

**REPORT OF THE
CHILD ADVOCATE
AND THE
ATTORNEY GENERAL**

"CHILDREN LEFT AT RISK"

**AN INVESTIGATION OF SUBSTANTIATION OF
CHILD ABUSE COMPLAINTS**

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EXECUTIVE SUMMARY

This report is the culmination of a joint investigation by the Child Advocate and the Attorney General into the Department of Children and Families' (DCF) system of investigating and acting on reports of abuse and neglect made to the DCF Hotline. The investigation was prompted by an apparent anomaly: a rapid decline in the number of reports of abuse and neglect that were substantiated by DCF at the same time that the number of reports made to the Hotline were rising.¹

As a result of the investigation, we have confirmed that the rate of substantiated reports has dropped significantly over the past six years for a number of reasons. However, the most troubling finding of the investigation was an unexpected one: a pattern within DCF of failing to take action to protect children even **after** physical and other abuse has been substantiated by the agency, and failing to follow up to ensure that services are provided to and utilized by families after referrals to community services have been made. An obvious lack of awareness on the part of the DCF administration of the depth and seriousness of this issue has been unveiled.

FINDINGS

1. The rate at which DCF staff have substantiated reports of child abuse or neglect *has* dropped significantly over the last six fiscal years for a number of reasons.
 - During FY 1997, DCF substantiated well over half of the reports of suspected abuse assigned for investigation; by FY 2002 the number of reports of suspected abuse substantiated by staff dropped significantly to slightly more than one quarter of the reports that were investigated.
 - At the beginning of the reporting period that we examined, the number of reports of suspected abuse was extremely high and well above national averages, with substantiations of well over half of the abuse and neglect allegations. This level of activity overwhelmed DCF and seriously impaired its ability to adequately protect the most vulnerable children.
 - Many factors contributed to the subsequent substantial decline in the rate at which reports of suspected abuse were substantiated, most notably amendments to the statutes governing child protective services which were administered by DCF, reducing reportable incidents, together with the resulting formal changes in DCF policy related to reportable situations.
 - In addition, institution of an Administrative Review Process may also have contributed to lower substantiation levels because the appeal and case review

¹ The investigation was requested by the Chairperson of the General Assembly Select Committee on Children, who asked that this review track changes in policy that potentially affected outcomes within the system and identify potential areas of concern related to current Department policies and practices around entry of children and families to the State's child welfare protective services delivery system.

process made some DCF personnel hesitant to substantiate allegations of abuse and neglect in marginal situations.

2. Our review of the declining substantiation levels showed that DCF personnel were failing to follow official policies and procedures concerning reports of suspected abuse that resulted in a failure to properly and timely respond to child abuse. For many children, protective services from DCF arrived only after multiple reports of their abuse and neglect. Tragically, some individuals making Hotline reports were required to contact the Hotline several times over a period of years before any significant help was provided to the child and family. For instance:

- a. Nearly 700 cases of substantiated physical abuse are improperly closed each year immediately after the allegation of abuse is substantiated, without DCF providing any protective services to the child and family involved. This number equates to an average of 28% of the cases of substantiated abuse every year. The Department's own review of a very limited pool of such cases indicates 4% were potentially erroneously closed, and another 16% of such closures were questionable.
- b. On average, 2600 investigations each year are closed as unsubstantiated within 24 hours of referral from the Hotline to regional investigators. Such case closings often result from overrides of the Hotline screening decision by regional DCF personnel. Such regional reversal clearly violates DCF policy, and was the basis of a finding from the U.S. Department of Health and Human Services that the Department's operations were in need of improvement.
- c. In about 10% of the reported cases, allegations of abuse are substantiated, but the family's case is closed and the family is referred to other agencies for social and corrective services. Case files, however, showed no evidence of follow-up by the DCF to determine if the family was actually connected to a specific service provider or ever received the services they needed.

3. Over the last six years substantial changes in agency policy appear to have been communicated to staff through informal e-mails and unrecorded management meeting discussions. Senior managers at DCF have often relied on each level of the organization to disseminate its instructions to the next level rather than following a more structured mechanism to disseminate policy directives throughout the Department and ensure that all staff are familiar with the new policies.

4. It is clear that Bureau Chiefs and other managers in the Department do not routinely use administrative data, such as that provided to the Office of the Child Advocate from the LINK system², to manage the quality of programs under their

² LINK is the DCF management information system. It contains descriptive and decision-making data and case narratives concerning all children reported to the agency.

supervision. The Bureau of Child Welfare began probing some of the anomalies identified through this review only after they were brought to the Bureau Chief's attention by the Child Advocate's staff.

RECOMMENDATIONS

Sadly, the recommendations flowing from this investigation are much the same as the recommendations from the Child Advocate and the Attorney General in many other reports produced previously. While the drop in the substantiation rate appears primarily to be a response to statutory and policy changes, we have noted a troubling level of questionable dispositional determinations. Beyond the clinical implications of the decisions that were made, the continued failure of managers of the Department to identify and correct systemic problems in its organizational response to child abuse and neglect causes grave concern.

- **The Department of Children and Families must improve its processes of investigation and assessment. A comprehensive, ongoing, formal assessment of functioning is essential to establishing the safety of children and the treatment needs of families.** The number of times allegations of abuse or neglect are unsubstantiated, or substantiated and closed without services (action), for children who need protection, reflects a lack of comprehensiveness and depth in the family studies undertaken by Department line staff. Increased training and on the job supervision must direct staff to implement effective social work/child welfare practices concerning individualized, holistic, family assessment. The focus of the decision making process throughout protective services intake must be on the welfare of the children involved. Case records indicate that investigative social workers and supervisors often do not complete thorough assessments, or do not adequately document the assessments, so that reasonable determinations of disposition can be pursued. There is no evidence that DCF has implemented the Child Advocate's earlier recommendations that more than two reports of abuse or neglect concerning a family should be reviewed by a multi-disciplinary team to determine the most appropriate course of action for children involved. We repeat that recommendation with a special urgency here.
- **The Department of Children and Families must be more willing to invoke the authority of the Superior Court for Juvenile Matters if families are unwilling to voluntarily participate in services.** DCF regularly fails to enlist the authority of the Superior Court for Juvenile Matters, even though the Department's experience in bringing court action has been extremely positive. Data maintained by the Courts shows that court rulings favor departmental motions in 90% of the cases actually

brought. Despite this, investigative staff are very conservative in their willingness to seek judicial support for protective service orders where necessary.

- **The Department must develop an effective internal quality assurance program.** DCF executive staff, managers, and supervisors have available multiple sources of data and information concerning the processes employed by the staff under their direction. There is no evidence, however, that those in authority within the Department make effective use of this data to monitor agency performance. The Office of the Child Advocate was not designed to provide ongoing monitoring for the DCF and should not be functioning as a substitute for effective internal quality assurance by DCF itself.

Quality assurance systems can and must be designed and used to provide accurate, timely data to those responsible for policy implementation in a form that allows managers to monitor and improve the operations of the functional units who report to them.

