STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
165 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106

- EXECUTIVE SUMMARY, LIAM RIVERA – OCTOBER 24, 2023

Sarah Healy Eagan, J.D.
Child Advocate

The Office of the Child Advocate is issuing this Fatality Investigation Findings & Recommendations Report ("Findings Report") following the death by homicide of 2-year-old Liam Rivera. Liam died from blunt impact injury to the head with subdural hematoma. His body was found buried in a park in Stamford, Connecticut. Liam's family had an open child abuse/neglect case with the Department of Children and Families (DCF) and the Superior Court for Juvenile Matters (Juvenile Court) at the time of his death. He had an attorney and Guardian Ad Litem (GAL) appointed to represent him by the Office of the Chief Public Defender (OCPD). Liam's father was on Adult Probation supervision administered by the Connecticut Judicial Branch Court Support Services Division (JB-CSSD) at the time of Liam's death. OCA examined the circumstances preceding Liam's death: the supports and services provided by DCF, the supervision of Liam's father by JB-CSSD, the role of the Juvenile Court in overseeing Liam's best interests, and the legal representation provided for Liam in the child protection proceeding. OCA reviewed records from state agencies, the court, and Liam's medical providers. OCA met with the agencies and medical providers identified herein. The purpose of fatality and critical incident review is to inform statewide child injury prevention efforts.

All agencies identified herein were provided an opportunity to comment/offer corrections to a draft report. Written agency responses are included at the conclusion of the OCA's Full Report. OCA also shared a draft of this Report with the State's Attorney for the Judicial District of Stamford and with the Office of the Chief Medical Examiner.

SUMMARY OF FINDINGS

2017 - December 2020

Liam's family had a history of reports to DCF due to reported allegations of child maltreatment, including child abuse by Ms. Rivera. Reports were not substantiated.

January 2021

Six-month-old Liam was found to have multiple unexplained injuries, suspected to be caused by child abuse, including a broken arm, a healing leg fracture, and bruising on his chest.

February 2021

The Juvenile Court adjudicated Liam abused and neglected and "committed" him to DCF's custody and guardianship, along with a sibling. Doctors found he had unmet medical needs. He was in the 1st percentile for weight and was diagnosed as Failure to Thrive.

Liam and his sibling were appointed a lawyer to represent them in the child protection proceeding in Juvenile Court, and a Guardian ad Litem was later appointed as well.

April and May 2021

Additional reports were made to DCF regarding one Liam's siblings, alleging domestic violence, child neglect, and substance misuse by Ms. Rivera. Concerns centered on domestic violence in front of a child were not substantiated. DCF records do not address the allegations of substance misuse.

July 2021

Liam gained weight in foster care and lost the Failure to Thrive diagnosis. He showed positive developmental gains at his 12-month well-child visit to his pediatrician.

August 2021

DCF noted that the parents had created separate households and Liam's mother was benefitting from support services—DCF developed a plan for eventual reunification of the children with Ms. Rivera and made a referral for a reunification service to begin work with her.

Liam's father, Mr. Ismalej-Gomez, was arrested on a single count of Risk and Injury and Assault due to his admission that he may have hurt Liam's arm trying to keep him from falling off the bed. A full protective order was issued with Liam as the protected party, and Mr. Ismalej-Gomez was ordered to comply with DCF expectations. JB-CSSD internal review found that, contrary to agency policy, pretrial services closed the condition to comply with DCF, which resulted in pretrial services neither monitoring this condition nor providing a progress report to the Court for two subsequent hearings.

DCF inaccurately documented in its case record, and later to the Juvenile Court, that Liam's father acknowledged responsibility for all of Liam's injuries.

October 2021

On October 7, 2021, a call was made to the DCF Careline alleging that Ms. Rivera was using drugs and expressing concern about returning the children to Ms. Rivera's care. There is no follow up in the DCF record. Concerns were not shared with the children's attorney, GAL, or the Court.

