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**Case Review: Jack Loiselle
September 4, 2015**

This report provides a comprehensive overview of the chronology of services provided to Jack Loiselle and his father, Randall Lints, from September 2014 to July 2015. It should be noted that this investigation was the first time all the information related to this case was compiled in a comprehensive manner. The Department of Children and Families (DCF) is dedicated to learning from this review of Jack's case. It is our intent and resolve that the sharing of these findings and recommendations will lead to positive changes within DCF and across systems that were involved with Jack and Mr. Lints.

July 14, 2015

On July 14, 2015, Jack Loiselle, age 7, was found unresponsive in his home by his father, Randall Lints. Jack was transported by ambulance to the hospital. Upon admission, Jack was in a coma and had bruising on his head, arm, back, spine, and buttocks. He had burns on the soles of his feet, appeared malnourished, and weighed 38 lbs. In response to three 51A reports¹ filed alleging the abuse and neglect of Jack by his father, DCF took emergency custody of Jack. Jack is currently receiving post-acute treatment in a long term rehabilitation facility.

Jack and his father had been receiving services through DCF for the past five months. No fewer than sixteen DCF staff, eight Children's Behavioral Health Initiative (CBHI) professionals and community providers, a neuropsychologist, medical providers, teachers, a guidance counselor, and other school personnel were familiar with Jack and his father. The tragic outcome for Jack illustrates how difficult it can be to protect a child and provide appropriate services and interventions to a family, even when there are multiple providers and multiple systems involved. DCF views the failure to protect Jack as an indication of systemic failures both internal and external to DCF.

Process for Review of Jack's Case

The Department of Children and Families Special/Case Investigation Unit (CIU) conducted a review of DCF involvement and case practice as a result of the near fatality of Jack. CIU is responsible for the internal review of all critical incidents within DCF. CIU's review was intended to capture the full

¹ A report filed with DCF on behalf of a child that alleges the abuse or neglect of the child is called a "51A report". Section 51A of chapter 119 of the Massachusetts General Laws requires certain individuals, such as medical or school staff, to file a report with DCF when they have reasonable cause to believe that a child is the victim of abuse or neglect.

chronology of events in Jack’s case and to conduct an analysis of these events and related decisions in the context of DCF policy, case practice, and agency operations.

The CIU reviewers examined the DCF record and all documentation available related to the Department’s history with the Lints/Loiselle family, records from CBHI providers, school records, and medical records. The reviewers conducted interviews with more than 25 individuals within the Department, service providers, school personnel, and medical professionals.

System Level Implications and Needed Reforms

Over more than a decade and through several tragic and high-profile cases, Massachusetts has initiated child welfare reform efforts to improve outcomes for children at risk of or experiencing abuse and neglect. DCF has, however, been unable to successfully implement and sustain meaningful change over time. While a number of factors, including increased caseload growth and budget fluctuations, have played a role here, it is quite clear that DCF does not have the policy framework, operating rules, and executional follow-through that is required to properly serve and support all children with which it is involved.

In addition, to achieve lasting reform, the Department must focus all of its efforts on delivering on its most fundamental mission - protecting children from harm.

Based on this context and the specific findings articulated below, the following system level reforms must be and will be addressed if we are to achieve lasting reform to protect children from harm.

1) Model of Social Work Practice for Services Provided to Children Living at Home and Not in DCF Custody

The vast majority of children served by DCF are, like Jack, living at home with their families and are not in DCF custody. The goal of the Department’s work in these situations, in partnership with others, is to provide support and services to enable children to safely remain at home. Many of the Department’s current resources, policies and formal structures, however, focus primarily on children in the Department’s custody who are living in out-of-home placement. The Department needs to develop and implement a comprehensive, evidence-based and structured model of intervention, and ongoing risk and safety assessments for children living at home who are not in DCF custody.

2) Consistent Implementation of Policy and Practice Requirements

DCF has struggled to effectively develop, negotiate, implement, sustain, and monitor policy and practice requirements. Agency staff and managers seeking guidance generally have to rely on policy and procedure documents that are outdated or wade through a myriad of well-intended but often confusing policy memoranda that have been issued as interim guidance. As a result, implementation of new requirements and emerging best practices is spotty, difficult to measure, and poorly sustained over time. For example, the Intake Policy has not been formally updated for more than a dozen years; it has been “updated” by a series of memos, directives, and guidance.

Over the past year, DCF, working in partnership with the union representing DCF social workers, SEIU local 509, has made progress in the development of several key policies. Progress in this area must continue with a focus on the areas highlighted throughout this case review, including access to health and medical services, assessment of parental capacity, use of clinical and managerial case reviews, and consultation protocols. Management structures and capacity must be assessed and built within the agency to ensure effective and timely adherence to new policy requirements. Further, labor and

management must continue to work productively together towards the shared goals of clarity, quality, and consistency in our work with children and families across the Commonwealth.

3) Assessment of an Adult's Ability to Parent

As early as December 2014, Mr. Lints expressed concern that he was not able to parent Jack. Although some service providers considered him to be cooperative and willing to try recommended interventions they noted signs of stress, his difficulty in comprehending and processing some information, and his difficulty reading and writing. At no time was Mr. Lints' parenting capacity formally assessed by DCF, the probate court, or any of the service providers. It is imperative that DCF complete or arrange for a parenting assessment when DCF is involved with a family and a concern is expressed about the capacity of a parent to protect the child and to make decisions in the child's best interest.

4) Worcester Area Offices

Several recent high profile cases have originated from towns and communities in the greater Worcester area. The Worcester DCF offices are part of the Western Region. The Western Region is the largest in the state, in terms of both geography and numbers of staff and cases. Targeted and immediate attention is needed to understand the unique challenges faced by children, families and the DCF area staff working within these communities and to ensure the management structures and resources are in place to mitigate risk and address needs.

5) Service Delivery Partners

DCF relies on partnerships with family members, service providers, schools, law enforcement, the courts and others to support child safety. An array of providers and systems were involved with Jack and his family. Rather than increasing child safety, however, this fact may actually have diffused responsibility and decision-making. This review makes evident that not only is greater communication and understanding needed across systems and individuals working with a complex family but there is a need –at the case and system level – to make clear and ensure common understanding of roles, responsibilities, and authority.

