narratives are completed in LINK and support the case closing.
☒	☐	☐	All visits have been documented and the last visit is within the visitation plan guidelines.
☒	☐	☐	Written reports have been sought from all service providers who have worked with the family members and are filed in the case record. When written reports have not been forthcoming from the providers, documentation of verbal discussions shall be recorded in LINK.
			The following additional collateral checks have been made and support the closing:
☒	☐	☐	Police Checks (state or local) within the last six months
☐	☒	☐	School or Day Care within the last thirty (30) days
☐	☒	☐	Pediatrician for child five (5) years of age or younger, or in cases where medical concerns were an issue, within the last thirty (30) days
☐	☐	☒	Therapist for child, within the last thirty (30) days, or after last visit if therapy terminated
☐	☐	☒	Therapist for parent, within last thirty (30) days, or after last visit if therapy terminated
☐	☐	☒	Other community providers involved with the family – List name and date of contact:
☐	☐	☒	Diligent search completed for family members whose whereabouts are unknown
			When services have been refused:
☐	☐	☒	- AAG/PA consulted
☐	☐	☒	- RRG consulted
☒	☐	☐	Treatment Plans are filed in the record
☒	☐	☐	Supervisory conference notes are documented in LINK

The DCF closing checklist does not have any direct reference to safety issues for particularly vulnerable children: e.g., a child under age 5 or a child with a disability.

Checklists should be immediately revised to reflect existing agency directives and the need to ensure cases are not closed without seeing children, assessing safety, addressing uniquely vulnerable children, and ensuring appropriate internal and legal consultations.

SYSTEMS ISSUES AND RECOMMENDATIONS

CHILD WELFARE RECOMMENDATIONS: CHILDREN WITH DISABILTIIES AND THE CHILD WELFARE SAFETY NET

Improving reliability and utility of DCF Risk, Safety and Needs assessments is an urgent priority

DCF utilized, per agency policy and practice, standard tools[135] to assess the ongoing risk of child abuse and neglect in the Tirado home as well as the safety of the children at the time of each investigation and at periodic junctures in the family's child protection case from 2014 through 2017. Several of the tools were utilized incorrectly, erroneously assessing the ongoing risk of abuse/neglect as LOW on multiple occasions. The Risk tool guides the agency's decision to open or close a case because the score purportedly reflects the likelihood of a caregiver's future abusive or neglectful conduct.

Risk Tool, in Detail

The SDM *Risk Assessment* tool asks a series of questions, assigning a point value to the answers. In Connecticut, the number of points added together will determine whether the caregiver's Risk Score is "Very Low," "Low," "Moderate," or "High--"[136] rating the caregiver's likelihood of recommitting child maltreatment. The SDM Risk Assessment Guidelines call for the agency to open cases for ongoing supervision/treatment when the caregiver's risk of child maltreatment is scored as Moderate or High. Connecticut DCF internal practice requirements expressly state that Risk Assessments shall be completed "on all initial investigations including new investigations on existing cases," and that "[t]he risk level is used to determine whether or not the case should be transferred for ongoing services or be closed."[137]

Safety Tool, in detail

The SDM *Safety Assessment* tool lists multiple questions such as (but not limited to):

- [Caregiver] caused serious physical harm to the child [y/n];

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[135] In 2007 DCF adopted research-based actuarial risk and safety assessments to guide its determinations regarding which children's cases needed to be opened for ongoing treatment/supervision and which children needed to be removed from their homes. Connecticut utilizes the Structured Decision-Making (SDM) Risk assessment, "a research-based tool that estimates the likelihood that a family will abuse or neglect a child in the future." *The Structured Decision- Making Model: An Evidence-Based Approach to Human Services*, CRC, Children's Research Center, a division of the National Council on Crime and Delinquency, found on the web at http://www.nccdglobal.org /sites /default/ files/publication_pdf/ 2008_sdm_book.pdf.

[136] In several states the SDM scores correlate to risk findings of "**Low," "Moderate,"** "**High," or "Very High**."

[137] DCF Practice Guide, http://www.ct.gov/dcf/lib/dcf/policy/pdf/Case_Planning_Practice_Guide_11-12-13.pdf

- Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care [y/n];
- Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs current ability to supervise, protect, or care for the child [y/n];
- There is a pattern of prior investigations or behavior AND current circumstances are near the threshold for any other safety factor [y/n].

If the SDM Safety tool reveals the presence of *any* safety factors, DCF must determine whether there are any interventions that will allow the child to remain in the home or if the child needs to be taken into protective custody.

To be effective, both tools must also be utilized correctly and answers to the questions must match information contained in the case record. Previous research facilitated by the promulgator of the tool, the Children's Research Center (CRC), has shown that families identified as high risk per the tool were significantly more likely to be re-substantiated for child maltreatment.[138] As a result of such studies, the CRC has found that "maltreatment experienced by children in high risk families is both more frequent *and more severe*,"[139] and the CRC had recommended that child welfare agencies focus on opening cases for ongoing services where the risk is identified as high.[140]

- A Risk Assessment completed on November 28, 2014, determined the Risk for abuse/neglect to be Moderate, due to the family's history of involvement with DCF, Matthew's disability, and other factors.

- A follow up Risk Assessment conducted in May 2015 after new reports were made to DCF for neglect determined the Risk for abuse/neglect to be Low. This assessment included answers that were inconsistent with the previous assessment and the historical record with regard to the number of prior investigations, the nature of prior DCF involvement, and whether Ms. Tirado had a past or current mental health problem.

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[138] According to the Children's Research Center, a non-profit entity and author of the tool, a risk validation study conducted in California demonstrated that for families classified as highest risk, almost half had a new maltreatment substantiation during a 24 month follow up period, compared to families who had been classified as low risk and who were re-substantiated at a rate of only 8%, see *Structured Decision-Making Model*, supra at n. 132. These findings were echoed in a 2010 Risk Validation study conducted in Connecticut wherein CT DCF reported that families assessed as moderate and high risk were re-substantiated for maltreatment at rate 4 x that of families assessed as "very low" or "low" risk.

[139] Id. at 11.