- **DCF executive staff, bureau chiefs, managers, and supervisors must receive training in data systems and quality assurance processes.** During the course of this investigation, staff appeared unaware or uninterested in using the management information resources placed at their disposal. Training of those in authority in the Department must include instruction on the effective use of information for quality improvement.
- **The management structure and protocols for internal communication at the Department of Children and Families must be revamped.** Regulations and policy are the publicly accepted statement of the parameters of DCF operation. Unrecorded or unofficial operating instructions undermine staff's ability to perform the functions assigned to them appropriately, and leave little protection for families attempting to fend off unwarranted state intrusion into their lives. The use of informal communications, and hand-me-down information results in a decision making process guided by piecemeal instructions and lack of public accountability.
- **The Department of Children and Families should develop a long term planning unit that operates separately from program administration.**
 - DCF still does not appear to do adequate long term planning. Once again, the Child Advocate and Attorney General recommend that DCF undertake an ongoing comprehensive analysis of the needs of all children reported to the Department who require protection. This exercise should be part of a systematic long-term planning effort, integral to anticipating and meeting the needs of children at risk while protecting the organizational resources from being inundated.
 - A meaningful planning function should be separate and independent from those divisions of DCF responsible for program administration. Decision-

making suffers when the pressures of the day drive functions that should be independent. Proper long term planning involves careful assessment of future needs, matching those needs to existing programs and ascertaining what change is needed in order to serve children better.

- **The Department of Children and Families should review the need for legislative changes to ensure that the Department has the requisite authority it needs to protect children who are being abused or neglected.** This report has highlighted systemic weaknesses in DCF's responsiveness to reports of abuse of children. In light of the findings of this report DCF should carefully review whether additional legislation is needed to improve DCF's responsiveness to these critical issues.

INTRODUCTION

Background

In August 2002, spokespersons for the Department of Children and Families (DCF) announced that the number of substantiated reports of child abuse and neglect in Connecticut had fallen for the third year in a row. At that time, the State's Child Advocate and the Chairperson of the General Assembly Select Committee on Children, acting separately, requested clarification from the DCF Commissioner regarding the rapid decline in the substantiated reports of abuse or neglect during a period in which the number of children reported to the DCF Hotline as abused or neglected was rising. Each was concerned whether the decline in the proportion of reports of abuse or neglect substantiated actually represented a reduction in the number of child victims in Connecticut, or whether significant amendments to DCF policy or data collection and analysis methods were at the root of the changing numbers. No explanation was forthcoming from the DCF at that time, and DCF has yet to provide adequate response to the concerns of the Select Committee on Children and the Child Advocate.

Due to these concerns, Chairperson of the General Assembly Select Committee on Children called upon the Attorney General and the Child Advocate to conduct an investigation to determine how the Department of Children and Families protective services system for children operated during the past six years. He requested that this review track changes in policy that potentially affected outcomes within the system and identify potential areas of concern related to current Department policies and practices for entry of children and families to Connecticut's child welfare protective services delivery system.

“Substantiation” within the Department of Children and Families Child Welfare Program

In the State of Connecticut, the agency responsible for protecting children who have been abused or neglected by those responsible for their care is the Department of Children and Families. This investigation focused on the decision-making process in which determinations are made about how DCF will respond to allegations that children have been abused or neglected, or have been left uncared for. “Substantiation” is a protective service finding in which a DCF social worker determines that “there is reasonable cause to believe that child abuse or neglect has occurred,” (CTDCF, 32.4, 2000). Because child protection is a system of public intervention, however, the determination of the veracity of a report of maltreatment is not the sole function of the investigative process. The investigation that leads to a substantiation finding is the primary intake/assessment process for a State system meant to protect children through public social services provided to them and their families. Findings of “substantiated” or “unsubstantiated”

abuse or neglect determine the extent to which families will be subject to state intervention, sometimes involuntarily, and will be provided services designed to protect the children.

The Protective Services Decision Making Processes

There are three basic decision points in the protective services intake process. At each point, a DCF caseworker must make a determination about whether the reported incident meets statutory and policy criteria that moves the case to the next stage. At each of these points, cases may be closed and children and their families may be removed from the process because DCF staff determines that they do not meet the legal and policy definitions that allow the agency to continue to intervene on behalf of the child.

1. Step 1 - Intake

The process begins with the filing of a report to the DCF Hotline alleging that a child has been abused or neglected. Both mandated professionals and concerned citizens call a central Department number to report the abuse or neglect of a child under 18 years of age. Staff screens the allegation to determine if it is sufficient to be considered a report of child abuse, neglect, or a child in danger of abuse. To be screened in and referred for investigation, the allegation must

- concern a child under 18 years of age, or under 21 years of age and committed to the Department
- report injuries inflicted by a person responsible for the child's care or by a person given access to the child by a person responsible for the child's care
- contain sufficient information to locate the child
- meet the statutory definitions of abuse, neglect, or in danger of abuse. (CTDCF 33-6-14, 1996), meaning that the allegation made must concern physical abuse or neglect, medical, educational, moral or emotional neglect, or that a newborn is at risk.

If the allegation does not meet these base standards, the report is **screened out** and noted in the DCF information system, but no further actions are taken.

2. Step 2 - Investigation

If the allegation meets the criteria for a valid report, an investigation continues the process of gathering facts and information already begun during the report-taking phase. The investigator, located in regional DCF offices, must acquire and analyze information from background records and interviews with the parents or guardians, children, and other involved parties to determine what has happened to the child. In order to substantiate the report, the investigator must find **reasonable cause to believe that a**

child has been a victim of physical abuse or neglect, sexual abuse, emotional neglect, educational neglect, moral neglect, or medical neglect or that an infant is a high risk newborn, and that the perpetrator is a person responsible for a child’s care or given access to the child by the person responsible for the child’s care. If the investigator, in conjunction with his/her supervisor, does not find a situation meeting statutory definitions of abuse, neglect, or uncared for within the “reasonable cause to believe” standard, he/she makes a determination that the report is **unsubstantiated**. In cases where the investigation worker finds evidence of service needs in families, even where the reports of abuse are unsubstantiated, he/she *may* refer the case to other Departmental or community services, but the family is not considered a part of the protective services effort.

3. Step 3 – Substantiated Reports

If a report is **substantiated**, Department staff must make further determinations based upon child safety and child and family needs and circumstances concerning the nature of further treatment assistance and intervention with the family. If physical abuse is substantiated, policy provides:

Transfer to a DCF service unit is mandatory in all cases in which **abuse** is substantiated, unless deemed inappropriate by the Program Director (CTDCF, 34-14).

For all other substantiated allegations, the usual disposition assumption also would be to transfer the family for treatment services. However, in these cases the investigations staff has the authority to close the case with a referral to other community agencies or close the case with no further services provided – even though abuse or neglect has been substantiated.

Methods Used in this Investigation

The Child Advocate staff has taken several different approaches to collecting information and data upon which to base our investigation of the intake process for protective services for children and their families. In general these efforts fall into four general categories:

1. data collection and analysis,
2. discussions with individuals involved in the provision, management, and oversight of DCF’s child protective services,
3. policy reviews, and
4. reviews of a small number of randomly pulled cases based upon cross tabulations from the DCF LINK data system.

Initially, we reviewed national and state publications that analyzed protective services operations in Connecticut and other states over the period 1996 through 2002. Since 1991, the National Child Abuse and Neglect Data System has published **Child**

Maltreatment: Reports from the States to the National Child Abuse and Neglect Data System (NCANDS). This report contains data from most states, including Connecticut, concerning abuse and neglect reports and investigation outcomes, rates of citizen reporting within states, and rates of child victimization based upon reported and verified incidents. Since 1997, the DCF has produced annually **Town Reports** that present statewide and town-by-town data on the incidence and prevalence of reported child abuse and neglect within the state. These annual compilations also were reviewed.