Specific Findings and Recommendations

1) Findings Related to the Screening and Intake Process

Insufficient Procedures Were In Place in the Area Office for Reviewing Multiple 51A Reports

Nine 51A reports were filed with DCF over the course of six months alleging abuse or neglect of Jack. In response to each report, DCF examined the reported allegations and responded to those allegations. During the review of Jack's case, DCF staff reported that they were unable to screen in² or support a

² Upon receiving a 51A report, DCF screens the report to determine if the allegation meets DCF's criteria for suspected abuse or neglect, if there is immediate danger to the child and whether DCF involvement is necessary. During screening DCF obtains information from the reporter and contacts professionals involved with the family (e.g., doctors, teachers). DCF may also contact the family, if appropriate. A report will be "screened-out" if it does not meet the criteria for a reportable concern or the perpetrator is a non-caretaker of the child. All other reports are "screened-in" and assigned either for investigation or an initial assessment. Cases of sexual or serious physical abuse or severe neglect will be assigned for investigation. The severity of the situation will dictate whether it requires an emergency or non-emergency investigation. All other cases will be assigned for an initial assessment. Generally, moderate or lower risk allegations, are assigned for an initial assessment. The primary purpose of the assessment is to determine if DCF involvement is necessary and to engage and support families. After the investigation or assessment, a determination is made as to whether the child can safely remain

specific allegation related to Jack because it did not involve a caregiver and they did not have the evidence to substantiate that the reported perpetrator was abusive or neglectful. Jack, at the age of six and seven, was the central figure to all of these allegations; yet, DCF did not take into account the volume of reports being received involving the neglect or abuse of this one young child.

Interviews conducted during the review of Jack's case revealed that the area office did not have a clear understanding or practice in place for reviewing multiple 51A reports. When multiple 51A reports are filed on a single child, as occurred in Jack's case, the area director and designee should be informed and a review convened. During the review of Jack's case, the area director acknowledged that there had been a lack of clarity about process and that Jack's case had not undergone a review. Additionally, DCF area intake screeners acknowledged that they did not examine all past history and related cases as part of a screening decision because of the high volume of reports and intense work pressures.

Better Oversight Was Needed In the Area Office to Ensure Proper Investigations Occurred

Before Jack's case was opened with DCF, there were several 51A reports made by several different mandated reporters. The investigation revealed that when new reports were received on allegations that had been made previously, the area office believed that another investigation was not warranted. Since area staff had recently completed an investigation of the same or similar concern, area staff believed those concerns were being addressed with the father by several of the family's in-home service providers. Repeated reports, however, indicated that there was significant and growing concern about Jack's safety and well-being from a variety of reporters. Rather than conclude that allegations were made by new reporters because they might not have been addressed sufficiently, the area office continued to give credence to Mr. Lints' descriptions of events in the home and Jack's behaviors.

The Area Intake Unit Did Not File A 51A Report When There Was Evidence of Concern for Jack

Two 51A reports were screened out because the allegation was not against a caregiver. The first report alleged sexual abuse of Jack by a non-caregiver and the investigation revealed concerns by providers about Jack's treatment by his father. Moreover, the school and a home-based provider expressed that the family would benefit from an open DCF case. The second report alleged that Jack hurt a younger sibling. While the screen out decision on the specific allegation was warranted for both reports, the area intake unit did not follow up by filing a 51A report on the concerns for Jack or his young sibling that were highlighted during the screening process. In these two situations, there was sufficient concern to warrant discussion of whether the alleged incidents implied a lack of supervision by adults, constituting possible neglect.

at home and whether the family would benefit from continued DCF involvement. If DCF involvement continues, a Comprehensive Assessment and Service Plan is developed with the family.

Recommendations:

- DCF will revise its current policy regarding intake to ensure that more consistent and informed screening and intake decisions are made. Policy revisions will clarify:
 - the expectation for review of parental history with DCF, any previous 51A reports concerning the child or caregiver, and any related cases with DCF;
 - the expectation for managerial review when there have been multiple reports concerning a child/family in a three or six month period;
 - the criteria for expanding allegations or filing additional 51A reports when new or additional allegations surface during screening/intake;
 - the circumstances under which an area program manager should send a screening back for additional information from collateral contacts in lieu of relying on the screener's conversation with an alleged perpetrator;
 - the criteria for repeat investigations when allegations are made a second time, especially if the allegations come from a different mandated reporter than the original reporter; and
 - documentation protocols when screeners and their supervisors disagree about a screening decision.
- Upon completion of the intake policy revision, DCF will retrain area office managers and staff who conduct or supervise screenings, investigations, and initial assessments.

2) Supervision, Case Review, and Consultation

DCF Area Staff Did Not Appropriately Seek Managerial Review

There were multiple points in Jack's case when managerial review or a team discussion was warranted but did not occur. These opportunities occurred throughout the case, during screening, during investigation and decision-making, and while Jack and his father had an open DCF case. For example, when a therapist told the DCF area social worker that Jack should be removed from the home, the supervisor and social worker met and discussed filing a care and protection petition. The supervisor, however, did not believe that there was sufficient information to obtain custody. The area program manager was not consulted regarding this decision nor was there a consultation with legal staff to explore the sufficiency of evidence for filing a care and protection petition. During the investigation, both the area program manager and the area director expressed the expectation that a managerial consult should occur when a provider states that a child should be removed from the home.

The review of Jack's case demonstrates that DCF area staff generally reported having concerns for what was happening in Jack's home. However, they did not identify the risks that existed or the increasingly concerning reports. DCF area staff did not recognize that despite the number and frequency of services in the home, the risks to Jack were not mitigated and Mr. Lints' parenting capacity was not improving. DCF area staff did not utilize the area clinical review team, even when the staff "struggled with" or "had reservations". The social worker and supervisor had never utilized an area clinical review team for case consultation. The social worker and supervisor did not appear to know that the team was available as an option for the review of difficult cases, and managers stated that case reviews were not used frequently in the area office.