[140] Id. at 17. CRC also suggests that families with higher risk scores should be seen more often and that child welfare agencies should utilize differential service standards for families based on risk score. The CRC's finding should be read as recommending focus on families in Connecticut with "moderate" risk scores as well as "high." In most states the same scores as used in CT for "moderate" or "high" risk determinations correlate to findings of "high" or "very high" labels. So the CRC recommendation for concentrating on families with "high" risk scores essentially means concentrating on families that score with 5 or higher points on the Risk score and/or have 1 or more unresolved safety concern identified using the Safety tool.

- The last Risk Re-Assessment completed by DCF, dated January 17, 2017, erroneously found the Risk Score to be Low. The Score should have been higher as a result of the mother's history of DCF involvement and her lack of cooperation with the case plan and refusal to permit DCF access to her children.

SDM Family Strength and Need Assessments, the findings of which are meant to be addressed in DCF Family Case Plans, were also substantially inaccurate:

- Assessments completed in January 2015, and July 2016 erroneously found that Ms. Tirado had an "adequate support system," "adequate coping skills," and "adequate[] parenting and protect[ive]" skills," despite DCF investigations concurrently having found that Ms. Tirado identified no support system outside of her mother, that Ms. Tirado engaged in "egregious" neglect of Matthew, and that Ms. Tirado would be placed on the Central Registry[141] due to the severity of her conduct.

- DCF's SDM assessment tool permits a finding that the parent was "maltreated as a child, [with] major current negative effects." But here, the completed tool, due to inputting errors, repeatedly indicated that Ms. Tirado had "no child maltreatment history," despite contrary information in the DCF record.

- The final assessment completed by the caseworker in January 2017 contained many of the same errors identified above and included a finding that Matthew had no "Education/Development" goals and that he had achieved "satisfactory achievement/development." The tool permits a finding that the child has "severe educational difficulty/development issues."

The pattern of unreliable risk, safety, and needs assessments in Matthew's case is consistent with previous findings by the OCA, the *Juan F.* federal court monitor, and federal government auditors with regard to this foundational and systemic practice concern.

A July 2014 report from the OCA regarding the death of infants and toddlers in Connecticut found that the level of intervention provided by DCF to certain families where a child later died did not consistently match the risk to the child, and that risk often was under-assessed. OCA recommended

[141] Conn. Gen. Stat. § 17a-101g provides that "[a]fter an investigation into a report of abuse or neglect has been completed, the commissioner shall determine, based upon a standard of reasonable cause, whether a child has been abused or neglected,… If the commissioner determines that abuse or neglect has occurred, the commissioner shall also determine whether: (1) There is an identifiable person responsible for such abuse or neglect; and (2) such identifiable person poses a risk to the health, safety or well-being of children and should be recommended by the commissioner for placement on the child abuse and neglect registry…" Such information may be disclosed, per §17a-101k and other applicable statutes, to a public or private entity for employment, licensure or other delineated reasons where a check of the child abuse or neglect registry is required by statute.

that DCF develop a child welfare practice model specific to children birth to three and inclusive of an effective high risk infant policy with appropriate caseloads and supervision.[142]

A December 2015 child fatality investigative report published by OCA also found poor risk and safety planning for a young child and her family, and OCA found that DCF did not have an adequate system for ensuring the reliability and efficacy of risk assessment and case planning. At that time OCA recommended DCF revise and strengthen its use of assessment tools to ensure that children at higher risk of abuse and neglect are adequately identified and protected.[143]

During child fatality review activities in 2016, OCA sought information from DCF regarding its use of SDM risk and safety tools, its quality assurance activities, and any data regarding DCF's adherence to the tool's guidelines. OCA continued to be concerned that the tools were not adequately evaluated for their efficacy in practice and that agency practices substantially departed from the CRC's guidelines regarding case disposition.

A March 2017, a federal audit of DCF child welfare practice found that child safety outcomes were not substantially achieved in part because DCF practice was found to be "inconsistent in assessing safety and risk in the child's living environment," and a "lack of accurate ongoing assessment of risk and safety factors contributed to the agency's lower performance."[144]

A July 2017 report from the *Juan F.* federal court monitor's office in Connecticut expressed concern regarding inconsistent risk and safety assessments by DCF staff and urged attention to both staffing resources and managerial/supervisory practices and protocols.[145]

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[142] Office of the Child Advocate, *Preventing Infant-Toddler Deaths in Connecticut, A Comprehensive Review and Assessment of Infant And Toddlers Deaths in 2013, Best Practice Recommendations*, July 31, 2014, available on the web: http://www.ct.gov/oca/lib/oca/Final_OCA_Infant_Toddler_Fatality_Report.pdf. See Public Act 17-92, which requires DCF to "establish protocols for the investigation of and response to reports of child abuse or neglect of children from birth to three years of age. Such protocols shall include, but need not be limited to, (1) appropriate supervision of the case, (2) appropriate visitation by department personnel to such children, (3) documentation of case activities relevant to the safety and wellbeing of such children, and (4) a case supervision tool specific to the unique needs and risk status of children from birth to three years of age.

[143] Office of the Child Advocate in Consultation with the State Child Fatality Review Panel, *Child Fatality Investigate Report: Londyn S.*, December 22, 2015, available on the web: http://www.ct.gov/oca/lib/oca/fatalityreport_londynfinal.pdf. See Public Act 16-190 which amended the state's statute creating the Family Assessment Response program to strengthen requirements that protect children's safety.

[144] U.S. Department of Health and Human Services' Administration for Children and Families, Children's Bureau, *Final Report: Connecticut Child and Family Services Review*, at 3, available on the web: http://www.ctnewsjunkie.com/upload/2017/04/children-and-families-CT_FinalReport_2016.pdf

[145] *Juan F.* v. Malloy Exit Plan Status Report Oct. 1, 2016- March 31, 2017, published July 2017, available on the web: https://assets.documentcloud.org/documents/3886922/Status-Report-4th-Quarter-2016-and-1st-Quarter.pdf.

DCF is currently working on a Performance Improvement Plan required by the 2016-17 federal audit, and continued improvement of the agency's risk and safety assessment processes is identified therein as a DCF priority.[146]

Recommendations

- Risk and Safety Assessments and resulting interventions must give appropriate weight to a child's vulnerability, whether due to age or disability. Where a threat to a child's safety or well-being is identified along with a clear vulnerability that heightens the risk of harm, the resulting case plan or safety intervention must clearly state how the child's ongoing vulnerability will be addressed and how the case plan/safety intervention will mitigate the threat to the child. Disability-related concerns should be specifically and clearly addressed in risk and safety assessment and case planning.