Child Advocate staff reviewed revisions that have taken place in DCF policy regarding the investigation and disposition of reports of child abuse and neglect. This process included discussions with DCF Administrative Law and Policy staff concerning policy development over the last six years, and with current and former field and management staff concerning the mechanisms by which formal policy decisions and policy interpretations are made known throughout the agency. Formal and informal discussions were conducted with parties in and out of the DCF with knowledge of child protective policies and practices over the last 7 years to secure their insights into the reduction of the rate at which DCF Investigators substantiated reports of child abuse and neglect.

Finally, the Child Advocate secured from the DCF LINK system a database containing the files of all reports made to the DCF Hotline between July 1996 and June 2002 (CT FY's 97, 98, 99, 00, and 01). Using this database of over 200,000 unrefined files, Child Advocate staff extracted various data items and conducted simple cross tabulations to identify areas that would describe Departmental practice more completely, and would identify groups of cases that seemed not to have progressed as expected. Random cases from these groups were reviewed to determine what Departmental practice seemed to be in these cases.

CONNECTICUT SUBSTANTIATION RATES 1996-2002

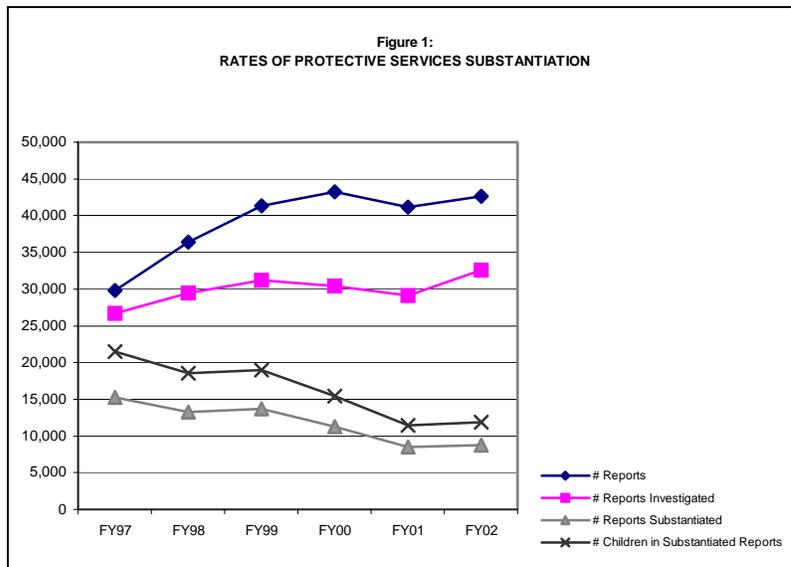
In reviewing both raw data from the DCF LINK information system, DCF public reporting, and Connecticut data supplied to the National Center for Child Abuse and Neglect Data (NCCAND), it is clear that child abuse and neglect substantiation rates and the absolute number of cases substantiated by the state have decreased over the period from the beginning of CT Fiscal Year 1997 to the end of FY 2002. Based upon data in the Connecticut DCF Internet Town pages (see Table 1, below), the rate of substantiations has fallen from a high of 57% in FY 97 to less than half of that (27%) for the fiscal year ending July 2002. The number of children included in these substantiated reports dropped by 45% over the same period, even though the total number of reports, and the number of reports referred for investigation, rose by 43% and 22% respectively over the same 6 fiscal years. In actual numbers, the number of children classified through the investigations process as "victims of abuse and neglect" has fallen by over 10,000.

**Table 1:
Substantiation Rates FY 1997 thru FY 2002**

	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
# Reports	29,799	36,370	41,312	43,251	41,151	42,648
# Reports Investigated	26,693	29,477	31,162	30,405	29,088	32,582
#Substantiated Reports	15,252	13,238	13,719	11,303	8,456	8,753
%Investigated Reports Substantiated	57%	45%	44%	37%	29%	27%
# Children in Substantiated Reports	21,506	18,510	18,957	15,402	11,472	11,861

Based upon Connecticut DCF Town Pages Fiscal Year Reports 1997-2002.

The figure below demonstrates the growing gap between the number of actual reports and the number of substantiated reports over this time period. While the most significant annual decline in substantiations in relation to cases investigated occurred between FY 1999 and 2001, the greatest annual change in the ratio of reports substantiated to reports received occurred at the very beginning of the period, between FY 1997 and 1998. Until the last fiscal year, the number of cases referred for investigation has remained relatively stable.



The decline in rates was consistent across regions, i.e., regions with higher rates of substantiation in 1997 remained proportionally higher than their counterparts during this time although their rates fell as rapidly as did the other regions.

In FY 1997, the DCF substantiated 37,524 of the allegations contained in reports; by FY 2002, the agency substantiated approximately 19,686 individual allegations.³ In most reported categories of possible child maltreatment -physical abuse, neglect, educational neglect, medical neglect, moral neglect, high-risk newborn, and sexual abuse -the state experienced a 20-25 point drop in the percentage of cases substantiated.

On the other hand, the rate of substantiation for reports of emotional neglect- allegations that a child or children had been subjected to repeated negative acts or statements, had been exposed to repeated violent acts, or had been rejected by their parents or caregivers- dropped 54% from 70% in FY 1997 to 16% in FY 2002. The percentage of reports that a child was deemed at risk of physical or sexual abuse, neglect or emotional abuse or was in circumstances injurious to a minor also fell dramatically from 41% at the beginning of the period to 8% by its end. This decline was more dramatic because by the end of the period the number of at-risk reports had dwindled by almost 90%, so that the number of such cases substantiated fell from 9,190 to only 20 in FY 2002. These two categories alone accounted for a drop of 13,902 cases between the two annual periods, from 18,981 in FY 1997 to 4,289 in FY 2002. These cases represent over 75% of the reduction in the *number* of reports substantiated over the six years period.

Imbalance in State's Reporting and Substantiation Rates

Historically, the State of Connecticut has had much higher rates of enrolling children in its protective services delivery system than many other states in the country. Over the five years prior to the period under scrutiny here, 1991-1996, the number of children brought into the child protective services system of the State (the Department of Children and Youth Services or DCYS was the responsible agency for most of that time) climbed by almost 60% as compared to an increase of 18% nationally. Based upon the data supplied by Connecticut and other States to the National Center on Child Abuse and Neglect Data for the Center's annual reports (see Table 2 below), by 1997, the DCF was receiving reports of abuse and neglect at a rate 26% higher than national averages. The agency substantiated about 40% of the child maltreatment reports it received, and the investigative process classified 23 of every 1000 children in the state as a victim of child abuse or neglect. This compared to a national "victimization" rate of slightly less than 14 victims per 1000 children in that year.

³ A single report may contain multiple allegations. Each individual allegation is substantiated or unsubstantiated. The number of reports substantiated is the number of reports that contain one or more substantiated allegations.