DCF decided, with agreement from Liam/sibling's attorney and GAL, to informally reunify Liam's sibling with Ms. Rivera. DCF did not seek approval from the Juvenile Court. The sibling's reunification was facilitated through a DCF practice of placing children home "under [DCF] commitment."

OCA finds state law does not grant DCF discretion to place children who are under the state's guardianship (commitment) back into the custody of the parent from whom the child was removed as the Juvenile Court has exclusive jurisdiction to address custody in child protection proceedings.

November 2021

DCF made a referral for reunification assessment and support services for Liam and Ms. Rivera. Four supervised visits took place, with the provider using a translator on speaker phone as Ms. Rivera is primarily Spanish speaking. Reunification was recommended.

December 2021

In early December, Liam remained in foster care. His foster mother took him for a sick visit to a local provider. Liam was in the 50th percentile for weight.

DCF filed legal motions asking the Court to restore Ms. Rivera's custody of Liam's sibling, and to approve a goal of restoring Ms. Rivera's custody of Liam. DCF did not inform the Court of the October call to the DCF Careline expressing concerns about reunification of the children. The Court granted DCF's motions.

Although a separate legal motion was required to place Liam back home with Ms. Rivera, a week after the Court hearing, DCF informally reunified Liam "under DCF-commitment." Did not seek approval from or provide notice to the Court. No assigned staff visited Liam for three weeks.

January 2022

In late January, Ms. Rivera called police and alleged that Liam was kidnapped by a paternal relative. Police found Liam late at night outside with his father, with no coat, no shoes, and wrapped in a towel. Mr. Ismalej-Gomez was arrested and incarcerated following the incident. One week later Ms. Rivera recanted her kidnapping accusation and stated that she gave Liam to his father for a visit but became nervous when she could not reach him by phone. Ms. Rivera was criminally charged with making a false statement to police. DCF investigated the incident, substantiated Mr. Ismalej-Gomez for neglect, and closed its investigation on February 17, 2022. DCF's investigation report does not reference Ms. Rivera's earlier recantation to the police, or any recantation to DCF, and does not address the discrepant information.

February 2022

A DCF supervisor entered a note into the record (backdated to September 2021) that acknowledged there are "still concerns/questions surrounding Liam's unexplained injuries as neither parent have given explanation as to how they may have occurred."

March 2022

Text messages authored by the assigned DCF caseworker indicate staff had learned of Ms. Rivera's discrepant statements to police and reflect DCF's concern about Ms. Rivera's judgment and capacity to keep Liam safe. Texts also reflect Ms. Rivera's feeling that the protective order, still in place, was unjust and that DCF was cruel in keeping Liam from his father. She acknowledged being financially dependent on the paternal family to meet the children's needs. While texts indicate that DCF was having internal meetings regarding whether to keep Liam informally with his mother or return him to foster care, the DCF record contains little to no information about DCF's internal review of the matter or its decision-making process in leaving Liam home with Ms. Rivera.

DCF did not inform the Court or Liam's attorney and GAL of the January violation of the Protective Order or DCF's concerns. According to the Court record, Liam remained in DCF foster care, with DCF responsible for ensuring all of his needs were met.

DCF delayed filing a legal motion with the Juvenile Court to restore Ms. Rivera's custody.

Liam's lawyer and GAL did not request any DCF records during much of the case and did not visit with Liam during this time. They would visit Liam at home only once prior to his death in December.

April 2022

Liam went to his local pediatrician who recorded a declining weight trajectory and that Liam failed a developmental screen for Autism. A referral for a birth to three evaluation (for early intervention services) was made. Records from Liam's multiple medical providers indicate that he had lost weight since returning home.

DCF did hold the required six month case review meeting, designed to review information regarding Liam's safety and wellbeing.