- Quality assurance reviews related to case planning, risk and safety assessment, must include assessment of whether the child is uniquely vulnerable to future harm due to age or disability and whether the case plan/safety plan adequately considers the child's vulnerability/disability through appropriate supervision and intervention.

- Quality assurance improvements by DCF must include systematic case reviews and sampling to determine the reliability of risk and safety assessments, with attention to highly vulnerable populations such as children with disabilities.

- DCF should annually track and publicly report regarding the efficacy of its risk and safety assessment practices with clear demonstration of the methodology for determining the reliability of its practice, fidelity to evidence-based practice and tools, and the effectiveness of the assessment process for identifying children at risk of child abuse or neglect.

- DCF should require a legal consult and an updated risk and safety assessment whenever a parent refuses access to a child or refuses to acknowledge a child's whereabouts, whenever such refusal occurs during the life of a child protection case and the child's safety cannot otherwise be established.

- DCF closing check-lists should be immediately revised to require documentation regarding 1) assessment of child safety; and 2) any concerns regarding unique vulnerability of child in the home due to child's age or disability.

[146] DCF's Performance Improvement Plan, dated June, 2017, provides that it will "achieve accurate initial and ongoing assessments to ensure safety and appropriate risk determination," with key action steps completed by mid-2018. A "risk assessment validation study to assess how well the current [tools] estimate future maltreatment," is estimated by DCF to be completed at the end of 2017.

- OCA supports DCF's effort to rebuild its case management database and agrees that this is an urgent priority for the agency, as assessment processes outlined above require reliable and efficient mechanisms for the inputting and retrieval of critical information. Such a system *does not exist today*, and social work staff are greatly hampered in their ability to do time-sensitive and comprehensive case reviews regarding families who may have extensive prior involvement with the agency. In the interim, the agency may consider a practice wherein managerial or internal consultation staff assist with case record review for families with high risk of recurrent child abuse and neglect.

DCF Must Develop Policies and Practices to Support Investigation and Case Planning for Abused/Neglected Children with Developmental Disabilities

A theme running throughout OCA's review and this report is a concern regarding how state and local child-serving systems assess and respond to the unique needs and vulnerabilities of children with developmental disabilities. Children with multiple disabilities, intellectual disabilities, communication disorders, and Autism Spectrum Disorders, are more vulnerable to abuse and neglect and often less able or even unable to advocate for themselves or even tell someone what is happening to them. Our safety net for these children *across systems* must be improved.

Child welfare records and even court records reviewed after Matthew's death do not reflect adequate appreciation for the substantial and even life-long harms to Matthew created by his mother's neglect. OCA's conclusion is that professionals did not fully appreciate the risk of or actual harm to Matthew or know how to effectively respond. **At the time Matthew's case was closed, he had missed most of his education for the past five years, and had been alleged to be a victim of physical abuse on at least two occasions.** He received no specialized services or therapeutic supports. He had no transition plan from school, no adolescent or young adult services, he was engaged with no community-based provider, and he had *no capacity to obtain this help on his own*.

As stated above, OCA was not able to locate any specific agency guidance regarding what steps a DCF caseworker or supervisor should follow when attempting to assess the safety and well-being of an older child with a developmental disability, despite several DCF staff (those involved with the family and others) commenting to OCA that there is a growing number of children served by DCF who have developmental or other complex disabilities.[147] In this case, there was no contact with the family by anyone other than the caseworker, no internal consults with mental health or educational experts, and no outside consultation with agencies or providers that serve children with disabilities. Multiple DCF staff also acknowledged to OCA that there are no specific internal resources in the agency that can

[147] DCF's Early Childhood Practice Guide for Children Aged Zero to Five (2016) includes information regarding the "increased vulnerability in children with developmental disabilities." Practice Guide at 35. The Guide explains that children with developmental disabilities "may be more isolated, may lack knowledge of boundaries, and may have increased dependency on caregivers. A child who is cognitively limited may be vulnerable due to a limited ability to recognize danger, to know who can be trusted, to meet his or her basic needs, to communicate concerns and to seek protection."

provide expert guidance regarding case planning for children with developmental disabilities.[148] It is clear that DCF caseworkers felt stuck and unable to engage the children's mother and move the treatment goals forward, but they admittedly lacked training and specific guidance regarding how best to proceed to ensure the safety and well-being of Matthew and other children like him.[149] OCA urgently recommends that staff be provided with additional support and training as soon as possible.

DCF's Case Planning Guide for staff does address the primary importance of assessing a child and family's "current level of functioning across all domains," and that assessment must include identification of "[t]he risks, physical and psychological safety concerns and the needs of the family."[150] There is also guidance regarding the importance of conducting regular and structured risk and safety assessments. But there is no mention of how to conduct case planning for children with complex disabilities. Notably, the section of the DCF's practice guide that speaks to case planning for children who are age 13 and older makes no mention of children who have specialized needs or significant disabilities that may profoundly affect transition planning and acquisition of life skills.[151] As one DCF employee told OCA "17 year olds [like Matthew] are not kids we spend as much time worrying about as that very young population, birth to 1, birth to five, we spend a lot of time there, we don't with the teens. I can certainly appreciate, and I know this, that a 17 year old typically developed and a 17 year old with autism, are very different. I have that working knowledge, [but] I don't have that kind of reinforcement day to day, with training."

DCF's visitation guide provides useful direction regarding how to engage with caregivers and children in developmentally appropriate ways, and the guide provides checklists that include sample questions for children or about children of various ages and developmental stages.[152] These documents need to include materials and information regarding engagement with caregivers who have children with disabilities, and guidance for social workers regarding assessment of and visitation with children who have multiple or developmental disabilities.