**Table 2:
CONNECTICUT VS. NATIONAL DATA FROM NCCAND SYSTEM**

	<i># CT Reports</i>	<i>Reporting Rate per 1000 Children in Population</i>	<i>CT Reports Accepted for Investigation</i>	<i>% Accepted for Investigation</i>	<i>CT # Reports Substantiated</i>	<i>% of Investigated Cases Substantiated</i>	<i>Children per 1000 Children in Population Substantiated</i>
1997							
CT	36,388	53.1	29,676	81.5%	14,028	47.2%	23.0
US		42.0		69.2%		34.1%	13.8
1998							
CT	41,340	52.3	31,221	75.5%	14,015	44.9%	21.4
US		34.7		66.0%		29.8%	12.9
1999							
CT	43,153	52.1	30,452	70.6%	11,281	37.0%	17.5
US		42.4		60.4%		29.4%	11.8
2000							
CT	42,725	50.8	29,850	69.9%	11,001	36.9%	17.2
US		38.7		61.7%		31.4%	12.2
2001							
CT	42,013	49.8	31,224	74.3%	9,373	30.0%	14.4
US		36.6		67.3%		31.9%	12.4

Note: Federal Reports are compiled on a Calendar Year, not a Fiscal Year basis. Therefore Connecticut data here will not necessarily correspond to that in Table 1.

Over the 5 years of the study period for which there is comparable data⁴, the reporting rate in the state has remained above national levels, as has the rate at which the DCF Hotline accepts reports for investigation. At the same time, however, the rates of substantiation of these reports, and the number of children per thousand substantiated as victims has declined; Connecticut statistics, therefore, have come to more closely resemble national averages. In the last year for which the Administration for Families has reported data, 2001, Connecticut fell for the first time to a substantiation rate slightly below the national rates.

Departmental Explanations of Decline

Department staff members at various levels have offered several explanations for the decline in the rate of substantiations:

- Legislative changes in the situations that met the criteria for child abuse and neglect, that led to changes in Department policy concerning children “at risk of abuse or neglect;”
- Promulgation of a policy establishing formal regional and central Administrative Review processes; and

⁴ Federal figures are released on a calendar year basis, usually within two years of the end of the year.

- Shifts in agency philosophy that questioned the validity of previous substantiation numbers.

Each of these factors could have impacted the substantiation rate, and a few very directly did.

Legislative and Policy Changes in Definitions of Abuse and Neglect Categories

Prior to 1996, the Connecticut General Statute that governs the Department's responsibilities for the care and protection of children, required mandated reporters to report to the Department any child who was "abused or neglected, or *who was in danger of being abused or neglected.*" (Conn. Gen. Stat. §17a-101a (revised to 1995)). The DCF Hotline and its predecessors accepted reports alleging that a child was "at risk", and could substantiate reports based upon facts that led the investigator to have reasonable cause to believe that a child was in a situation that **might result** in abuse or neglect. In the early 1990's, reports of children "at risk" accounted for 25-30% of the allegations received by the DCF Hotline, with the Department substantiating over 40% of these allegations. Department social workers could substantiate allegations and intervene in a family because persons responsible for a child were impaired by substance abuse or other causes, and were seen as potentially unable to provide consistently for the child or were at risk of injuring the child. In many cases, the fact that parental problems or living conditions potentially jeopardized the health or safety of a child provided grounds for Departmental intervention in families even where no immediate harm could be substantiated.

In 1996, PA 96-246 amended both the reporting requirements and Department substantiation standards by replacing the broad "at risk" language with a more limited standard: mandated reporters were required to file a report when a child was "placed at **imminent risk** of serious harm". In response to this change, in October 1996, DCF amended its policy, removing "at risk of abuse or neglect" as a reportable allegation, and replacing it with a more specific standard that, like the legislation, required children be "*at imminent risk of harm*" before their circumstances became reportable. Investigators could no longer substantiate if they had reasonable cause to believe that children were in situations that *could* cause harm. Injury or harm had to be very likely to occur in the near future because of direct action or inaction of a parent or guardian to justify substantiation.

The Department began training on this new policy during the winter of 1997. In general, Hotline staff were instructed to continue accepting community reports that a child was at risk until further notice. Community members had been trained repeatedly to report situations that were potentially injurious to children, and DCF administrators agreed that such reporting, because it was broader than current mandates, should not be discouraged until the new standards were well known in the community. On a practical level, the tracking system in LINK was not updated until Spring 2003 (six years after the promulgation of the policy) with new "at risk of imminent harm" codes and deletion of "at risk" codes. At the same time, however, investigative staff were instructed that they

could no longer substantiate an allegation of “at risk” unless the risk was deemed serious and imminent. If the investigation showed that children had actually been harmed, the “at risk” allegations could be translated into other appropriate allegations and substantiated as abuse or neglect. If, however, children (other than newborns) had not been harmed and were not at risk of imminent harm, the allegation could not be substantiated.

Between FY 1997 and 1998, the number of at risk allegations accepted as reports fell by 90% (from 22,460 to 2627 accepted reports) with a concomitant rise in other reportable conditions; of those at risk reports accepted, the number substantiated declined significantly from year to year. By FY 2002, “at risk” allegations that had made up almost 1/3 of reported allegations and ¼ of substantiated allegations dwindled to a small fraction – a mere 20 substantiated allegations per year. In addition, the translation of cases that marginally met Department criteria in categories that called for substantiation of actual injury or harm could reasonably be expected to add the number of unsubstantiated cases in these other categories. This change by DCF to bring its policy concerning children at risk into compliance with new legislative requirements appears to have been responsible for some of the reduction in the number of substantiations. The closure upon report or redistribution of some 20,000 reports per year (between 25 and 30% of the allegations reported in previous years) of children “at risk” throughout the range of other reporting categories, had the effect of raising the proportion of unsubstantiated reports.

Establishment of Administrative Review Process in Policy

In May 2000, the DCF instituted, through policy changes, several levels of administrative review available to parents who wished to appeal Department substantiation determinations concerning their families. The new policy allows anyone substantiated by the Department as the perpetrator of abuse or neglect, or the parent of a perpetrator, to appeal the Department finding. At the first level, individuals may request a review of their cases by the Regional Administrator/ Hotline Director. This is generally a record review conducted within the Regional Office or at the Hotline. If Regional Administrators or the Hotline Director uphold the substantiation findings and individuals still disagree with the determinations, they may then request a Substantiation Hearing in front of the Administrative Hearing Unit. These are full administrative appeals hearings with the right to present and contest evidence of “whether the Department’s substantiation of the complainant as a perpetrator of child abuse or neglect is supported by a *fair preponderance* of the evidence.”

During this investigation, DCF had not yet updated LINK to include the results of regional reviews and administrative hearings. (Fields tracking this data were implemented in July 2003.) At the request of the Child Advocate, the Hearing Unit staff conducted a survey of the regions and collected data describing regional review outcomes for the calendar year 2002. During that year (the only year for which the DCF Administrative Hearing Unit was able to provide statistics), Regional Administrators

received 1508 requests for substantiation reviews, with 302 or 20% of the determinations overturned after review. As may be seen in the table below, there were wide regional variations in the number of requests received from alleged perpetrators, and a 15% difference in the rates at which Regional Administrators overturned the determinations made by their staff investigators. Statewide, the overturned cases represent about 3% of the total substantiations that year.