Recent Changes Made in the Worcester Area Office

The area office recently examined utilization of case reviews and is in the process of implementing protocols for case consultation and clinical review. The area director has initiated two review processes

in the area office: area clinical review, which the area director participates in, and consultation team, difficult case review panel. The former began in July 2015 and the latter is scheduled to begin in September 2015.

In April 2015, the area director ensured that all policy memos were re-distributed to the management team and supervisors in the area office. In addition, the area director has restructured its semi-monthly supervisory-managerial meetings to focus on case practice and policy adherence.

Recommendations:

- The area office will continue its planned improvements for case review, consultation, and discussion of policies and practices.
- DCF will develop guidance for content of discussion during supervision of workers by supervisors and of supervisors by area program managers.
- DCF will revise its current policy regarding supervision, case review, and consultation to clarify:
 - circumstances that warrant manager consultation and the threshold for raising issues for managerial review;
 - circumstances that warrant internal and external team meetings to conference cases;
 - circumstances under which managers must request additional information before approving decisions;
 - circumstances under which workers and supervisors are to seek consultation with area office or regional specialists; and
 - that responsibility for referral of cases for legal, clinical, or medical consultation is shared by workers, supervisors, and managers, any DCF staff can request consultation.
- DCF will develop protocols for case review and consultation when services are provided to children living at home.
- DCF will develop guidance for consultation with area office and regional nurses or medical specialists.
- DCF will complete hiring of quality improvement staff and will implement a quality improvement case review process as recommended in the 2014 CWLA Report.

3) Multi-Disciplinary Perspectives and Lack of Integration to Provide a Coordinated Service Plan

Children's Behavioral Health Initiative (CBHI) services were initiated at the request of Mr. Lints, who wanted assistance dealing with Jack's behaviors.³ CBHI services included an in-home therapist to work

³ CBHI is an interagency effort to provide appropriate behavioral health services to MassHealth-enrolled children under age of 21 with serious emotional disturbance (SED). The intent is to have an integrated system of state-funded behavioral health services for children, youth, and their families. Among the values of the program are that services should be child-centered and family driven, and strengths-based. CBHI services are voluntary and are provided to families that are worried about the way their child is acting or feeling. Services may include a range of in-home services, designed to address behavioral health issues. CBHI's purpose is to provide sufficient services to each family to preserve the family and prevent out-of-home placement whenever possible.

with the family, a therapeutic mentor for Jack, an intensive care coordinator, and a parent partner.⁴ In addition, DCF arranged for a parent aide to work with Mr. Lints starting in May 2015. The referral guided CBHI's intervention with the family. There was no information in this referral about Mr. Lints' Department of Mental Health (DMH) history or his DCF history. Further, no concerns about his parenting capacity were identified, but rather, the focus of the referral was on the child's behaviors.

The first CBHI intensive care coordinator and the parent partner did not have the same level of concern about Jack's safety as other CBHI staff. The parent partner reported that Mr. Lints' parenting style and view of discipline for Jack were based upon his own experience in residential treatment. While other members of the team, believed that Mr. Lints was overly punitive and did not have an understanding of normal behavior for a 6 - 7 year-old child. The in-home therapist, a Master's level clinician, recognized that Mr. Lints needed to address his own mental health needs before he could parent Jack effectively, and clearly articulated that Mr. Lints' mental health impacted his capacity to parent.

CBHI staff reported that in May they met together to discuss their concerns with Mr. Lints. CBHI staff felt that at any time Mr. Lints might terminate their services and they had mounting concerns for Jack's safety and well-being.⁵ The in-home therapist that had recently worked with the family emphasized that the team was trying to convey every significant concern to DCF to ensure that someone would address the concerns when the team would no longer be seeing Jack. One CBHI professional explained that never before in her career had she told DCF "a child should be removed from the home."

There was a wide discrepancy among service providers depending on the focus of their intervention; providers whose services primarily focused on Mr. Lints gave positive reports while providers in the home whose services primarily focused on Mr. Lints' interactions and care of Jack were continuously and increasingly concerned for Jack. The DCF area social worker was also concerned about Mr. Lints' interactions with Jack. At the same time, the parent aide said Mr. Lints appeared to be engaging with Jack in a more positive manner and they had spoken about the three of them going fishing together on an upcoming visit. The parent aide believed that things were going well enough so that closing the service was a possibility, to be assessed at the end of July. The DCF worker noted that during her June visit to the family, Jack was happier than she had ever seen him. While CBHI staff are mandated reporters, the service's purpose is not primarily a child protective service. In Jack's case, DCF area staff may have been too confident that the number of eyes on Jack each week would contribute to his safety. These discrepancies were flags that, in retrospect, were indicative of deeper issues that needed more intensive examination.

Additionally, there was significant discrepancy between reports from Mr. Lints about Jack's behavior and reports from Jack's school. School regarded Jack as eager to learn, generally cooperative, pleasant, and respectful, with minimal behavior problems. Mr. Lints reported that Jack was oppositional and defiant at home, displaying aggressive behaviors toward other children and animals, engaging in self-harming behaviors such as head-banging and biting, as well as engaging in dangerous behaviors such as playing with matches.

School personnel reported that Jack was often hungry and that Mr. Lints was particular about snacks provided to Jack. Several 51A reports alleged that Mr. Lints withheld food as a form of discipline and

⁵ Mr. Lints is reported to have discontinued the services of several CBHI personnel because they were critical of his parenting or had filed a 51A report.
⁴ These services were in place before DCF opened the case and resulted from a referral that originated from Jack's evaluation at a hospital in September 2014.

that he restricted Jack's intake of liquids, especially in the evening to avoid toileting accidents at night. In contrast, some observers in the home noted that Jack was eating snacks and drinking juice or water when they visited the home after school and on weekends. An in-home provider noted that during a July visit, Jack was eating slowly while sitting at the kitchen table and engaged in math activities with Mr. Lints.

Issues in Jack's case were discussed routinely within DCF at the worker/supervisor level; however, supervision did not entail integration of all available information, and did not encourage further steps to obtain greater clarity from screeners, investigators, and social workers. There was a lack of integration of all available information, both internally at DCF as well as between DCF and external service providers.