An examination of a 2017 training catalogue forwarded by DCF to the OCA includes many training opportunities related to important topics such as childhood trauma, substance abuse, racial justice,

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[148] Each DCF region has a Regional Resource Group which includes internal consultants on matters ranging from substance abuse, domestic violence, education, medical, and mental health. However, while one of these consultants may have some experience assisting families who have children with developmental disabilities, staff interviewed by OCA indicated that there is not a "point person" within the consultation group who can reliably direct case activities for a child with autism or other developmental disability. Multiple staff indicated that this is a growing need, and such help would be greatly beneficial.

[149] During the course of this investigation, OCA was asked by the Public Defender's Office to offer a training at the Public Defender's Child and Youth Law Forum regarding advocating for children with developmental disabilities. In attendance at this training were certain employees of DCF as well as state-assigned counsel for children and parents.

[150] DCF Case Planning Practice Guide (2014), at 6. Found on the web: http://www.ct.gov/dcf/lib/dcf/policy/bpguides/caseplanningbpg.pdf

[151] Id at 12. There is a bullet that plans for children who are age 13 and older should consider the "need for future referrals to adult services."

[152] DCF: A Practice Guide to Purposeful Visitation (2012), found on the web: http://www.ct.gov/dcf/lib/dcf/policy/bpguides/purposefulvisitationbpg.pdf.

cultural competency, and general case planning. But the catalogue lists no specific training opportunity or curriculum addressing the needs of children with complex disabilities, and OCA was informed by multiple DCF staff, including staff assigned to the Tirado family, that no such training exists at this time.

One DCF staff member stated to OCA "this is a deficiency the agency has," and "I am not aware of any [internal resource in the office] that has any specialty in dealing with children with autism. There is an increase in children coming to our attention on the spectrum and there isn't a go to person."

Notably, OCA also received information that while DCF social workers are expected to participate in 30 hours per year of training, that this requirement has been hard to track and enforce. Recent efforts have been made to improve supervision and compliance with these requirements.

DCF has worked in recent years to develop stronger case planning guidance and training regarding the unique needs and vulnerabilities of children age birth to three. It is equally imperative that DCF develop and strengthen its institutional knowledge, guidance and resources for staff regarding working with children who have developmental and other complex disabilities.

Recommendations

- Child welfare agency workers will need specific training regarding working with families who have children with developmental or multiple disabilities, including 1) the unique vulnerability of children with disabilities to abuse and neglect; 2) signs of abuse and neglect for children with disabilities; 3) assessment and investigation practices for children who may have limited or no capacity for communication; 4) guidance regarding purposeful visits to families ; 5) guidance regarding utilization of internal and external consultation resources to assist with serving and protecting such children; and 6) guidance regarding community-based and state-agency funded resources that assist with case planning and service delivery for families that have children with developmental disabilities.

- DCF should ensure that assessment tools are accurately identifying children with disabilities early in the investigation process and that service and safety-related needs are directly addressed in the safety assessments and family case plans.[153] If a child is assessed as having a disability, practice should include "asking basic follow-up questions regarding the disability's severity, age of onset, and potential causes,"[154] and appropriate referrals should be made to ensure proper assessment and service delivery if such services are not already in place.

- DCF should collect and report data regarding incidents of abuse and neglect, including critical incidents and fatalities, involving children with disabilities.

[153] United State Dept. of Health & Human Servs., Child Welfare Information Gateway, *The Risk and Prevention of Maltreatment of Children with Disabilities (*Mar. 2012), found on the web: https://www.childwelfare.gov/pubPDFs/focus.pdf, at 14.
[154] Id. at 12.

- DCF must have protocols for investigation and case planning that are specific to the specialized needs and unique presentations of children with disabilities, including children with intellectual and developmental disabilities and concomitant communication disorders. Families who have children with disabilities will benefit from connection to a community-based provider that is knowledgeable and experienced in working with families whose children have neurodevelopmental or other developmental disabilities, and emphasis must be placed on engagement and care coordination for the whole family. DCF's Family Assessment Response program contracts may be examined to determine if the Community Partner Agencies working with DCF-referred families can help fill this role and offer families sustained connections to relevant community-based supports.

- DCF should work with partners from the Office of Early Childhood, and the Department of Developmental Services, including the embedded Abuse Investigation division (now housed within DDS, formerly within the State's Office of Protection and Advocacy) to assist with the development of investigation, assessment, and case planning processes that are responsive to the unique needs of children with developmental disabilities. Joint agency strategies and mission statements should be developed to identify common goals in serving and protecting children with disabilities, and supporting their families' need for services.

- DCF should develop a Community of Practice, with membership internal and external to the Department, to assist with its review and revision of policies, training supports, and accountability with regard to recommendations contained in this report.

State Law Should Be Amended to Strengthen Protections for Children Who May Be Hidden From DCF or the Court.

While OCA identified steps that could have been taken to further protect Matthew from harm and prevent his death from child abuse and neglect, OCA still has concerns regarding the adequacy of the safety net for children who are suspected or documented victims of abuse or neglect but who are hidden from the view of child welfare investigators and/or the Juvenile Court. While DCF has constrained authority to remove a child from his or her home or even to interview a child who may be abused or neglected without a caregiver's permission, the state must examine whether it has granted DCF adequate authority where a reasonable suspicion of harm has been articulated and a parent refuses to allow DCF to ensure the child's safety or even see the child. Matthew's case is *not* an isolated event in that regard, and OCA has reviewed several cases where parents refuse to allow DCF to assess the safety and well-being of a child. Multiple DCF staff have shared similar concerns with the OCA.

Law: State's Authority to Remove a Child from His or Her Caregiver is Limited

State and federal law permit a child welfare agency to remove a child from the custody of his or her parent only where there is a concern that a child is in imminent physical danger.[155] A court order must be issued either immediately prior to the child's removal or immediately thereafter, and

[155] Conn. Gen. Stat. § 17a-101g.

parents/guardians, *and children,* have the right to an immediate hearing to concede or contest the allegations.

Law: State's Authority to Interview and Meet with a Child Suspected of Being Abused and/or Neglected is Also Limited

Generally, consent of the child's parent/guardian is necessary to interview a child suspected of being abused and/or neglected.[156] However, a statutory exception to that requirement exists if DCF "has reason to believe such parent or guardian or other person responsible for the care of the child or member of the child's household is the perpetrator of the alleged *abuse* or that seeking such consent would place the child at imminent risk of harm."[157] (Emphasis added). In response to questions from OCA, DCF stated that it "attempted to get more permissive statutory changes during several General Sessions and was not successful due to legislators' concerns for parents' rights." Accordingly, DCF is concerned that a child who is suspected of being neglected by a parent, or a child who *historically* has been abused by a parent may not be lawfully interviewed by child welfare investigators without permission of the parent or guardian.