	Requests	Overturns	% Overturned
Region I	178	19	10.6%
Region II	212	24	11.3%
Region III	289	33	11.4%
Region IV	661	183	27.7%
Region V	168	43	26.6%
Total	1508	302	20.0%

Between the adoption of the new policy in May 2000 and December 31, 2002, 373 families involved in allegations upheld at the regional level requested formal administrative hearings concerning their cases. In these hearings, DCF determinations of substantiation were upheld in whole or in part in 185 cases; hearing findings overturned substantiations for 187 families. While the overturn of more than 50% of line staff and regional findings seems troublesome, it also must be remembered that the evidentiary standards used in the hearing proceedings at this stage are higher than those used by investigators in making their determinations⁵. The higher evidentiary standard at the administrative hearings results in overturn of more marginal cases.

While the number of cases appealed by alleged adult perpetrators and overturned upon either regional or administrative review has not been large enough to influence significantly substantiation numbers, some former DCF staff have reported that, faced with the possibility of reversal of their decisions, staff has become somewhat more reluctant to substantiate in marginal situations.

Individuals to whom we spoke noted that the 350-400 cases overturned each year had some effect on the decision-making of investigative staff. Case workers stated that they believed the existence of an appeals and case review process made staff somewhat more cautious in their decision-making and may have had some small impact in the willingness of investigators to substantiate in some cases.

Shifts in Agency Philosophy

Between 1997, when the new “At Risk” policy became effective, and 2003, the DCF made no other major changes in its Policy requirements that would be expected to affect substantiation rates. Training during the latter half of the 1990’s addressed the change in the at risk policy and included review of policies concerning requirements for

⁵ In order for the investigative social worker to substantiate a report, he or she must determine that there is *reasonable cause to believe* a child has been abused or neglected. As noted above, the Administrative Hearing process, however, must find that an allegation is supported by *a fair preponderance of the evidence*.

substantiation, but nothing in the curriculum materials indicates any shift in Departmental instruction of its personnel concerning more rigorous application of standards that would reduce substantiation rates.

DCF administrative staff pointed to the availability of alternative routes to service created by legislative changes in the Non-Committed Treatment program for children needing mental health services as an explanation for some of the decline in the substantiation determinations. Prior to this change in classification for obtaining mental health services, children were sometimes categorized as emotionally neglected because their parents were unable to provide physical care for children with serious emotional disturbances. On the surface, this explanation is plausible, but , the relationship between this change and the dramatic increase in the number of reports of emotional neglect that were unsubstantiated - from 3900 (30% of reports) to 22,000 (84% of reports) over the six years - is less clear.

First, the entire rationale for reporting was removed if a child was voluntarily committed to DCF. However, unlike at risk reports, there has not been a steep decline in the number of reports of emotional neglect made and accepted. Second, the primary drop in the substantiation rate for such allegations took place between FY1999 and FY 2001. The KidCare Initiative, which provided a reasonable route to mental health services outside the protective services system is still not yet fully implemented, so it is doubtful such a significant number of reports were found unsubstantiated because alternative routes to assistance were available. It is unlikely, therefore, that this policy change led to any substantial drop in substantiations. It is possible publicity surrounding changes in the State's treatment of Seriously Emotionally Disturbed children may have had some effect on investigators' willingness to substantiate emotional abuse.

Communication of Policy Changes to Staff

Recent events subsequent to the death of an infant in the state, and reports by current and former managers within the Department, lead us to believe that shifts in policy application may have in the past been communicated to staff outside of regular policy channels. A memorandum from the Governor's office in May 2003 concerning removal of siblings from abusive homes has resulted over the last few months in a significant upswing in the number of petitions filed by the DCF for temporary custody. Managers and supervisors in regional offices have reported that they received periodic e-mails from the Commissioner's Office during the mid-1990's regarding various concerns about program operational changes. Neither of these activities was reflected in official DCF policy, and yet they potentially affected the way decisions were made by line staff in the Department.

The Department was able to provide few records to the Child Advocate to allow tracking of instructions to staff through non-policy channels, making it difficult to evaluate their impact. Such high level directives may well be appropriate. However, in an agency as large and complex as DCF, they need to be implemented through established methods of communicating policy directives in order to ensure that all levels of management and

supervision effectively implement and monitor the directives to ensure proper accountability throughout DCF.

SERIOUS CONCERNS RAISED BY DATA

As part of this investigation, Child Advocate staff drew multiple samples from files in the DCF LINK system based upon certain criteria that could have impacted the DCF decision-making process. Investigation determinations were specifically reviewed to gauge the impact of various recorded factors not already presented in DCF fiscal year statistics, such as multiple referrals, status at report, duration of investigation, and perpetrator type. In order to determine what happened after an allegation was substantiated, we drew further samples that compared dispositions for both substantiated and unsubstantiated reports. Once these lists of cases meeting the basic criteria were drawn, several cases were then chosen randomly from each list for an in-depth review.⁶

This review has exposed four troubling trends that raise deep concerns in the Department's decision-making process: the need for multiple reports of abuse or neglect to the Hotline before referrals for treatment or protective services are made; the closing of cases immediately upon referral to regional offices from the Hotline; the closing of cases without services where abuse or neglect was substantiated; and the referral of cases in which the abuse or neglect was substantiated to outside agencies for services, but records show DCF provided no support or follow-up to determine if these services were received.

CASE A: The F Family

Since 1996, the DCF Hotline has accepted over 18 referrals from mandated and lay reporters concerning the F Family. Of these referrals for investigation, only 8 have had dispositions. The other 10 reports have been merged with ongoing but not completed investigations, or have been closed because Investigative Social Workers have not made contact with the family. Even the first recorded investigation was completed well after investigation time limits had passed.

There are no narrative notes in the case record to explain what was happening regarding this family until August 1997. In August 1997, the DCF received a reported that a teenaged daughter had been seriously physically assaulted by her brother, and her mother appeared not to have intervened either to protect her daughter or secure medical care. There were three children ages 6, 10, and 12 living at home with their mother once the Investigative Social Worker visited the home. The 15 year old brother who had assaulted his sister had been removed from the home by his grandmother. All children were reported as having chronic school attendance problems, and several had Serious Emotional Disturbance diagnoses. The Mother was reported in all referrals as being a chronic drug user. She failed, however, to complete all but one of the drug screens she agreed to have as part of the investigative process; the one completed test was positive for cocaine.

All of the 8 reports that were investigated, ranging from allegations of neglect to physical abuse to sexual abuse were closed as unsubstantiated. The inability of the Department to verify drug use through testing was noted as the basis of the "unsubstantiated" determinations. No protective services treatment case has been opened for the F Family, although the maternal grandmother has assumed care for some of her grandchildren, and the older children appeared to be entering DCF services as juvenile offenders.

⁶ It must be noted here that the review undertaken by OCA staff, was not, and was not intended, to follow formal, highly structured research protocols. It relied upon extraction of basic tables from information system data such as would be used by a manager involved in basic program monitoring to identify potential trends and issues. The data tables were used to identify a limited pool of cases to be subjected to in-depth case review.