Recommendations:

- DCF leadership will meet with leadership of the MassHealth Office of Behavioral Health / Children's Behavioral Health Initiative (OBH/CBHI) to identify steps to enhance communication and the exchange of appropriate information between DCF and providers of CBHI services.
- DCF will identify a senior manager in each area office to be the designated liaison to CBHI. Each CBHI liaison will be the contact person for community-based CBHI providers and In-Home Therapy (IHT) program directors in cases where either DCF or CBHI personnel identify a need to communicate a safety concern involving a child receiving CBHI services.
- DCF and OBH/CBHI will work together to establish and implement a communication protocol regarding cases where a safety concern is raised.
- DCF and OBH/CBHI will co-develop a training module to be delivered to DCF staff and community-based CBHI providers concerning:
 - DCF mandates and procedures regarding the protection of children in Massachusetts;
 - how DCF evaluates signs of risk and safety;
 - various levels of DCF involvement with children and families, and corresponding legal status;
 - CBHI personnel responsibilities for filing 51A reports versus reporting concerns to assigned DCF workers;
 - mechanisms CBHI staff should use to report safety and other concerns about risk to DCF; and
 - mechanisms CBHI staff can use to escalate reports of concern, when necessary.
- DCF will incorporate into policy that when there is discrepant and conflicting information presented, the information should be examined closely during supervision to explore possible reasons for differing opinions, and the steps to be taken to resolve discrepant information.
- Differing opinions among professionals must be a criterion for referral for a case conference or managerial review.
- Upon development of policy concerning discrepant information, DCF will provide training to all staff.

4) Risk Assessment and Decision-Making

During this review, DCF area staff reflected on decisions made to screen out allegations concerning non-caregivers. One report alleged physical abuse of Jack by a teen-aged relative and another alleged

aggression by Jack toward a younger sibling. Area office staff viewed both of these as “child on child” allegations, which should be screened out and referred to the district attorney. According to area staff, the risk to Jack was mitigated by Mr. Lints’ ceasing Jack’s visits to his grandfather. DCF area staff believed that the toddler, allegedly the recipient of Jack’s aggression, was not a resident of the home, and the report only included children in the home. The “child on child” nature of these two reports was the single biggest factor for reaching the screen out decision. The screen out decision was further supported because Mr. Lints had called the police. DCF area staff viewed Mr. Lints’ calling the police when Jack was out of control as a strength. CBHI services were in the home and DCF had recently unsupported allegations on the family.

A Risk Assessment Tool was used several times during the course of the case. Once, the risk assessment was marked correctly; for all other uses, the tool was marked incorrectly that the primary caregiver did not have a mental health history. At one point, the assessment tool yielded moderate risk when the case was unsupported. During interviews, an investigator and supervisor reported that this result was not uncommon, and neither was aware of any review or approval needed when the tool resulted in moderate risk. Records and DCF staff interviews indicated that risk assessment tools are not utilized consistently for decision-making in the area office. While risk assessments are completed, decisions are not necessarily made with consideration of risk assessment results. Some area staff stated that they do not find the risk assessment tool to be helpful because, in their opinion, the tools do not accurately reflect the level of risk perceived by staff.

Additionally, as early as December 2014, Mr. Lints expressed concern that he was not able to parent Jack. Although providers considered him to be cooperative and willing to try the interventions they recommended, providers noted signs of stress, noted Mr. Lints’ difficulty in comprehending and processing some information, and noted his difficulty in reading and writing. At no time was Mr. Lints’ parenting capacity formally assessed by DCF, the probate court, or any of the service providers.

Recommendations:

- When DCF is involved with a family and a concern is expressed by a mandated reporter about the capacity of a parent to protect the child and to make decisions in the child’s best interest, DCF shall complete or arrange for a parenting assessment.
- DCF will devise and implement updated protocols and tools for risk assessment, related safety decision-making, and service planning, and will clarify and enforce expectations for their use by staff.

5) Trauma-informed Services

There was much discussion in the case record and during interviews about Jack’s trauma history. He had four different primary caregivers, several housing relocations, and some significant losses, including the absence of his mother for an extended period of time, as well as possible physical abuse by a teen-aged relative, and reports of sexual abuse by his grandfather and uncle. DCF service providers in the home and a neuro-psychological evaluation attributed Jack’s alleged behavioral difficulties in his father’s home to his trauma history.

Although in-home providers and DCF area workers were aware that Mr. Lints had received services as a youth, including out-of-home placement, they were not aware of the specifics of his trauma history. DCF area staff was aware that Mr. Lints had a DCF record from his childhood, but did not review the

record. Mr. Lints had shared some information about his history, but not the details. CBHI providers and some DCF area staff did not know that Mr. Lints had himself survived significant physical abuse by multiple caregivers, had been the victim of violence by his brother, had been isolated from his siblings because he had allegedly threatened his siblings with a knife and had been the subject of a children in need of services (CHINS) petition as a result, had been in a residential program for two years, and had received DMH services, with diagnoses of bi-polar and ADHD. Providers and DCF area staff did not know that as a child, Mr. Lints was alleged to have been “locked in his bedroom without any food or furniture. He was forced to sleep on the floor and urinate in his closet.”⁶

Although a few DCF area staff reported that they were unable to obtain Mr. Lints record, the assessment was located on DCF’s internal database, Family Net, and outlined his diagnoses, medication, and assessment findings for DMH services, and described his reported earlier abuse by caregivers. In addition, the case closing summary from the year before Jack’s birth outlines Mr. Lints’ DMH placement history and reunification with his mother. At that time, Mr. Lints was eighteen and declined further services from DCF.

Had in-home providers and DCF staff been aware of Mr. Lints’ trauma history, they might have assessed him and Jack at a higher level of risk.

Recommendations:

- DCF staff will routinely examine records for previous history or abuse, neglect, or other trauma to understand the potential impact of trauma on individuals and the family unit.
- As a complement to intake and comprehensive assessment policy, DCF will develop trauma assessment guidelines for conducting or facilitating trauma assessment of any parent who is himself/herself alleged to have been a victim of abuse or neglect as a child.

⁶ This information was contained in an assessment of Randall Lints completed by DCF in 2001.