Among the questions generated by OCA's review of Matthew's death are: What if a parent refuses to permit DCF to interview a child even where DCF has clear statutory authority to do so? Or what if the allegation made to DCF is that a child is neglected (rather than abused) and therefore the allegation does not meet the requirements of the statute that would allow DCF to interview or see the child absent parental consent?

Legally, DCF cannot take steps to assess or protect a child unless the child is in immediate physical danger. In virtually all other circumstances where imminent concerns are not immediately obvious, but where a concern of abuse or neglect has been alleged or founded, DCF must seek orders from the Juvenile Court to conduct its work if a parent refuses to cooperate. This is true even where the *child* may wish or seek to talk with DCF social workers.

A court may order that parents produce a child for assessment or that DCF interview a child absent parental consent. The court may also order that DCF, or the child's attorney, may interview the child at school or other community location, or that DCF or the child's attorney may obtain other information about the child, such as medical or educational records. [158]

What if children are not attending school and they are being hidden in the home, as was the case for Matthew? In this case, court marshals were unable to serve the mother with the court's subpoena to appear as her building was not accessible and they could not physically locate or identify her. Because

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[156] Conn. Gen. Stat. § 17-101h.

[157] Id. If consent is not required due to one or both of the conditions being present, DCF may interview the child "in the presence of a disinterested adult unless immediate access to the child is necessary to protect the child from imminent risk of physical harm and a disinterested adult is not available after reasonable search."

[158] The Juvenile Court has broad authority to issue "make and enforce such orders directed to parents … or other adult persons owing some legal duty to a child… as the court deems necessary or appropriate to secure the welfare, protection, proper care and suitable support of a child subject to the court's jurisdiction." Conn. Gen. Stat. § 46b-121.

of this lack of personal service,[159] the Court determined it was unable to issue a warrant to secure Ms. Tirado's appearance in court.[160]

Recommendations

- DCF, in partnership with the Public Defender's Office, the Attorney General's Office, and the Judicial Branch, should review current state law and procedure to determine how best to strengthen the safety net for children who are suspected or documented victims of abuse or neglect and yet remain inaccessible to state or local officials due to parental lack of engagement and non-cooperation.

- Legislators should consider amending state law to permit DCF authority to interview a child where there is a reasonably felt concern for the child's safety or well-being, including where allegations have been made of physical, emotional or educational neglect. State law should also expressly allow for DCF to assess the safety and well-being of children with disabilities where there are pending allegations of abuse or neglect and where the child is not capable of communicating concerns about his or her own safety.

- There should be a procedure (and forms) that children's attorneys can follow to ask the court to compel a custodial parent's presence in court and to seek orders, where necessary, to see or interview their child client.

No Recommendation to End a Child Protection Proceeding Should Be Submitted By DCF without Legal Consultation and Ensuring the Safety of a Child

- DCF, in consultation with the Attorney General's Office, should revise and clarify its policies regarding the use of internal and external legal consultation in the development and submission of documents to the Juvenile Court that seek to end a child protection proceeding or otherwise seek judicial order affecting the safety or well-being of a child, whether during a trial, pre-trial or short calendar proceeding.

- DCF, in consultation with the Attorney General's Office, should revise and clarify its policies regarding the use of internal and external legal consultation regarding any obstacle to ensuring the safety and well-being of a child. For example, whenever children who are the subject of a Juvenile Court proceeding have not been seen or assessed within a reasonable time frame, DCF should conduct a case review with its internal lawyers or the Attorney General's Office

[159] The Court was permitted to proceed with the neglect petition as abode service had already been confirmed by the marshal. However, the Court sought to potentially issue a warrant for Ms. Tirado's arrest if she continued to fail to appear, necessitating personal service of a summons to appear.

[160] An individual must have actual knowledge of the requirement to appear in court and a potential consequence of arrest in order for a capias warrant to issue if a parent fails to appear. In Juvenile Court, the initial neglect petition while including a summons to appear does not contain a warning that a parent can be incarcerated for failure to appear and the Practice Book does not require the petition to be personally served. Therefore, the record of abode service for the neglect petition was deemed inadequate by the court to permit it to issue a capias warrant for the mother's failure to appear.

for the purpose of determining the legal strategies that may be utilized to assess the safety of the children. Such case consultations should be mandatory.

- DCF staff should be trained regarding the use of legal resources for commencement of, strategizing regarding, and termination of child protection cases and proceedings.

- No child welfare proceeding should be closed without having assessed the safety of the children and without children having been seen. Documentation of the child's visibility and physical safety should be included in the court record prior to closure. A closing check-list that addresses child safety *and vulnerability* should be reviewed by DCF and the Attorney General's Office and submitted to the court as part of any submission of a request to close a case.

- No disposition of a child protection case in the Juvenile Court should be modified or vacated without an offering and finding that such modification serves the best interests of the child. Consideration should be given as to whether a statutory or Practice Book rule change is required to ensure such finding issues. Requests to modify or vacate judicial orders that protect the interests of children should be required to cite the relevant Practice Book rule or statutory sections.

- Practice Book rules should be amended to require that social studies or status reports submitted as part of the court's review of Protective Supervision be filed with the Court and the parties no later than 5 days prior to the court proceeding.

- The DCF administrative closing checklist does not have any direct reference to safety issues for particularly vulnerable children: e.g., a child under age 5 or a child with a disability. Checklists should be immediately revised to reflect existing directives regarding case closures and the need to ensure cases are not closed without seeing children, assessing safety, addressing uniquely vulnerable children, and ensuring appropriate internal and legal consultations.