Mr. Ismalej-Gomez was released from prison with probation conditions to cooperate with DCF. DCF records reflect no attempts to contact him after May 2022, contrary to DCF policy.

Adult Probation Services was to monitor Mr. Ismalej-Gomez. Probation did not verify Mr. Ismalej-Gomez' address consistent with agency policies. Given the family violence related charges, JB-CSSD internal review found that a separate screen, the Domestic Violence Screening Instrument-Revised (DVSI-R) should have been completed in Mr. Ismalej-Gomez' case to inform the risk and supervision level, which would have resulted in a High supervision level, increasing the expectations and contacts with JB-CSSD significantly.

June 2022

By June, Mr. Ismalej-Gomez stopped contacting his assigned probation officer. He was later deemed by probation to be in "violation status." JB-CSSD's review found that assigned staff did not consistently follow the agency's "absconder" policy.

Also in June, DCF filed a legal motion in the Juvenile Court to end its commitment/guardianship of Liam and restore Ms. Rivera's custody. DCF's motion to the Court included information about the January 2022 protective order violation by Ms. Rivera and Mr. Ismalej-Gomez, but did not inform the Court of DCF's investigation, or the felony charge pending against Ms. Rivera for allegedly making a false complaint of kidnapping to the police. DCF erroneously reported to the Court that Liam was in the 50th percentile for height and weight, when in fact he had been losing weight since leaving foster care. DCF's filing inaccurately listed the injuries that led to Liam's placement in foster care, omitting information about his leg fracture, torso bruising and the Failure to Thrive diagnosis. DCF incorrectly reported to the Court that Mr. Ismalej-Gomez's previous arrest incorporated all of Liam's injuries.

Based on the information provided, the Court granted DCF's Motion to Revoke Commitment, restored Ms. Rivera's legal custody of Liam, and ordered nine months of Protective Supervision.

July 2022 through Liam's Death on/about December 28th, 2022

Assigned DCF staff visited Liam in his home twice each month. All visits were announced. DCF records reflect no discussion of unannounced visits, contrary to DCF practice expectations.

Assigned DCF staff did not consistently use interpreter services while conducting home visits, contrary to DCF policy and federal law requirements.

DCF did not contact Liam's medical provider or obtain his medical/developmental records, contrary to DCF policy and federal law requirements. Liam was never connected to Birth to Three services due to non-engagement by his mother.

In August 2022, a warrant for Mr. Ismalej-Gomez' arrest due to violation of probation was signed by the criminal court.

In September 2022, Liam was observed by DCF during a home visit to be thin and unable to verbalize. DCF made another referral to Birth to Three to assess Liam's development.

On October 28th, Liam was seen by his local pediatrician, who found that he has continued to lose weight and who re-diagnosed him with Failure to Thrive. The doctor called the DCF caseworker the same day to report the concerns about Liam's weight and noted that he had normal weight trajectory while in foster care. The DCF record did not reference this call until a month after Liam died. There was no DCF follow up with the doctor, and Liam was a "no-show" for his follow up appointment the following month—no additional notification to DCF made.

In November, Ms. Rivera falsely reported to DCF that she had followed up with the doctor and that Liam was gaining weight.

In December, DCF noted that Liam looked thin, and looked like he had lost weight again. While DCF encouraged Ms. Rivera to follow up with the doctor, DCF did not contact the pediatrician.

Liam's lawyer and GAL did not visit with him during the period of Protective Supervision and did not obtain any records regarding his care, thereby not meeting the standards established by federal law, state law, and the Public Defender's Office for representing children.

January 2023- Autopsy

Ms. Rivera disclosed through her lawyer that Liam had died due to an injury and could be found in a park in Stamford, CT. She denied responsibility. The Connecticut Office of the Chief Medical Examiner conducted an autopsy on January 3, 2023. The OCME determined that Liam died from blunt impact injury to the head with subdural hematoma. Liam's weight at autopsy was 17 pounds, five pounds less than he weighed during his last doctor's appointment at the end of October, and 7 pounds less than he weighed when he left his foster home. Liam was 2.5 years old at the time of his death.