6) Integration of Medical Information into Practice

DCF staff made efforts to contact and receive information from Jack's pediatricians during the investigations and once the case was opened. Assertions made by Mr. Lints (for example, that Jack's pediatrician had determined there was not a medical explanation for his enuresis⁷) were not confirmed with Jack's medical providers. DCF tracked child wellness visits and visits for illness and alleged accidents were documented in the case record. There was not an up-to-date growth chart in the case record, nor was there consultation with medical professionals about Jack's enuresis. Until his hospitalization in July, Jack's DCF record did not include complete information about his medical history with his pediatrician, nor did it include substantive information about his eczema diagnosis and appropriate treatment for the condition. DCF staff had two conversations with the school nurse.

It was reported that Jack suffered many injuries. In September 2014, Jack had a black eye. In October 2014, Jack had a new bruise to his right temple and old bruises to his right forearm. In December 2014, he had a bruise on his face. In February 2015, he had marks and bruises. Later that month, he received sutures for a laceration. DCF, the school, and providers did not thoroughly explore any of these injuries but rather they relied on the explanation provided by Mr. Lints as to how the injury occurred. DCF was not informed of all of the injuries listed above at the time they were sustained.

School personnel and CBHI providers reported concern about Jack's food and liquid intake to DCF on several occasions. The DCF-contracted parent aide addressed nutrition and monitored the food in the house and observed Jack eating and drinking when he was present in the home. There was no consultation with medical professionals about Jack's nutrition, nor was there monitoring of his weight.

Recommendations:

- DCF and its new medical director will outline requirements for documentation in each child's record, including:
 - medical visits,
 - hospital visits,
 - medications and side effects, if any,
 - immunizations,
 - allergies,
 - medical problems,
 - mental or behavioral health treatment, and
 - assessments and plans based upon the information above.
- DCF and the medical director will establish clear guidelines for circumstances under which medical consultation should be sought by workers, supervisors, and managers.
- Each area office will have designated personnel to support obtaining the above medical information to ensure that DCF staff have access to medical consultation and to help staff synthesize medical information with other information about the child and family.

⁷ Enuresis is more commonly known as bed-wetting or urination. This behavior may or may not be purposeful. The condition is not diagnosed unless the child is 5 years or older.

7) Behavior Management

Several of Mr. Lints' interventions for Jack's alleged behaviors were described by DCF staff and providers in the home as "concerning," "severe," "overly punitive," and inappropriate for Jack's age and developmental level. At various times, Mr. Lints expressed that he utilized: time out for a number of minutes corresponding to Jack's chronological age; squatting against the wall while holding a basketball; confinement to his room; monitoring Jack's movement with a cell phone camera; and requiring Jack to clean up after urinating in his room. Each time Mr. Lints introduced a new punishment or intervention DCF and CBHI staff stressed the need to reward positive behaviors and ignore or be less punitive in response to negative behaviors.

DCF staff reported that Mr. Lints did not come across as angry and that he did not feel it was abusive to have Jack clean up after himself. DCF reported that Mr. Lints gave appropriate responses to their questions and he was receptive to services.

Recommendations:

- DCF will provide staff training and resources for staff about developmentally normal behaviors for children, appropriate behavior interventions for children at various ages and developmental stages, and the efficacy of positive behavior support and intervention rather than punishment.
- DCF will increase its capacity to provide behavioral consultation when staff faces complex behavioral issues, including resources for determining the possible causes of negative and anti-social behaviors displayed by a child.

8) Workforce

All DCF area staff involved in Jack's case have appropriate degrees and experience. Staff either hold social work licenses or are in the final stages of obtaining them. The social worker and supervisor assigned to the Lints/Loiselle case were both relatively new to their positions.

Interviews indicate that area office staff believe that short staffing, vacant positions, and growing caseloads may have been contributing factors in this case. An area program manager recalled being the only area program manager staffing the office during the week that she approved one of the unsupported decisions. Review of allocated positions between October 2014 and February 2015 indicate that the following positions were unfilled for the entire six months: area director, area administrative manager, one area program manager, and one supervisor. The following positions were unfilled for at least two of the six months: an additional area program manager, an additional supervisor, four social workers, and a clerk. Average weighted caseloads in the area office ranged from 18.33 to 19.60 during the examined timeframe.

The case was reassigned twice when it was referred for initial assessment on October 29th. The first social worker went out unexpectedly on medical leave. The initial assessment was reassigned to another worker who also went out on an unplanned medical leave. The third worker to whom the initial assessment was assigned had a vacation scheduled and was not able to see the family until December 1, 2014. As a result of these case reassignments, DCF did not see Jack until more than one month after receiving the October 51A report. As a result of two staff going out on leave in a short time frame, several other cases also required reassignment.

The Worcester DCF offices are part of the Western Region. The Western Region is the largest in the state, in terms of both geography and numbers of staff and cases. DCF does not have sufficient resources to increase the number of regions or to fill all identified positions recommended by the CWLA Report in May 2014. Therefore, the number of DCF regions has not increased and the corresponding positions, including mental health specialists, needed to staff the Western Region at recommended levels have not been hired.

Recommendations:

- Continue to hire social workers in order to lower caseloads and implement workload standards.
- DCF will assess the regional management structure to allow for adequate oversight and to ensure adequate consultation resources for area office workers and supervisors.
- DCF will reestablish a central region to oversee the four area offices located within the central part of the state.
- DCF will review its social worker, supervisor, and manager training and support to ensure inclusion of skill-building, coaching, and mentoring.

9) Custody Determinations

In 2014, upon agreement of the involved parties, the probate court approved transfer of custody of Jack from his maternal grandmother to his biological father. A paternity test had confirmed that Mr. Lints was Jack’s father. Father and son had no relationship prior to the custody proceedings. Although Mr. Lints had been aware of Ms. Loiselle’s pregnancy he did not initially claim paternity and his name was not listed on Jack’s birth certificate. In response to the maternal grandmother’s pursuit of a plan to adopt Jack, Mr. Lints asserted his parental rights and sought custody of Jack.