Lawyers for Abused and Neglected Children with Disabilities Must Be Trained and Well-Prepared to Take Protective Action On Behalf of Child Clients as Contemplated by the Rules of Professional Conduct

OCA's review led to concerns as to whether Matthew's state-appointed lawyer in the Juvenile Court neglect proceeding took adequate protective action on Matthew's behalf as contemplated by the professional rules for lawyers, state performance guidelines and state law. Matthew had a legal right to representation in the neglect proceeding filed in the Juvenile Court and for his lawyer to advocate for his best interests.[161] He was a party to the proceeding and entitled to counsel in all phases of the

[161] Conn. Gen. Stat. § 46b-129a.

proceeding.[162] As a highly vulnerable child with diminished capacity who DCF had already found was a victim of and at continued risk of abuse or neglect, he was entitled to have his legal counsel take protective action on his behalf. While Matthew's lawyer made efforts to see him and contact his parent, no further protective actions were taken, and no objection was offered to the closure of Matthew's case.

The performance guidelines promulgated by the Public Defender's Office set appropriately rigorous standards for the representation of children, articulating guidelines for visitation, investigation and counsel on behalf of children, and the Public Defender's Office has been active in reviewing, strengthening and enforcing standards, where required, to ensure appropriate representation for children and indigent parents. The Public Defender's Office also provides lawyers with regular training, both pre-service and in-service, to assist with high quality representation of clients. Representing children, with their varied capabilities, needs and presentations is often very complex work. Lawyers and other professionals working with children will benefit from additional guidance and training regarding representing children with diminished capacity, including children with complex disabilities. Young children and children with disabilities are highly vulnerable and dependent on state actors, and above all else, their legal counsel, to offer guidance and protection.

Recommendations

- That the Public Defender's Office review performance guidelines for lawyers to determine whether further guidance is necessary regarding the representation of children with complex disabilities, and specifically when lawyers are obligated to take protective action on behalf of their clients as contemplated by the Rules of Professional Conduct, Rule 1.14.

- Ensure that training regarding the representation of children with disabilities is included in all pre-service training, and that training regarding advocating for the needs of children with developmental disabilities is regularly provided as in-service training for lawyers representing children in child protection proceedings.

- Where lawyers for children encounter structural obstacles to fulfilling their obligations as counsel to a child, such concerns should be brought to the Court and/or to the Office of the Public Defender so that a plan for remedy can be devised.

Juvenile Court Judges Should Receive Training and Information Regarding the Unique Needs of Children with Disabilities Who Have Been Abused or Neglected

The OCA concludes that the Juvenile Court took several steps to appropriately process the neglect petition filed on Matthew's behalf. Between August and December, 2016, the Court scheduled hearings on at least six (6) occasions for the purpose of ascertaining Ms. Tirado's whereabouts,

[162] Practice Book Section 32a-1 provides that "[t]he child or youth as the rights of confrontation and cross-examination and shall be represented by counsel in each and every phase of any and all proceedings in child protection matters, including appeals."

determining how DCF wished to proceed to protect the children, and developing strategies to secure Ms. Tirado's appearance in Court. The Court even offered at one point to issue orders that would help DCF or the child's attorney seek additional information regarding the children (including educational information), and deferred to DCF regarding its effort to secure an adjudication of neglect and a period of Protective Supervision for the children. The Court made an additional effort to have Ms. Tirado personally served with a summons to appear in court, though this effort was not successful due to the marshal's inability to locate her.

It is important to note that the Court's reviews of the matter took place in the schedule of "short calendar" hearings in the Hartford Superior Court for Juvenile Matters, where multiple cases are docketed and heard each hour regarding children and families with complex presentations and concerns of child abuse and neglect. The Court is necessary reliant on the information presented to it from DCF and the attorneys for the parents and children regarding the well-being and safety of children and the needs of the family. In this case, the Court listened to information from the parties, and granted all of the requests from DCF for an adjudication of neglect, a disposition of supervision, and then ultimately for closure of the family's case due to the mother's lack of cooperation.

OCA also sought information from the Judicial Branch regarding what steps it can take when a parent refuses to appear in Court despite being properly noticed. The Judicial Branch responded that pursuant to current state law, where a parent has been "properly notified of the court appearance and does not appear, there are limited options available to a judge. The court may consider issuing a capias [warrant] for the non-appearing parent but successful execution of a capias often proves challenging."[163] The Judicial Branch added, when asked by OCA if it had any recommendations regarding how best to address the lack of compliance or appearance of a parent suspected of abusing or neglecting a vulnerable child, that "this remains a challenging aspect in juvenile court practice and the Judicial Branch remains open to further discussion and exploration of the issue."

Acknowledging the effort the Court made to secure Ms. Tirado's appearance and offer remedies to DCF and the children's lawyer, the OCA is still concerned that the case of a maltreated child with significant disabilities and who had not been visible to anyone for many months was closed in a manner that did not comply with Practice Book requirements and did not ensure the safety of the child. Accordingly, OCA recommends the following:

Recommendations

- That the Judicial Branch develop and implement use of a bench card to assist with case review and safety assessment for child protection matters involving children with disabilities.

- That the Judicial Branch canvas attorneys for children at critical points in litigation as to whether they have consulted or met with their child clients, and in the case of a client with diminished capacity, whether the lawyer has been able to obtain adequate

[163] Judicial Branch responses to the OCA, received May 24, 2017

information necessary to inform the need for protective actions consistent with the child's safety, the Rules of Professional Conduct, and state law requirements.

- Consistent with other recommendations in this report, the Court should require DCF to submit documentation regarding its safety assessment and the whereabouts of the child prior to case closure.

EDUCATIONAL SYSTEM AND THE CHILD SAFETY NET

Inadequate Safety Net for Children who are Withdrawn from School for the Purpose of Home-schooling—Safety Net Must Be Improved

In November 2016, only three months prior to Matthew's death, Ms. Tirado successfully filed papers with the Hartford Public Schools allowing her to withdraw Matthew's sister, a third grade student, for the purpose of home-schooling. HPS officials did not notify DCF of the child's withdrawal from school despite HPS having made 5 child protection reports to DCF within a recent 18 regarding this child and her brother, Matthew. A call by HPS officials to DCF at this time, while the Juvenile Court case was still pending, could have potentially altered the trajectory of the family's case, perhaps leading to DCF's ongoing involvement and efforts to see the children. It was the very brief information provided by an HPS elementary school to DCF the month before that Matthew's sister was attending school that gave DCF some measure of assurance of the younger child's safety.

