State of Connecticut
SENATOR LEONARD A. FASANO
SENATE REPUBLICAN PRESIDENT PRO TEMPORE
34TH DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
www.SenatorFasano.com

HARTFORD: (860) 240-8800
TOLL FREE: (800) 842-1421
FAX: (860) 240-8306
Len.Fasano@cga.ct.gov

Testimony
Committee on Children
February 26, 2018
Testimony in Support of Senate Bill 188
An Act Establishing a State Oversight Council on Children and Families

Chairman Suzio, Chairman Moore, Chairman Urban and Representative Zupkus and members of the Children's Committee. Thank you for the opportunity to submit testimony in support of Senate Bill 188 which would establish the State Oversight Council on Children and Families in place of the State Advisory Council on Children and Families, and require the State Oversight Council on Children and Families to report annually to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and children.

There is no obligation of state government more critical than protecting its most vulnerable children. No child welfare system will ever be perfect or prevent every tragedy. However, we must work together to ensure that we are doing our best to prevent the unnecessary abuse and neglect of children in our care. The Department of Children and Families has done a tremendous job bringing children home from out of state and out of institutional settings. We all agree that children thrive best when in their homes with their families.

However, with this shift to keeping children in their homes comes additional risks and challenges. It is our obligation to recognize and address these risks to ensure that all children are safe, wherever they reside. In this, DCF has struggled. Senate Bill 188 is intended to help the agency, and us as policy makers, provide the necessary oversight to maximize our chances of success and keep kids safe.

Numerous reports from the Office of Child Advocate and other state officials over the last several years have highlighted "gross systems failures" and "institutional failures and omissions" within DCF operations that have contributed to the abuse, neglect and even death of children under DCF supervision. These include (1) the Child Fatality Report analyzing the unprecedented number of 2013 fatalities involving children under DCF supervision or with DCF histories finding that, in many cases, DCF ignored obvious known risk factors and prematurely closed cases leaving children in unsafe conditions; (2) the report on the 2014 death of two year old Londyn Sack which found that DCF ignored a long documented history of abuse and neglect, drug abuse and mental health issues when it inappropriately categorized the case as "low risk", referred the family to the Family Assessment Response program and closed its case; (3) the July 2015 report documenting a pattern of unlawful and dangerous restraints used on children residing at the Connecticut Juvenile Training School that rose to the level of causing the Child Advocate to report DCF for child abuse; (4) the report on the 2016 severe abuse and neglect to near death of 18 month old Baby Dylan which found that DCF violated state law and its own foster care

licensing standards when it improperly placed Dylan in an unsafe home despite prior substantiated abuse and neglect cases and a history of violence, and then failed to properly monitor his safety; (5) the Child Advocate's report on the death of Matthew Tirado, which found many shortfalls in a system that allowed a case involving a mother who was on the child abuse and neglect registry and who had a neglect petition filed against her in July 2016 to be closed and supervision of her special needs child terminated just 6 months later despite the agency's failure to document the child's wellbeing (according to the report, *"Several supervisory directives to the DCF caseworker were not followed between July and December 2016, including to conduct a case consult with the Attorney General's Office, confirm the family's whereabouts through their landlord, follow-up with the school system, or request a police well-child safety check"*); (6) recent court monitor reports which have repeatedly indicated that DCF continues to fail to meet the needs of the children under its care and supervision in over 30% of its cases and "issues exist regarding the quality of the investigative work" in abuse or neglect cases, and also (7) the recently revised court oversight exit plan which, while it will "smooth" the path for DCF's exit from court supervision, also acknowledges that DCF continues to fail to meet the quality standards for critical outcome measures such as case planning and meeting children's needs.

These reports identify recurring areas of concern and areas in need of improvement within DCF operations including:

1. ***Appropriate and Effective Risk Assessment*** – In many of the cases cited above, DCF failed to identify and respond appropriately to obvious known risk factors. As a result, cases that should have been classified as moderate or high risk, instead were handled as low risk cases, not properly monitored, and children suffered unnecessarily.