The Court ordered a visitation and transition plan. It does not appear that clinical consideration was given to the decision to remove 6-year-old Jack from his maternal grandmother’s care and place him with a father that he did not know. There is no documentation of exploration by the court of whether it was in Jack’s best interests to transfer custody to his father. The court record has no reference to Mr. Lints’ significant mental health history or his lengthy history with DCF as a child. It is unclear whether supervised visits occurred prior to Jack moving into his father’s home. DCF was not a party to any of the probate court’s proceedings.

Recommendations:

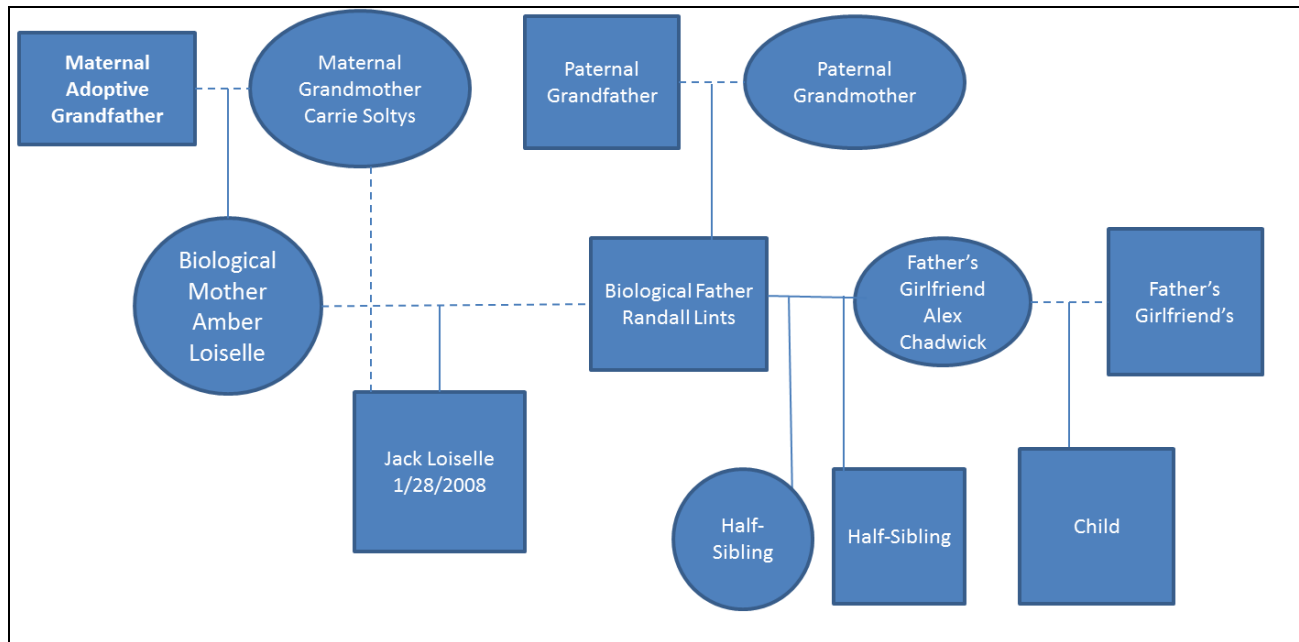
The court should review its protocols and consider if statutory changes are needed for cases where DCF is not involved and the custody of a child is being transferred to a parent or other individual who has had no involvement with the child for a period of time, including:

- appointing a guardian ad litem, when warranted, to determine the best interests of the child, including but not limited to visitation, transition planning, and other incidents of custody;
- an assessment of the parent’s capacity and a determination of any services that would assist in the transition;
- a determination of any prior or current DCF involvement of any of the parties, what the involvement was or is currently, and services provided. Involvement should include any

investigation conducted by the Department along with the results of such investigation and any reports of the individual as an alleged perpetrator of abuse or neglect; and

- a review of the home and any individuals living with or frequently visiting the home of the proposed custodial parent. Such review shall include a CORI and SORI check of the proposed parent and whether there are any protective factors to consider in granting custody or in making orders regarding the transition of the child to the individual.

Family Members



Court Case Chronology for Custody of Jack

Below is the chronology of court cases related to custody of Jack that predate DCF providing services to the family.

- November 9, 2008, court records indicate that Ms. Loiselle agreed to have Jack's maternal grandmother serve as his guardian.
- January 7, 2009, the court granted permanent guardianship to Jack's maternal grandmother.
- October 2012, Jack's maternal grandmother petitioned the court to adopt Jack.
- December 18, 2012, Jack's maternal grandfather filed a petition for grandparent's visitation.
- January 18, 2013, Jack's maternal grandfather filed a petition in court to remove Jack's maternal grandmother as guardian and petitioned to be appointed guardian.
- May 9, 2013, the court dismissed the maternal grandfather's guardianship action.
- Shortly thereafter, Mr. Lints retained counsel, opposed guardianship of Jack by the maternal grandmother, and requested custody of Jack.
- December 2013, the court ordered supervised visitation between Mr. Lints and Jack.
- Summer 2014, Jack began living fulltime with Mr. Lints.

- June 2014, court cases resolved. Jack’s parents and maternal grandmother agreed that Mr. Lints would have sole legal and physical custody of Jack and the maternal grandfather was granted visitation with Jack.

Chronology of Contacts between DCF and Service Providers with the Family⁸

- **March 7, 2008**, anonymous reporter filed a **51A report** alleging the neglect of Jack, who was one month old, by his mother. This report was screened in for an investigation and DCF determined the allegations were not supported.
- September 15, 2014, Jack received a psychiatric evaluation at Wing Memorial Hospital. A referral to Children’s Behavioral Health Initiative (CBHI) was made.
- **September 17, 2014**, a mandated reporter filed a **51A report** alleging the physical abuse and neglect of Jack by Mr. Lints. The report was screened in for an investigation and DCF determined the allegations were not supported.
- September 20, 2014, MassHealth Children’s Behavioral Health Initiative (CBHI) enrolled Jack in services through LUK.
- September 30, 2014, in home meeting with Mr. Lints and the in-home therapist.
- October 6, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- October 17, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- **October 18, 2014, two 51A reports** were filed alleging the physical and sexual abuse of Jack by a family member not living in the home and Jack physically abusing a younger child. The reports were screened out because the alleged perpetrator did not live in the home and the child on child nature of the report.
- October 20, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- October 22, 2014, in home meeting with Mr. Lints and the in-home therapist.
- October 27, 2014, in home meeting with Mr. Lints and the in-home therapist.
- **October 28, 2014**, a mandated reporter filed a **51A report** alleging: the neglect of Jack by Mr. Lints related to untreated eczema with cracked and bleeding skin; and that Jack was punished by having to wash urine soaked clothing with a bleach-type product. The report was screened in for an initial assessment. DCF spoke with school personnel, medical professionals, and CBHI service providers. On December 4, 2014, DCF determined there were no to minimal concerns for the family based largely on the fact that a CBHI team was working with Mr. Lints and Jack.
- October 28, 2014, in home meeting with Mr. Lints and the in-home therapist.
- November 3, 2014, in home meeting with Mr. Lints, the in-home therapist, and the family partner.