HPS reported to OCA that the district employees who processed the home-schooling application for the child were unaware of the prior abuse/neglect history or the district's history of calls to DCF. HPS policy does not require employees to check such information prior to processing a parent's request to withdraw a child from school. HPS also correctly noted that state law does not permit it to deny a parent's application to home-school their child so long as the minimum application requirements are submitted.

State law acknowledges parents' right to instruct their children at home, so long as minimum procedures regarding notice and the parents' commitment to facilitate equivalent instruction are provided to the district. OCA does not dispute the right of parents to provide adequate and equivalent instruction to their children in lieu of sending them to a publicly-funded program. However, OCA finds that state law and agency guidance regarding home-schooling provide an inadequate safety net for children who are documented victims or at-risk of abuse and neglect.

There is no specific language in state law regarding home-schooling requirements. There is no specific law regarding when and how a district should or must address any concerns it has about a parents' intent to home-school where there are recent or active concerns about child abuse or neglect. OCA finds, however, that other state laws regarding the duties of mandated reporters, including school employees, to report suspected abuse and neglect of children may implicate a district's procedures for processing home-school notifications. There must be a safety net to protect children who are victims of abuse and neglect from being withdrawn from the safe harbor and *visibility* of school and removed to a less or even potentially non-visible environment, with the consequence of either no education or

continued lack of protection from abuse and neglect. Even for children who have never been victims of abuse or neglect, there must be some mechanism for ensuring that children are actually being home-schooled.

In Matthew's and his sister's case, when Ms. Tirado filed a request to home-school her daughter only months after the district contacted DCF and the Judicial Branch with educational neglect concerns about that child, and while Ms. Tirado had not permitted Matthew to attend school for *almost a year* (with no formal withdrawal or request to home-school), the district should have immediately contacted the DCF Careline with a new report.

Minimally, districts should have policies that require responsible staff to cross-reference home-school applications with a child's record and any reports from the district regarding abuse or neglect of the child or another school-age child in the home. Child abuse/neglect concerns must be maintained by the district in a central manner and referenced to avoid situations such as what occurred in Matthew's case where personnel responsible for processing the "intent to home school" application was unaware of current or recent child safety concerns.

As part of its review of this issue, OCA sought information from HPS regarding children in its district who were being home-schooled during the last three school years. OCA cross-referenced the children's names with the DCF case management database and learned that more than one-third of the children who were withdrawn to be homeschooled lived in families who had prior DCF involvement due to concerns of abuse or neglect of a child.[164]

OCA then provided the district with a list of more than a dozen children and requested that the district provide documentation regarding any annual portfolio reviews or other efforts it had engaged in to ensure that the children were indeed being homes-schooled, consistent with district policies. HPS did not have any such documentation but responded that the portfolio review is discretionary on the part of the parent and the purpose of the review "is to give the parent the opportunity to ask questions and receive helpful feedback. It is not to assess the portfolio or certify that the student has demonstrated a particular level of mastery," and that it is the parent that is required to "contact the school to arrange for the portfolio review."

However, the district's statement that any follow up is discretionary is not consistent with state statute that provides that the parent must be "able to show that the child is elsewhere receiving equivalent instruction," and that the district must "cause each child … living in the school district to attend

[164] Histories with DCF varied by date and severity. But this overlap between home-schooling applicants and families with prior child protective services histories bears further review and response. HPS provided information that there were 69 children withdrawn from the district between 2013 and 2016 to be home-schooled. Of those 69 children, 29 of the children's families had prior DCF history, and approximately 12 of the children's families had recent involvement with DCF (within a year prior to or concurrent to withdrawal from school). A district will only know of abuse/neglect reports that it made to DCF or that DCF contacted the district about (if a record of such inquiry is kept). Numbers provided here are an estimate based on data received by the school district. Exact dates of withdrawal from school were not always provided, and other data contained inconsistent dates. OCA's findings are based on the data provided by the district and other child welfare records.

school … and shall perform all acts required of it … to carry into effect the powers and duties imposed by law."[165] Further, the SDE guidance to districts regarding home-schooling requirements provides that parents "must show equivalency as described in Section 10-184 [of the Connecticut General Statutes] and local boards of education must determine whether or not such child *is receiving* equivalent instruction."[166] SDE's circulated procedures for home instruction include that "continued refusal by the parent to comply with the reasonable request of the school district … to participate in an annual portfolio review may cause the child to be considered truant."[167]

OCA inquired with six other school districts[168] during the pendency of this investigation to seek the same information regarding children who have been withdrawn from school for the purpose of homeschooling. OCA's review is ongoing but so far has found similar concerns in other districts, including a number of children who had been withdrawn from school whose families had prior histories with DCF, and a lack of documentation that portfolio reviews or any other follow up by the districts has been occurring. Certain district officials acknowledged to OCA their concerns about the current framework for withdrawing children from school. One Connecticut school district official stated that they used to conduct portfolio reviews as recommended by the SDE Circular Guidance but stopped the practice due to protest from some parents.

OCA acknowledges parents' legal right to direct the upbringing, including the education, of their child, and OCA does not aver that local officials should be defensive or suspect of all parents' notifications to home-school a child. However, OCA has reviewed several cases as part of the current investigation that raise concerns about the adequacy of the current framework for withdrawing children from school, the safety net for children who are at-risk of not being educated at all, and children who may be withdrawn from school and subjected to abuse or neglect. OCA has communicated these concerns to state officials from DCF and SDE, and OCA anticipates that the agencies will continue to work together to develop appropriate recommendations going forward. Home-schooling is regulated by many states, though approaches to such oversight and regulation vary. Connecticut is identified by home-schooling advocacy organizations as a state with few compliance requirements.[169]

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165 Conn. Gen. Stat. § § 10-184 and 10-220.