<u>DCF Record Review</u>

After Liam's death, OCA found that there were several serious concerns with the DCF case record:

1) there were no entries corresponding to critical case events and internal discussions about Liam's safety in Ms. Rivera's care;

2) there were multiple late entries entered by the supervisor/s, some entered months after the fact; and,

3) there were material entries/corrections made to the record after Liam's death (all entries are date-stamped and identify the entrant), per the directive of the Commissioner and DCF Regional Office Director that assigned staff ensure a complete and reliable record. Corrections/additions were made to indicate that the caseworker met with Liam's sibling alone and behind closed doors during home visits, that the caseworker saw no signs that Mr. Ismalej-Gomez was living in the home during the Protective Supervision period, and another entry recorded the fact of the pediatrician's October 28, 2022, call expressing concerns about Liam's weight. One entry, stating that the caseworker met with Liam's sibling alone during her last home visit to the family, was contradicted by the statement the worker provided to the police.

Forensic interviews later indicated that Mr. Ismalej-Gomez was living with or spending time with the family in the months prior to Liam's death.

SYSTEM ISSUES AND RECOMMENDATIONS

Department of Children and Families

I. Need to Address Urgent Concerns in DCF Case Practice—Quality Improvement and External Oversight Needed

Multiple OCA fatality/near-fatality reviews as well as DCF systems data confirm inconsistent case practice with "in-home" cases like Liam's. Agency data since DCF's March 2022 exit from class-action driven federal court oversight (*Juan F. case*) shows significant concerns in critical practice areas including risk and safety assessment, staff contact with children, case supervision, and the monitoring of safety plans. These are historical areas of concern for DCF based on previous federal auditing.

Recommendation. Continue to strengthen DCF's quality improvement framework. Ensure external oversight of DCF operations. Strengthen the DCF Statewide Advisory Council. Provide staff to the Office of the Child Advocate to enhance independent review. Require additional public reporting on operations and service delivery to children and families. The legislature should review agency workloads and workforce needs, and the impact of telework (workers and supervisors are eligible for 80% telework) on case practice.

II. Improve Practice with Children Birth to Three

OCA supports maintaining children safely in their homes whenever possible as undue use of foster care can be traumatic and destabilizing for a child. Very young children like Liam are at greatest risk of poor outcomes.

Recommendation. Develop clear protocols/supervisory checklists to help in operationalizing DCF's Birth to Five practice guide. Staff must gather information at least monthly regarding the health and development of young children, with clear protocols for when to seek internal consultation. Work with external stakeholders to update policy and case expectations. Ensure quality assurance case review tools specifically audit/address case practice and service delivery to young children.

III. Statutory Amendment Needed to Permit Transitional Reunification of Children in Foster Care

Current law does not authorize placing children home "under DCF commitment," as once a child is committed to DCF guardianship, they remain committed until further order of the Court, and DCF is authorized to place children only in homes licensed or approved to provide care.

Recommendation. Amend state law to provide for transitional reunification plans, establish parameters and notice requirements.

IV. Statutory Amendment Needed to Ensure Foster Parents Are Consistently Notified of Juvenile Court Hearings and the Right to Be Heard as Required by Federal and State Law

Liam's foster parent was not provided with written notice of her right to be heard in Court regarding Liam's permanency plan. Other foster parents report the same concern to OCA.

Recommendation. Amend State law or Connecticut Practice Book rules to require DCF to provide the Juvenile Court with a copy of the written notice sent to the foster parent.

V. Reliable Notification to Lawyers and Guardians ad Litem of DCF Case Plan Meetings

OCA found that in this review and another recent critical incident review, DCF did not provide the lawyer/GAL for the child consistent written notice of administrative meetings concerning the child.