1. Multiple Referrals

Of the 202,000 investigations done over the last 6 years, only 52,759 involved final dispositions regarding families that had been reported to the Hotline only once. Approximately 1200 families were the subjects of 10 or more reports over the same period and over half of the families were reported at least five times before a final disposition was made. Certainly the DCF Hotline sometimes receive multiple reports of the same incident, and each telephone call is considered a separate report, so some duplication is inevitable. But a very limited review of those cases of families with multiple referrals shows a disturbing finding: often, multiple reports of abuse or neglect have been made to the Hotline involving the same families—sometimes over a period of months or years—but the cases have been closed as unsubstantiated or closed within days of substantiation without services provided, before finally DCF substantiates abuse or neglect and implements a protective treatment plan. It is possible that in some of these cases initial reports were insufficient to establish a basis for substantiation. However, because it is often difficult from the case narratives to determine how thoroughly allegations were investigated or why some decisions not to substantiate or provide services were made, we have deep concern that some children who should be receiving protective services are left in abusive or neglectful environments sometimes for years.

2. Immediate Closure after Referral for Investigation

Over the six years under review, LINK data indicates that over 16,000 reports were closed immediately (within 0 days) after a case was referred by the Hotline for investigation. Cases showing such action are distributed relatively evenly over the annual data, although the data shows some slight diminishment of the practice in recent years.

Approximately 2000 of these closures were in cases identified as already opened for

CASE B: J's History

J was a 12-year-old girl brought to the attention of the Hotline through a hospital report that her mother had physically abused the child. J, who suffered from serious mental health problems, was subsequently hospitalized several times over the next 3 1/2 years. After one hospitalization her mother made it clear she did not want to resume care of her daughter, but DCF could find no alternative placement for J, and she was discharged to her home. DCF retained the case as they sought residential treatment for the girl.

Three months later, J's mother once again abused her now 16-year-old daughter, and threw her out of her home. A neighbor reported the child's circumstances to the DCF hotline that accepted the report as physical abuse and neglect. However, a regional administrator familiar with the case "approved the case for Administrative Screen Out" giving as a reason that the case was "an active treatment case and contained no new allegations." For over 2 weeks the child continued to live on the streets. Because she refused placement in an RTC selected for her by DCF, the agency moved to have J's commitment to them revoked.

investigation, which may mean that they were consolidated with ongoing investigations but improperly coded. An additional 3000 appear to involve the cases of families already in treatment with the Department, in which investigators may have been able to gain access to the children and families to make a determination in less than one day. Undoubtedly, some cases contain miscoding, as we have found multiple invalid LINK entries, particularly in date fields. However, for the remaining 11,000 reports, we have been unable to determine why a case was closed after an investigation of less than 24 hours.

Determination that a report is

unsubstantiated without a meaningful investigation amounts to an override of the screening decision made by the Hotline staff. Administrative override of Hotline screening decisions is clearly prohibited in Department policy. In conducting its Child and Family Service Review in Connecticut, the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) has criticized the DCF for this very practice. Based upon its review of a small sample of cases, ACF scored the DCF as having some need for improvement in investigative processes because of the very issue of administrative “screen outs” at the regional level. The large number of cases in which this practice has occurred is very troubling and warrants a full review by DCF to determine whether cases are being closed inappropriately.

3. The Closing of Substantiated Cases of Physical Abuse

Once a report of abuse or neglect is substantiated, it means that a child or children are in need of protection. At that point, under DCF regulations, it is necessary to determine “whether or not further Department actions are required to protect and promote the well-being of the child or to assist the parent(s) or other child caring person to more appropriately respond to and care for the child's needs”(DCF Agency Regulations, 17a-101(e)-4).

DCF policy requires that, if an allegation of physical abuse is substantiated, the family’s case must be transferred to a protective services treatment caseworker unless an administrator gives formal approval to close the case. For other substantiated cases, the investigator, with supervisory oversight, can refer the family for voluntary or mandated treatment within the DCF, close the case with the DCF but refer the family to other services within the community, or close the case completely with no further services. Most families receive either protective services treatment through the DCF or are referred to other community agencies for assistance, but, over the last six years, DCF staff annually has closed without any service referrals an average of 28% of all cases in which reported allegations have been substantiated.

Percent of Substantiated and Unsubstantiated Cases with Specific Dispositions

	Transfer to Protective Services	Transfer to Voluntary Services	Closed Referred to Other Services	Closed No Further Services	Open Case: Close the Current Report
Substantiated	54.4%	.3%	11.3%	28.4%	5.6%
Unsubstantiated	5.6%	.6%	13.1%	75.2%	5.5%

Based upon DCF-supplied LINK data for July, 1996 through June, 2002.

We are extremely concerned that such a large proportion of cases in which reports that children were abused or neglected were substantiated then closed with no services or referrals. **This appeared to happen with some regularity even with children were**

found to be physically abused⁷. Over the 6 years under study, when physical abuse of children was the only allegation reported and substantiated, 37% of the families and children involved had their cases closed with no further services noted from any agency.

Although the LINK system allows 20 different case closing reasons, Department policy (34-14) calls for case closure after substantiation of a report only in three specific situations:

- The parent or guardian’s whereabouts are unknown;
- The parent or guardian has moved to another state; or
- The parent or guardian is not accepting of DCF services and the investigator and supervisor believe there are insufficient grounds to mandate involuntary services or to file petitions of neglect.

A review of a small number of the cases that were closed immediately upon substantiation identified several that met the first two criteria. More prevalent, however, were those cases that were closed with social worker and supervisor statements that, while the DCF did have reasonable cause to believe the allegations were true, the parents refused services and the DCF did not believe it had sufficient grounds to press for involuntary services.

Various DCF personnel have explained this seeming contradiction by pointing out that the DCF standard of “reasonable cause to believe” that a child has been abused or neglected is different from that applied by both internal Administrative Reviews and by the Juvenile Courts. Both use a standard of “a fair preponderance of the evidence” that a child has been abused or neglected. As a result, a DCF investigator may find adequate grounds to substantiate a report based upon

CASE C: H's Story

Eleven-year-old H called the police in his town to report he was home alone and that he feared his mother's return. She was angry with him and would hit him with a piece of wood she kept for that purpose. The police notified the DCF Hotline, who called for an immediate response to the report.

When first contacted by the investigative social worker, the mother signed an agreement not to hit the child again. The boy, she said, had behavioral problems and did frustrate her at times. She explained that she had begun a new job recently, and had not had childcare arranged yet when H called the police. She stated that her mother would immediately begin after school care for her son.

Despite her statements, however, over the twenty-six days of the investigation, the mother continued to leave H alone at home, and the investigative social worker discovered scars and marks indicating continuing physical abuse. On one occasion, a surprise visit by the social worker raised so much concern, that police were summoned to assist in an emergency removal of the frightened child from the home. H's mother arrived home in time to prevent this from happening, refused to agree to any further services, and slammed the door on the social worker while screaming at her son. Later attempts to contact the mother by telephone were unsuccessful.

DCF substantiated physical abuse and physical neglect (lack of supervision), but, despite a determination three days earlier that the child was in such imminent danger he needed to be removed from the home, the risk level assigned upon substantiation was low. Because the case was low risk, and the mother was refusing to cooperate in services, H's case was closed.

Three years later, H again came to the attention of the DCF Hotline when his mother beat him with a cane putting a 2-inch gash in his head. Again DCF substantiated but found the risk low because of the boy's age and the intervention of his maternal grandmother. This time, however, H's Guardian ad Litem filed a neglect petition with the court to prevent DCF from closing his case.