166 Circular Letter of CSDE C-14 (July, 1994-95).

167 Id.

168 The districts reflected geographic and demographic diversity.

169 States' approaches to home-schooling vary considerably, with Connecticut identified as a state with very few requirements or restrictions with regard to homeschooling. See Coalition for Responsible Home Education—Advocating for Homeschooled Children: https://www.responsiblehomeschooling.org/policy-issues/current-policy/record-keeping/ (Nov. 27, 2017). Another organization that collects information regarding home-schooling laws identifies neighboring states such as New York, Massachusetts, Rhode Island, Vermont, Pennsylvania, New Hampshire and Maine as having moderate to high regulation of home-schooling. See the Home School Legal Defense Association, https://www.hslda.org/about/ (Nov. 27, 2017). Certain states require a parent to keep records of a child's progress (E.g., Missouri, Maryland, and Georgia), submit an affidavit regard intent to home school (Arizona, Pennsylvania), annual renewal requirements (Louisiana, e.g.), or other requirements. Several states have a form of ongoing assessment requirement, qualifications of proposed home-school teacher (typically a high school diploma or equivalent), or other requirements for special-needs students. Connecticut statutes are silent on virtually all of the elements identified herein.

Recommendations

- As part of the home-schooling application process, districts should review the child's educational history to determine whether there have been notable or persistent concerns regarding truancy, chronic absenteeism, abuse or neglect or other unmet needs that affect the child's health and safety. Whenever a district has a reasonable suspicion that a child is or has been abused and neglected, such concerns must be reported to DCF consistent with state law. DCF and SDE should assist districts with guidance regarding when a child's withdrawal from school (or chronic absenteeism) may trigger an obligation to report suspected concerns to DCF.

- Districts must ensure that they are compliant with state law obligations to ensure that each school-age child "is receiving equivalent instruction" as required, whether through an annual portfolio review as recommended by SDE or by another means. The SDE should take steps to ensure that districts are aware of their obligations and are complying with General Statute section 10-184 with regard to home-schooled students.

- State law and regulatory or technical guidance from the SDE, in consultation with DCF, regarding the home-schooling of children should be reviewed and amended to ensure an adequate safety net for children at high risk of or who have documented histories of abuse and neglect. Consistent with approaches taken by other states, Connecticut should consider enacting statutory-regulatory language that minimally ensures a child withdrawn from school is receiving an education and is making progress in instructed areas.

Hartford Public Schools' Practices Regarding Withdrawal of Students from School Exposed Another Hole in the Safety Net for Children—Need to Ensure Children's Ongoing Enrollment

As outlined in this report, OCA reviewed Ms. Tirado's history of withdrawing Matthew from school on multiple occasions for lengthy periods of time. When Matthew was withdrawn from school in 2010 and 2012, his mother told HPS that she was moving out of the city. In 2016 she again reported to DCF and HPS that she was moving to justify her failure to send Matthew to school, but this time state and local officials did not believe her—though none of their efforts were successful in addressing the problem.

District officials acknowledged to OCA that no steps were taken in 2010 or 2012 to confirm that Matthew ever enrolled in a new district, and no records were ever requested from a receiving district upon Matthew's brief returns to school in 2011 and 2014. HPS acknowledged that at no time did it receive a request for Matthew's school records from another district, and each time, upon Matthew's return to school, HPS did not request such records. These basic failures in follow up and accountability contributed to Matthew's prolonged absence from school and unintentionally facilitated persistent neglect of a child in desperate need of education and protection.

Recommendation

- Districts and the SDE should create protocols that ensure that withdrawn students are actually re-enrolled in a school within a reasonable time frame, consistent with the provisions of General Statute § 10-184, and that the sending district follow up with a child's guardian when the it has not received confirmation of enrollment from a receiving district. SDE guidance should be developed, in consultation with DCF, to address concerns of persistent or prolonged non-enrollment of a child in school, particularly where there are historical or current risk factors involving the child.

Hundreds of Students with Significant Disabilities Were Chronically Absent from the Hartford Public Schools (2016-17 school year)—Urgent Strategies Needed To Address Chronic Absenteeism and Respond to Unique Vulnerabilities of Children with Disabilities

OCA's review of the days, months and years of Matthew's life prior to his death raised serious concerns about the multi-system safety net for children who don't attend, or are prevented from, attending school. OCA is particularly concerned about highly vulnerable children—children who due to their very young age or significant disability not only need high quality education but are also less visible to the community and more vulnerable to harm.

As part of this investigation OCA sought information from HPS regarding the number of children in the district who are chronically absent[170] or truant[171] and the percentage of such children who have developmental and intellectual disabilities or who are multiply disabled. State law requires that public school districts implement policies and procedures concerning children who are truant and chronically absent, and that districts who have a chronic absenteeism rate of 10 percent or higher "establish an attendance review team," that will meet "at least monthly" to review "the cases of truants and chronically absent children, discussing school interventions and community referrals for such children," and making recommendations.

From the data submitted by HPS as part of this investigation, OCA learned that on April 25, 2017, there were **834 students with disabilities** who were identified by the district as chronically absent, **287 of whom were in elementary school**. There were **160 chronically absent students who had been classified by the district as having Intellectual Disability, Multiple Disabilities, or Autism Spectrum Disorders.**[172] These numbers raise a serious concern regarding the well-being of children with significant disabilities who are frequently not in school. OCA has no additional information at this time regarding the varied reasons for these children's chronic absenteeism.

Recommendation

[170] State law defines a "chronically absent" child as a child who is enrolled in school and "whose total number of absences at any time during a school year is equal to or greater than ten percent of the total number of days that such student has been enrolled at such school during such school year." Conn. Gen. Stat. § 10-198c.
[171] Connecticut law defines "truant" as a child age five to eighteen who is enrolled in a public or private school and who has "four unexcused absences from school in any one month or ten unexcused absences from school in any school year." Conn. Gen. Stat. § 10-198a.
[172] Of these children, only 9 students had been the subject of a report to DCF for suspected abuse or neglect.

- Local and state efforts to address chronic absenteeism in schools must include a specific focus on investigation and remedies that address the needs of highly vulnerable children, including children who are very young and children with complex disabilities. OCA supports and encourages districts in their efforts to determine the underlying reasons for chronic absenteeism and address such reasons with positive child and family engagement, problem-solving and high quality programming for such children. Additionally, state and local frameworks for responding to chronic absenteeism must be well-informed regarding the specialized needs of children with disabilities, their unique vulnerability to abuse or neglect, families' fears and concerns about how their children may be served in school, and strategies to positively engage families whose children have complex disabilities.