Recommendation. OCA recommends an automated and electronic notification process to attorneys and GALs for client-centered administrative meetings, with regular reports to the Office of the Chief Public Defender confirming notice to attorneys. DCF Court filings should include information regarding dates of ACRs and permanency planning meetings, and attach a copy of the notice to the attorney/GAL.

VI. Parties Should Receive Notification of Any New Report of Abuse/Neglect of a Child

Recommendation. Amend state law to require notification to attorneys/GALs whenever a new allegation (accepted or non-accepted for investigation) of child abuse or neglect is made to DCF, and the disposition/follow up.

Office of the Chief Public Defender

I. The OCPD Should Strengthen Legal Representation of Children

Most parents and children are represented by private attorneys under individual contract and assigned by the Office of the Chief Public Defender of the Division of Public Defender Services (OCPD). While there is training and billing oversight by the OCPD, the system has been historically under-resourced, with accelerating attrition of lawyers from the contract panel. Strong representation for children is critical to ensure their needs for safety and permanency are met.

Recommendation. Following recent increases to the OCPD budget, evaluate whether resources are adequate to recruit and retain qualified counsel for children. Explore quality assurance measures for the delivery of legal services to children. Ensure attorneys can bill for activities required by contractual and federal law expectations, including reviewing records and communicating with service providers. Strengthen performance guidelines for GALs. The legislature should create a working group to review the delivery of legal services to children in child protection proceedings and make necessary recommendations to support high quality representation for children.

Judicial Branch-Court Support Services Division

I. JB-CSSD should strengthen aspects of agency policy impacting children, and certain quality assurance activities.

OCA and JB-CSSD met several times during the pendency of this investigation to review aspects of Mr. Ismalej-Gomez's case and the agency's policy and quality assurance framework. JB-CSSD provided OCA with its internal review of Mr. Ismalej-Gomez's case and what action steps the agency has/is undertaking to address identified system issues.

Recommendation. Modification of supervision policies and expectation should be considered where a child is a victim, including: enhanced home visit/address verification; explicit requirement for administration of the domestic violence/family violence screening tool; and specific expectations for DCF and service provider contacts. JB-CSSD should examine policies regarding engagement and supervision of individuals where there are risk indicators that may impact a child in the individual's household (e.g., individual impaired by substance misuse; individual convicted/charged with violent offenses), including consideration of whether the presence of young children dictates a more frequent contact/supervision schedule or more intensive supervision and service delivery. Consider