⁷ Department policy clearly notes that such action is considered extraordinary in cases of physical abuse, and requires Program Director approval. We did not find such approval noted in the narrative records of any of the cases we sampled.

Departmental standards of reasonable cause, but does not move forward on the case because of a perception that it does not meet judicial standards for requiring parents to participate in services. Therefore, the DCF enters a finding of substantiated abuse but no protection is offered to the child.

This concern on the part of DCF staff also was a cause for concern in the ACF Child and Family Service Review discussion of cases in which children known to the DCF system were re-abused. In discussing the issue with DCF staff, the ACF noted that many believed that

DCF lacked the legal authority to intervene in non-compliant families prior to a case being adjudicated by the court. Because adjudication may take several months, the child is left at risk for repeat maltreatment. (ACF Child and Family Service Review (2002), Safety Outcome 2, p.20)

CASE D: The B Children

When the B children were first reported to the DCF Hotline, they were 5, 9, 10, 11, and 13 years old. Their mother called the Hotline to report that she and her husband had been in a domestic dispute, and that he was becoming abusive to the children. When the Investigative Social Worker interviewed mother and children, the mother and older children reported that the father was that evening, and had been for some time, physically and emotionally abusive to her children who were not his biological children. Mrs. B. informed the social worker that she had in the past secured a restraining order against her husband, but she had dropped it almost immediately. She also informed the investigator that there had been a domestic violence problem in her first marriage. She stated her resolve to have her current husband removed from the home, and to secure another restraining order. After the 45 days of investigation, based upon the mother's statements concerning her future plans, the Department substantiated the allegation, but closed the case providing the mother with the names and telephone numbers of domestic violence programs in the area.

Eighteen months later, the family was the subject of another Hotline report, this time from hospital personnel. The father who was again living in the home had injured one child seriously and was alleged to have sexually molested both the teenage daughter and one of her friends. Again the Department substantiated the allegations but closed the case because Mrs. B, who admitted to feeling overwhelmed, once more stated her intention to secure alternative services. It was not until three years later that DCF finally intervened to protect the B children.

This erroneous belief is contrary to DCF experience with the courts. A review of statistics from the Superior Court for Juvenile Matters reveals that when the Department petitions for commitment or protective supervision of children, its determinations have been accepted in about 70% of the cases filed over the last 6 years. In addition, the Superior Court for Juvenile Matters has granted DCF petitions for Orders of Temporary Custody on an average of 90% of the petitions filed each year.

We are concerned that children who have been substantiated as abused or neglected are left unprotected because of a misunderstanding of the law. As noted above, many of these children come to the attention of the Department repeatedly, but are denied protection until serious injuries occur.

4. Referral of Families with Substantiated Allegations to Community Providers

Eleven percent of the cases in which reported allegations are substantiated are closed within days of the substantiation finding and the families are "referred" for services to community agencies. Referral, particularly when dealing with a family in which a child has already been abused or neglected, should mean that DCF staff assists the family in linking with

appropriate community providers and follows up to ensure that the necessary services are received. In reviewing a small group of cases with dispositions of "refer to other State agencies" or "refer to community providers", we found little evidence in the case narratives that DCF staff were actively involved in making those linkages and assuring that services were actually provided to the family. In most of the cases we reviewed, social workers simply told parents or guardians to seek help from community agencies, and then closed the case. In some cases, the narratives note that the investigator provided the families with service recommendations and names, but in none of those cases reviewed did DCF staff actually contact the agency to which the family was being referred before or after the referral and closure, nor was follow up provided to ensure that the families continued to receive the necessary services.

It is small wonder that so many of these children are eventually re-reported as being abused or neglected. It is essential that DCF staff insure that connections are made with outside providers and treatment is provided.

Departmental Data and Response

In the course of this investigation, staff in the Child Advocate called upon the Department to secure its explanations for several of the patterns found in the data supplied through their own LINK system and evaluated by Child Advocate staff. These discussions, particularly concerning the issue of disposition of substantiated cases, have raised serious concerns about the management of DCF's Bureau of Child Welfare Services (BCWS) on several levels.

First, the Department's own review confirmed that there is cause for concern about the practice of closing substantiated cases. The Office of the Child Advocate gave the BCWS a list of cases from one recent fiscal year in which physical abuse had been substantiated but the cases were closed without further services (a dispositional action which is supposed to be exceptional under DCF policy). From these 185 cases, the BCWS drew a sample of 65 cases. Of these, administrative staff found that 20% involved decision-making that was at least questionable, and an additional 4% were found to have been clearly closed erroneously. This means that **nearly a quarter of all substantiated cases may have been wrongly closed with no protective services provided.**

When this number is applied to the total pool of cases with a substantiated allegation of physical abuse for that one year alone, there were at least 40 children⁸ in the state potentially left unprotected despite abuse having been reported to and substantiated by the child protection agency, DCF. When the 20% finding is applied to all substantiated cases of abuse and neglect closed after investigation during that year (3441 cases), the number of questionable closures is 688. Even the 4% of cases identified by the BCWS as

⁸ Data from the LINK system provided to the Child Advocate is based upon "family cases". Each case may involve one or several children.

being incorrectly closed translates into more than 125 families with children left in danger of continued maltreatment. This is clearly unacceptable.

Second, the review of potentially troubling patterns in LINK data is not a routine part of the Quality Assurance practices of the BCWS. Some of the data requested by the Child Advocate (e.g., the outcomes of Regional Substantiation Reviews) had to be specially collected for this investigation, despite the fact that such data has important implications for managing the child welfare system.

More critically, despite the troubling implications of data trends such as the closure of substantiated reports, reviews such as that conducted by the Child Advocate do not appear to be part of regular Departmental management processes. The BCWS is currently conducting a review of the 13 problematic cases drawn from the limited sample supplied by the Child Advocate. Given these findings and the findings of the DCF review conducted in response to meetings between the Child Advocate staff and DCF administrators, this limited case review raises further concerns, as it leaves many other questionable closures unreviewed. And even this limited review would never have been undertaken if this investigation had not been undertaken in which the Child Advocate brought the issue to the attention of DCF staff.

Finally, the LINK system has the potential to be a valuable management tool for the Department. Because of the neglect of this system over time by the Department at all levels, however, administrators and their staffs are not able to easily interpret the data it provides. Codes no longer reflect Department policies and practices, as noted in the discussion of “at risk” reports; some are difficult to match with what actually takes place in the field. Because the data is rarely used for managing and holding divisions accountable, there is little incentive for staff to insure accuracy in the data entered into the system. BCWS staff, in responding to the Child Advocate’s concerns, had to speculate regarding some aspects of case disposition because LINK data was undependable, and corrections had to be made after their initial response because of issues with data interpretation.

It is ironic to compare the level of confusion in tracking protective service entry data with data entered in the foster care placement and payment system. If data is not entered completely or accurately in the latter, the system will not generate proper payment for foster care providers, and providers will demand attention from staff when they are not paid. Because that system thus holds users accountable for errors, DCF has reasonably reliable data for such tracking. However, because there is little evidence that management makes any significant effort to review and use detailed data of substantiations of abuse and neglect reports, there is little accountability for inaccurate or incomplete recording in LINK concerning child protection intake and substantiation decisions—the very decisions at the core of the DCF mission.

