INVESTIGATION STATUS REPORT

OFFICE OF THE CHILD ADVOCATE

MARCH 2022

REGARDING THE MULTI SYSTEM INVESTIGATION INTO THE DEATH OF DAVID ALMOND

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ABOUT THE OFFICE OF THE CHILD ADVOCATE

The Office of the Child Advocate (OCA) is an independent executive branch agency with oversight and ombudsperson responsibilities, established by the Massachusetts Legislature in 2008.[1] The OCA's mission is to ensure that children receive appropriate, timely and quality services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children have the opportunity to thrive. Through collaboration with public and private stakeholders, the OCA identifies gaps in state services and recommends improvements in policy, practice, regulation, and/or law. The OCA also serves as a resource for families who are receiving, or are eligible to receive, services from the Commonwealth.

Investigations

The OCA's enabling statute, M.G.L. c. 18C § 5, requires that state agencies providing services to children or young adults notify the OCA via a "critical incident report" if a child or young adult suffers a fatality, near fatality, serious bodily injury, or emotional injury. For the purposes of critical incident reporting to the OCA: a **fatality** occurs when a child or young adult between the age of birth to twenty-two dies, a **serious bodily injury** "involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ, mental faculty or emotional distress" and may be the result of an accident, an underlying medical condition, or abuse and/or neglect (M.G.L. c. 18C § 1), and an **emotional injury** occurs when a child or young adult is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.

The OCA conducts administrative reviews of each critical incident report to learn more about the circumstances of the incident and the reporting agency's involvement with the family. After these reviews, the OCA provides state agencies with case-specific and trend-related feedback to improve the policy and practice of state services to improve the safety and wellbeing of children. The OCA uses the data it collects through these reviews to inform our work in identifying gaps in systems of care, identifying trends in child welfare that require additional attention or action, and to support advocacy for changes that will make a realizable difference for children receiving state services.

The OCA has the authority to initiate a full-scale investigation into any critical incident. The OCA determines whether to initiate such an investigation based on numerous factors, including whether state agency involvement contributed to the harm suffered by the child. The purpose of an investigation, in accordance with M.G.L. c. 18C § 5, is to determine: (1) the factual circumstances surrounding the critical incident; (2) whether an agency's activities or services provided to a child and his family were adequate and appropriate and in accordance with agency polices and state and federal law; and (3) whether agency policies, regulations, training or delivery of services or state law can be improved. The scope of an OCA investigation is different from a criminal investigation, which will address any individual responsibility in the harm of a child.

[1] The Office of the Child Advocate Statute is M.G.L. c. 18C.

Confidentiality

The OCA is required by law, MGL c. 18C § 12(a), to ensure that no information submitted for review is disseminated to parties outside the office, except where disclosure may be necessary to enable the Child Advocate to perform her statutory duties. The Child Advocate bases her decision about the disclosure of information to the public on a weighing of several factors including, but not limited to: (1) whether the case has already garnered public interest and there is a value to the public in the OCA's perspective on the case; (2) whether public disclosure of the OCA's recommendations contributes to the public's understanding of state services; (3) the public nature of a case coupled with the underlying circumstances and whether transparency about what happened needs to be shared; (4) challenges in the provision of state services, or other valuable public policy conversations; (5) whether the OCA believes that the learnings from the case are so significant that the benefit to the public is substantial. Confidential information may not be shared with the public and for this reason many protected details are not included in this report.

EXECUTIVE SUMMARY

Early in the morning of October 21, 2020, the Fall River Police Department received a 911 call concerning an unresponsive child. Fall River police responded to the home of John Almond, Jaclyn Coleman and Ann Shadburn and found David Almond, a 14-year-old with Autism Spectrum Disorder,[2] emaciated, bruised, and unresponsive.[3] David was transported to Charlton Memorial Hospital where he was pronounced deceased. David's triplet brother Michael, also diagnosed with Autism Spectrum Disorder, and his three-year-old paternal half-sibling, Aiden,[4] were in the home as well. Michael was responsive but emaciated, and Aiden was well-nourished and appeared physically unharmed. David and Michael's triplet brother Noah[5] was not in the care or custody of this family at the time of David's death. The home was in deplorable condition and substances believed to be heroin and fentanyl were found in the apartment. On March 17, 2021, the Office of the Chief Medical Examiner ruled David's cause of death *Failure to Thrive and Malnutrition due to Starvation and Neglect in an Adolescent with Autism Spectrum Disorder* and the manner of death *Homicide*.[6] At the time of the release of this investigation status report, both Mr. Almond and Ms. Coleman remain in jail and facing criminal charges.

On October 23, 2020, the OCA received a critical incident report from the Department of Children and Families (DCF) about the death of 14-year-old David Almond, the serious bodily and emotional injury of his twin brother Michael, and the emotional injury of their younger paternal half-sibling, Aiden. Consistent with OCA practice, the OCA conducted an immediate administrative review to learn more about the circumstances of the event and DCF's involvement with the family. The DCF critical incident report detailing the harm that came to David, Michael, and Aiden was of such an extreme nature that the OCA initiated a full-scale multi-system investigation. Specifically, this investigation was based on the egregiousness of David's death, the harm to Michael and Aiden, the vulnerability of David and Michael due to their disability profiles, the interplay of the multiple state systems involved, and the complications the COVID-19 pandemic had on the provision of services to this family.