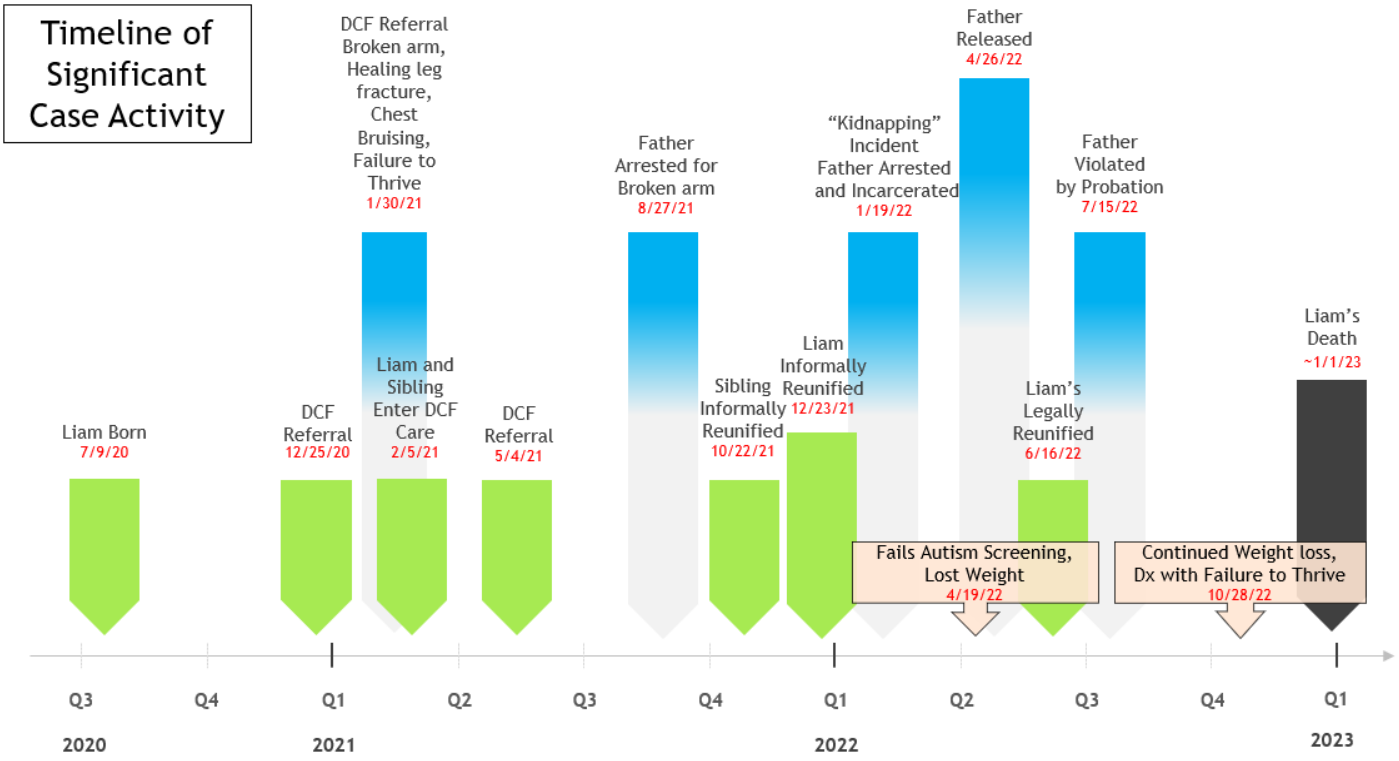
protocols for when a joint visit/s with DCF should be conducted when cooperation with DCF is a condition of release/probation. Consider enhanced/centralized methodology for auditing case supervision (both pretrial and probation). Audit the use of interpreters for individuals under supervision that are not English speaking.