FINDINGS

1. The rate at which DCF staff have substantiated reports of child abuse or neglect *has* dropped significantly over the last six fiscal years for a number of reasons.
 - During FY 1997, DCF substantiated well over half of the reports of suspected abuse assigned for investigation; by FY 2002 the number of reports of suspected abuse substantiated by staff dropped significantly to slightly more than one quarter of the reports that were investigated.
 - At the beginning of the reporting period that we examined, the number of reports of suspected abuse was extremely high and well above national averages, with substantiations of well over half of the abuse and neglect allegations. This level of activity overwhelmed DCF and seriously impaired its ability to adequately protect the most vulnerable children.
 - Many factors contributed to the subsequent substantial decline in the rate at which reports of suspected abuse were substantiated, most notably amendments to the statutes governing child protective services which were administered by DCF, reducing reportable incidents, together with the resulting formal changes in DCF policy related to reportable situations.
 - In addition, institution of an Administrative Review Process may also have contributed to lower substantiation levels because the appeal and case review process made some DCF personnel hesitant to substantiate allegations of abuse and neglect in marginal situations.

2. Our review of the declining substantiation levels showed that DCF personnel were failing to follow official policies and procedures concerning reports of suspected abuse that resulted in a failure to properly and timely respond to child abuse. For many children, protective services from DCF arrived only after multiple reports of their abuse and neglect. Tragically, some individuals making Hotline reports were required to contact the Hotline several times over a period of years before any significant help was provided to the child and family. For instance:
 - d. Nearly 700 cases of substantiated physical abuse are improperly closed each year immediately after the allegation of abuse is substantiated, without DCF providing any protective services to the child and family involved. This number equates to an average of 28% of the cases of substantiated abuse every year. The Department's own review of a very limited pool of such cases indicates 4% were potentially erroneously closed, and another 16% of such closures were questionable.
 - e. On average, 2600 investigations each year are closed as unsubstantiated within 24 hours of referral from the Hotline to regional investigators. Such case closings often result from overrides of the Hotline screening decision by regional DCF personnel. Such regional reversal clearly violates DCF policy, and was the basis of a finding from the U.S.

Department of Health and Human Services that the Department's operations were in need of improvement.

- f. In about 10% of the reported cases, allegations of abuse are substantiated, but the family's case is closed and the family is referred to other agencies for social and corrective services. Case files, however, showed no evidence of follow-up by the DCF to determine if the family was actually connected to a specific service provider or ever received the services they needed.

3. Over the last six years substantial changes in agency policy appear to have been communicated to staff through informal e-mails and unrecorded management meeting discussions. Senior managers at DCF have often relied on each level of the organization to disseminate its instructions to the next level rather than following a more structured mechanism to disseminate policy directives throughout the Department and ensure that all staff are familiar with the new policies.

4. It is clear that Bureau Chiefs and other managers in the Department do not routinely use administrative data, such as that provided to the Office of the Child Advocate from the LINK system⁹, to manage the quality of programs under their supervision. The Bureau of Child Welfare began probing some of the anomalies identified through this review only after they were brought to the Bureau Chief's attention by the Child Advocate's staff.

RECOMMENDATIONS

Sadly, the recommendations flowing from this investigation are much the same as the recommendations from the Child Advocate and the Attorney General in many other reports produced previously. While the drop in the substantiation rate appears primarily to be a response to statutory and policy changes, we have noted a troubling level of questionable dispositional determinations. Beyond the clinical implications of the decisions that were made, the continued failure of managers of the Department to identify and correct systemic problems in its organizational response to child abuse and neglect causes grave concern.

- **The Department of Children and Families must improve its processes of investigation and assessment. A comprehensive, ongoing, formal assessment of functioning is essential to establishing the safety of children and the treatment needs of families.** The number of times allegations of abuse or neglect are

⁹ LINK is the DCF management information system. It contains descriptive and decision-making data and case narratives concerning all children reported to the agency.

unsubstantiated, or substantiated and closed without services (action), for children who need protection, reflects a lack of comprehensiveness and depth in the family studies undertaken by Department line staff. Increased training and on the job supervision must direct staff to implement effective social work/child welfare practices concerning individualized, holistic, family assessment. The focus of the decision making process throughout protective services intake must be on the welfare of the children involved. Case records indicate that investigative social workers and supervisors often do not complete thorough assessments, or do not adequately document the assessments, so that reasonable determinations of disposition can be pursued. There is no evidence that DCF has implemented the Child Advocate's earlier recommendations that more than two reports of abuse or neglect concerning a family should be reviewed by a multi-disciplinary team to determine the most appropriate course of action for children involved. We repeat that recommendation with a special urgency here.

- **The Department of Children and Families must be more willing to invoke the authority of the Superior Court for Juvenile Matters if families are unwilling to voluntarily participate in services.** DCF regularly fails to enlist the authority of the Superior Court for Juvenile Matters, even though the Department's experience in bringing court action has been extremely positive. Data maintained by the Courts shows that court rulings favor departmental motions in 90% of the cases actually brought. Despite this, investigative staff are very conservative in their willingness to seek judicial support for protective service orders where necessary.
- **The Department must develop an effective internal quality assurance program.** DCF executive staff, managers, and supervisors have available multiple sources of data and information concerning the processes employed by the staff under their direction. There is no evidence, however, that those in authority within the Department make effective use of this data to monitor agency performance. The Office of the Child Advocate was not designed to provide ongoing monitoring for the DCF and should not be functioning as a substitute for effective internal quality assurance by DCF itself.

Quality assurance systems can and must be designed and used to provide accurate, timely data to those responsible for policy implementation in a form that allows managers to monitor and improve the operations of the functional units who report to them.

- **DCF executive staff, bureau chiefs, managers, and supervisors must receive training in data systems and quality assurance processes.** During the course of this investigation, staff appeared unaware or uninterested in using the management information resources placed at their disposal. Training of those in authority in the Department must include instruction on the effective use of information for quality improvement.

- **The management structure and protocols for internal communication at the Department of Children and Families must be revamped.** Regulations and policy are the publicly accepted statement of the parameters of DCF operation. Unrecorded or unofficial operating instructions undermine staff's ability to perform the functions assigned to them appropriately, and leave little protection for families attempting to fend off unwarranted state intrusion into their lives. The use of informal communications, and hand-me-down information results in a decision making process guided by piecemeal instructions and lack of public accountability.
- **The Department of Children and Families should develop a long term planning unit that operates separately from program administration.**
 - DCF still does not appear to do adequate long term planning. Once again, the Child Advocate and Attorney General recommend that DCF undertake an ongoing comprehensive analysis of the needs of all children reported to the Department who require protection. This exercise should be part of a systematic long-term planning effort, integral to anticipating and meeting the needs of children at risk while protecting the organizational resources from being inundated.
 - A meaningful planning function should be separate and independent from those divisions of DCF responsible for program administration. Decision-making suffers when the pressures of the day drive functions that should be independent. Proper long term planning involves careful assessment of future needs, matching those needs to existing programs and ascertaining what change is needed in order to serve children better.

The Department of Children and Families should review the need for legislative changes to ensure that the Department has the requisite authority it needs to protect children who are being abused or neglected. This report has highlighted systemic weaknesses in DCF's responsiveness to reports of abuse of children. In light of the findings of this report DCF should carefully review whether additional legislation is needed to improve DCF's responsiveness to these critical issues.