   While DCF purports to utilize an objective risk assessment tool "Structured Decision Making" (SDM), the Child Advocate has found that in many cases, perhaps as many as half, DCF workers deviate from the tool. A tool such as SDM is only effective if used consistently and faithfully. Inconsistent application of risk assessment tools results in ad hoc decision making. Cases that, according to a faithful application of SDM, should have been kept open and monitored have been closed with tragic results.

2. ***Adherence to Foster Care Licensing Guidelines*** – Placements with unlicensed relative caregivers are rightfully allowed and encouraged. However, to ensure that such placements are safe and appropriate, both state statutes and DCF licensing guidelines require that certain steps be taken. For example, certain risk factors automatically preclude placement without a waiver, and no child can be placed in an unlicensed home requiring a waiver if the waiver request has not been reviewed and granted.

   These safety guidelines are not being consistently followed. For example, Baby Dylan's placement should have been automatically ruled out without a review and waiver due to documented risk factors, yet DCF placed him in the home anyway with devastating consequences.

3. ***Appropriate Use of "Voluntary Safety Agreements" and Referrals to the Family Assessment Response Program*** – In many of the cases cited above, DCF ignored obvious known risk factors, improperly classified a case as "low risk" and then referred the case to the FAR program or used a "voluntary safety agreement" and closed the case. While these policies have allowed DCF to reduce caseloads, they have resulted in the unnecessary abuse and neglect of children the agency should have been monitoring.

   It is important to note that the legislature has not approved the use of "voluntary safety agreements." There does not appear to be any state policy or oversight regarding their use. In addition, while many states have effective FAR type programs to promote the use of community services in truly low risk cases, those states have stronger guidelines and oversight mechanisms to ensure that only low risk cases are diverted and to provide monitoring and accountability for outcomes post referral.[1]

In light of the ongoing chronic and systemic failure of DCF to protect our most vulnerable children, as documented in cases such as the Tirado case and Baby Dylan case among many others, it is hardly time to declare victory. If DCF is in fact to withdraw from federal oversight, it is clear we need stronger ongoing state oversight to ensure the implementation of effective child safety policies that will ensure that more children do not suffer avoidable injury and death on DCF's watch.

Senate Bill 188 is one important step to improve oversight. It would create an effective independent Child Welfare Oversight Council to monitor and analyze DCF operations and make recommendations to the agency and this legislature for improvements designed to improve the efficacy of our child welfare programs and address the "gross systems failures" identified in recent tragic cases involving the death, neglect and abuse of children while under the oversight of DCF.

While Connecticut has a "State Advisory Council on Children and Families" it lacks the independence and statutory authority to truly oversee the agency and effectuate change. Thirteen of the nineteen members are appointed by the Governor. The remaining six members come from the Regional Advisory Councils, the members of which are appointed by the Commissioner. Thus the entire "Advisory Council" is comprised of members appointed by the Governor or the Commissioner. There are no representatives of or appointees of the legislative branch. The Council depends on DCF for administrative support and the Commissioner is an ex officio member. It is not required to hold meetings. It has no specific powers to investigate DCF operations and no mandate to provide recommendations.

This legislation would replace the stagnant and powerless Advisory Council with an independent Oversight Council with the statutory authority and mandate to truly oversee DCF operations and recommend improvements and policy changes designed to specifically address the identified

[1] For example, Maryland and Tennessee have robust oversight committees monitoring and reporting on the implementation of their programs. Maryland and other states also have more statutory "rule outs" prohibiting the referral of certain cases such as those involving caregivers with prior substantiated abuse cases.

shortcomings in risk assessment, case management, and outcome measurement. This Council should be dominated by stakeholders and policy experts and reside outside DCF. It should include representatives of and appointees of this legislature. It should have the authority to investigate DCF operations and the mandate to regularly report on such operations and recommend improvements.

Thank you for raising this bill and for the opportunity to testify in support of this important measure to enhance oversight so that our state can do a better job protecting the most vulnerable children in our care.

Len Fasano
Senate Republican President Pro Tempore