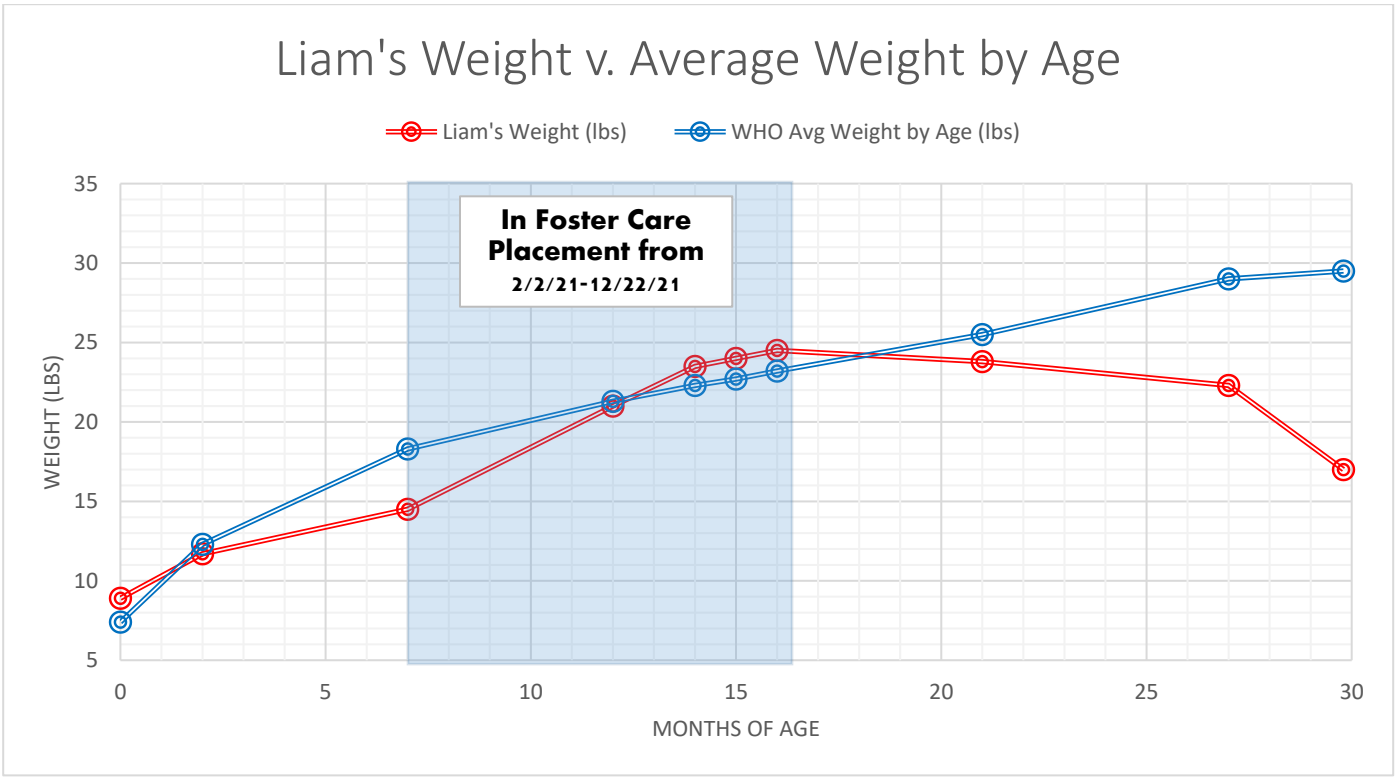
Judicial Branch- Superior Court for Juvenile Matters

I. Court Processes/Requirements Should Ensure Reliable Information Provided to the Court Regarding Children's Safety and Wellbeing.

OCA found that the Juvenile Court was not provided with complete and reliable information to support his safe reunification with Ms. Rivera. State law and procedural changes needed.

Recommendation. State law should be amended to include inquiry and/or findings by the Court that correspond to children's legal rights to adequate care. Specifically, the law should require judicial inquiry regarding the child's right to: appropriate medical and developmental services; a safe and/or licensed placement; be seen by their lawyer and DCF worker; and ensure DCF and the child's lawyer/GAL has obtained and provided information about the child's medical/service/support needs. All DCF reports to the Court should identify the source of information.


Timeline of Significant Case Activity
Liam Born 7/9/20
DCF Referral 12/25/20
DCF Referral Broken arm, Healing leg fracture, Chest Bruising, Failure to Thrive 1/30/21
Liam and Sibling Enter DCF Care 2/5/21
DCF Referral 5/4/21
Father Arrested for Broken arm 8/27/21
Sibling Informally Reunified 10/22/21
Liam Informally Reunified 12/23/21
"Kidnapping" Incident Father Arrested and Incarcerated 1/19/22
Father Released 4/26/22
Fails Autism Screening, Lost Weight 4/19/22
Liam's Legally Reunified 6/16/22
Father Violated by Probation 7/15/22
Continued Weight loss, Dx with Failure to Thrive 10/28/22
Liam's Death ~1/1/23
Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2020 2021 2022 2023


Liam's Weight v. Average Weight by Age
Liam's Weight (lbs)
WHO Avg Weight by Age (lbs)
In Foster Care Placement from 2/2/21-12/22/21
WEIGHT (LBS)
MONTHS OF AGE
35
30
25
20
15
10
5
0
5
10
15
20
25
30