⁸ This chronology includes all 51A reports and in-person meetings with the family and service providers, medical professionals, and school personnel. This chronology does not include all phone calls among and between service providers.

- November 10, 2014, in home meeting with Mr. Lints, the in-home therapist and the therapeutic mentor.
- November 14, 2014, in home meeting with Mr. Lints, the intensive care coordinator (ICC), and the family partner.
- November 17, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- November 22, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- November 24, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- November 25, 2014, in home meeting with Mr. Lints, the ICC, and the family partner.
- December 1, 2014, in home meeting with Mr. Lints, Jack, the DCF investigator, and the in-home therapist.
- December 4, 2014, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- December 8, 2014, care planning meeting at the home. Participants included: Mr. Lints, the family partner, the ICC, the in-home therapist, and the therapeutic mentor.
- December 9, 2014, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- December 12, 2014, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- December 18, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- December 19, 2014, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- December 22, 2014, in home meeting with Mr. Lints, Jack, and the ICC.
- December 24, 2014, in home meeting with Mr. Lints and the family partner.
- December 27, 2014, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- December 30, 2014, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- December 30, 2014, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- **December 31, 2014**, a mandated reporter filed a **51A report** alleging the neglect of Jack by Mr. Lints because Jack was excessively urinating on himself and the floor and Mr. Lints made him clean it up with a solvent that irritated Jack's eczema. Mr. Lints informed DCF that Jack cleaned up his urine as he would any other mess. The report was screened out, DCF noted that differences in opinion existed between Mr. Lints and the mandated reporter regarding Jack's behavior.
- January 3, 2015, in home meeting with Mr. Lints, Jack, and the mobile crisis clinician.
- January 4, 2015, in home meeting with Mr. Lints, Jack, and the mobile crisis clinician.
- January 5, 2015, school meeting with Jack, Mr. Lints, school personnel, and the mobile crisis clinician.
- January 5, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- January 6, 2015, in home meeting with Mr. Lints, the ICC, and the in-home therapist.
- January 7, 2015, in home meeting with Mr. Lints, the ICC, and the family partner.

- **January 8, 2015**, a mandated reporter filed a **51A report** alleging sexual abuse of Jack by a non-resident family member. The report was screened in for an investigation. During the investigation, Jack indicated he wanted to hurt himself and was evaluated at a hospital. During the sexual assault intervention network (SAIN) interview Jack did not disclose any sexual abuse and said he lied about it. The investigator spoke with school personnel and CBHI providers. DCF determined that the allegations of sexual abuse were not supported.
- January 12, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- January 14, 2015, in home meeting with Mr. Lints and the family partner.
- January 15, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- January 16, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- January 19, 2015, care planning meeting in the home. Participants included: Mr. Lints, the family partner, the in-home therapy clinician, the therapeutic mentor, and the ICC.
- January 21, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- January 26, 2015, in home meeting with Mr. Lints, Jack, the in-home therapist, and the therapeutic mentor.
- January 28, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- **February 3, 2015**, a mandated reporter filed a **51A report** alleging the neglect of Jack by his father because Mr. Lints did not follow the agreed upon safety plan, which stipulated that Mr. Lints would call the mobile crisis team if there was an incident of Jack's escalating behavior. Mr. Lints did not call the team during an incident where Jack was biting, pinching, and slapping himself and banging his head. Mr. Lints said the episode lasted two to three hours and then Jack calmed down. The allegations were screened in for an initial assessment.
- **February 4, 2015**, a mandated filed a **51A report** alleging the neglect of Jack by his father because Jack was cold and shivering two days in a row and by the second day his hands were purple. Mr. Lints was called and agreed to take Jack to the emergency room. Jack said that his hands and feet were cold because he had to clean up urine from the floor the night before and in the morning with cold water. The DCF screener notified DCF area leadership that this was the ninth report in six months. DCF workers spoke with the CBHI providers, the pediatrician, Jack, and Mr. Lints. DCF determined that DCF involvement was necessary and recommended ongoing services for the family.
- February 4, 2015, in home meeting with Mr. Lints, Jack, the in-home therapist, and the therapeutic mentor.
- February 19, 2015, Jack had an appointment with his Pediatrician, at this appointment he weighed 44.6 pounds.
- February 20, 2015, in home meeting with Mr. Lints and the family partner.
- February 23, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- February 25, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- February 26, 2015, Jack has his first child wellness visit since moving in with his father at West Brookfield Family Practice, at this appointment he weighed 47.4 pounds.
- February 27, 2015, care planning meeting in the home, participants included: Mr. Lints, the family partner, the ICC, the in-home therapist, and the in-home therapist supervisor.

- March 2, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- March 3, 2015, in home meeting with Mr. Lints, Jack, and the family partner.
- March 4, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- March 9, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- March 11, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- March 12, 2015, meeting at school with Mr. Lints, the Hardwick principal, Jack's teacher, the ICC, the in-home therapist, and the family partner.
- March 2015, psychological testing performed at Metrowest Neuropsychology in Westborough.
- March 16, 2015, Jack visits the pediatrician at West Brookfield Family Practice, at this appointment Jack weighed 50 pounds.
- March 17, 2015, in home meeting with Mr. Lints and the family partner.
- March 19, 2015, in home meeting with Mr. Lints, the DCF area social worker, and the family partner.
- March 24, 2015, in home meeting with Mr. Lints and the family partner.
- March 26, 2015, in home meeting with Mr. Lints and the family partner.
- March 26, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- March 27, 2015, family team meeting at the home, participants included: Mr. Lints, Jack, Mr. Lints' Girlfriend's Mother, the DCF area social worker, the in-home therapist, the family partner, and the ICC.
- March 30, 2015, DCF area social worker contacted the guidance counselor at the Hardwick Elementary School.
- March 30, 2015, in home meeting with Mr. Lints, Jack, the in-home therapist, and the therapeutic mentor.
- April 7, 2015, DCF social worker conducted a home visit; Mr. Lints and Jack were present.
- April 7, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- April 14, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- April 16, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- April 20, 2015, in home meeting with Mr. Lints, Jack, the in-home therapist, and the therapeutic mentor.
- April 23, 2015, in home meeting with Mr. Lints, Jack, and therapeutic mentor.
- April 30, 2015, in home meeting with Mr. Lints, Jack, in-home therapist, and therapeutic mentor.
- May 5, 2015, DCF social worker contacted the pediatrician at West Brookfield Family Practice.
- May 5, 2015, DCF social worker contacted the guidance counselor at Hardwick Elementary School.
- May 5, 2015, in home meeting with Mr. Lints and the family partner.
- May 5, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.

- May 7, 2015, in home meeting with Mr. Lints, Jack, the in-home therapist, and the therapeutic mentor.
- May 9, 2015, in home meeting with Mr. Lints and the parent aid.
- May 12, 2015, in home meeting with Mr. Lints, Jack, and the in-home therapist.
- May 13, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- May 13, 2015, in home meeting with Mr. Lints and the ICC.
- May 15, 2015, family team meeting at the home, participants included: Mr. Lints, the DCF social worker, Jack's therapist, the in-home therapist, the family partner, the parent aide, the ICC, and the intensive care coordinator supervisor.
- May 18, 2015, DCF social worker had phone call with the in-home therapist.
- May 18, 2015, in home meeting with Mr. Lints, Jack, the in-home therapist, and the therapeutic mentor.
- May 18, 2015, Jack's in-home therapist called the DCF area social worker and expressed concerns about Mr. Lints withholding food and water from Jack and noted that Jack looked a lot thinner. The therapist reported that the family went on a camping trip and Jack was not allowed to participate in any of the activities and had to sit in the corner during the trip. She stated that at one point Mr. Lints boarded up the windows in Jack's room so he could not look outside. The therapist said Mr. Lints would threaten not to send Jack to school knowing that Jack loved school. The therapist detailed Mr. Lints' harsh punishments of Jack and stated explicitly that Mr. Lints' own mental health issues compromised his parenting capacity. The therapist stated that "Jack should be removed from his care." The in-home therapist explained that not once in her entire career had she told DCF that "a child should be removed from the home." The DCF area social worker immediately raised the provider's comment that Jack should be removed from his father's care to the supervisor's attention. The supervisor decided against considering a care and protection petition because the parent aide reported that Mr. Lints was actively working on the concerns and there were providers in the home giving positive reports about Mr. Lints.
- May 20, 2015, in home meeting with Mr. Lints, Jack, and the therapeutic mentor.
- May 21, 2015, in-home therapist contacted DCF social worker to notify her that Mr. Lints terminated her services.
- May 21, 2015, DCF social worker conducted a home visit with Mr. Lints and Jack.
- May 26, 2015, DCF social worker contacted parent aide. The parent aide indicated that he felt Mr. Lints was trying to improve and was working on new discipline techniques. The DCF area social worker told the parent aide that the in-home therapist and DCF were concerned with what was going on in the home.
- June 1, 2015, the in-home therapist called the DCF area social worker to report that she had her last visit with the family because Mr. Lints decided to utilize other therapeutic services.
- June 1, 2015, in home meeting with Mr. Lints, Jack, and in-home therapist.
- June 4, 2015, Jack had Medical ear, nose, and throat (ENT) visit as a referral for a failed hearing test at school.
- June 5, 2015, Mr. Lints' parent partner called the DCF area social worker to report concerns regarding Mr. Lints as he had not been responsive to the services provided.

- June 8, 2015, DCF Social worker called the family partner.
- June 22, 2015, family team meeting in the home, participants included: Mr. Lints, the DCF social worker, the ICC, the family partner, the parent aide, and an intensive care coordinator in training. The team decided a new referral would be made for in-home therapy.
- June 29, 2015, DCF area social worker conducted a home visit. The parent aide was present for this visit and indicated that he had seen improvements in Jack’s behavior since Mr. Lints instituted the new behavior plan. The parent aide indicated that Mr. Lints appeared to be engaging with Jack in a more positive manner. The social worker observed that Jack “was the happiest she had ever seen him look” and encouraged Mr. Lints to engage in activities with Jack and work on their relationship. The social worker observed Jack eat a bowl of soup and drink water and juice. The social worker did not observe any visible marks on Jack.
- June 29, 2015, DCF social worker conducted a home visit. The parent aide was present for this visit.
- July 2, 2015, in home meeting with Mr. Lints, Jack, the newly assigned ICC, and the intensive care coordinator supervisor.
- July 6, 2015, CBHI parent partner visited the home, observed Jack on the back porch by himself, and observed Jack eat a sandwich.
- July 8, 2015, newly assigned intensive care coordinator (ICC) called the DCF area social worker and expressed concerns about Mr. Lints controlling behaviors and the veracity of his reports about Jack’s behaviors. The ICC recommended a therapeutic mentor for Jack but Mr. Lints did not agree.
- July 9, 2015, parent aide observed Jack at his home, saw Jack eat and drink, and noted that Jack was alert, personable, and engaging. This is the last known contact with Mr. Lints and Jack prior to July 14, 2015.
- July 14, 2015, three 51A reports were filed with the hotline alleging the abuse and neglect of Jack by his father. These reports were screened in together as an emergency response. DCF took emergency custody of Jack.

List of Service Providers

- Catholic Charities
- Community Healthlink
- LUK
- South Bay Mental Health
- West Brookfield Family Practice
- Wing Memorial Hospital