The OCA released its investigative report on March 31, 2021: A Multi-System Investigation into the Death of David Almond. The investigative report detailed themes, findings, and recommendations and determined that these children fell through gaps in our state system of care. Many of the gaps were created by the lack of understanding of how a child's disability may affect that child, how evaluation of risks and warning signs of abuse and neglect should take a child's disabilities into account, and how caregiver capacity should be evaluated considering the individualized strengths and needs of children.

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[2] According to the American Psychological Association, "Autism spectrum disorder (ASD) refers to a neurodevelopment disorder that is characterized by difficulties with social communication and social interaction and restricted and repetitive patterns in behaviors, interests, and activities. The symptoms are present early on in development and affect daily functioning. ASD occurs in all racial and ethnic groups, and across every socioeconomic status level. Boys are about four times more likely to have ASD than girls." https://www.apa.org/topics/autism-spectrum-disorder

[3] The apartment was leased to Ms. Shadburn, Mr. Almond's biological mother.

[4] Aiden is a pseudonym to protect this child's identity and privacy as his name was not known to the public prior to the release of the OCA's investigative report.

[5] Noah is a pseudonym to protect this child's identity and privacy as his name was not known to the public prior to the release of the OCA's investigative report.

[6] The OCA is sharing these details as death certificates in Massachusetts are public documents: https://www.mass.gov/death-certificates

These systemic gaps were compounded by the unprecedented strain the COVID-19 pandemic had, and is having, on the Commonwealth's children and families and on the public and private entities that provide support to them. The pandemic has required that state systems continuously shift and alter their operating procedures to continue their work in a manner that is safe.

The OCA findings are representative of missed opportunities for prevention and intervention with David Almond and his family. The OCA provided 26 recommendations for policy, procedure, and practice improvements within and across the Department of Children and Families (DCF), the Department of Elementary and Secondary Education (DESE), the Massachusetts Juvenile Court, and the Massachusetts Probation Service. The OCA knew that when it published its investigative report that the tragedy of David Almond's death would reverberate through the hearts of the public and of the public servants who devote their careers to improving the lives of children. The OCA recognizes the difficulty, and sometimes near impossibility, of protecting children from harm particularly when that harm comes to them behind closed doors. The investigative report recommended changes to the state system that we felt were not only correct, but also *possible*. The Commonwealth state agencies listed in the investigative report and the secretariats that those agencies sit under, as well as the Juvenile Court and entities under the judicial branch, all had the fortitude of mission, strength of character, and dedication to the difficult work to stand-up in the wake of the investigation and commit themselves to implementation of the recommendations. Not one agency or entity listed in the investigative report took a defensive stance to the OCA's recommendations. The OCA also notes that the dedication of Governor Baker in this effort has been extraordinary - he committed to expeditiously implementing all the OCA's recommendations for the executive branch state agencies involved and the work of his administration has made that a reality. The Commonwealth is a much better place for children today because of these agencies and entities and the individuals within them.

The OCA also recognizes the dedication of the Legislature to the implementation of the recommendations in the investigative report. The Legislature held hearings to discuss the investigative report, the findings within it, and the recommendations. The Legislature has provided ongoing oversight of implementation of the recommendations in the investigative report through meetings with the OCA as well as meeting with the state agencies and entities involved. The Joint Committee on Children, Families and Persons with Disabilities has kept the investigative report at the forefront of their work on behalf of the citizens of the Commonwealth.

There are approximately 14 other states in the United States that have an independent Office of the Child Advocate. Each office is designed differently. The Massachusetts OCA has one of the broadest, if not the broadest, mandate among OCAs in that we are responsible for monitoring the delivery of services to all children in the Commonwealth, unlike other OCAs who solely focus on children involved with their state's child protection and/or juvenile justice entities. The investigative report and its recommendations reflected that broad mandate in that the complexity of what happened to David Almond and his family could not be clearly examined without a system-wide view.

The other unique aspect of the Massachusetts OCA is that we have and enjoy collaborative relationships with state agencies and across the branches of government. Although we sit in an oversight role, we are

not hampered in our work with state agencies by animosity or combativeness. On a weekly basis, the OCA provides feedback and recommendations for state agency practice improvements for cases in real-time based on the information we gather through our Complaint Line, through our review of critical incident reports, and through our monitoring of abuse and neglect in out-of-home settings. We are an independent agency, and the results of the work of our office is difficult for state agencies and institutions to hear, acknowledge, and execute. However, the state agencies are staffed by persons who put mission above self-preservation which results in respect for the OCA's work. We note this because this relationship is a great benefit to the people, and particularly the children, of the Commonwealth. The OCA is immensely proud that we have a state where the focus is always on improving the work and we are privileged to be a part of that.

After the report was issued, the OCA turned its attention to implementation of the recommendations in the report. The OCA's statutory oversight responsibilities only extend to executive branch agencies. The OCA was invited to collaborate and consult on draft policy and practice changes for DCF and DESE. The OCA has strong relationships with the Juvenile Court and the Massachusetts Probation Service (MPS) and the OCA maintained open and collaborative conversations with those entities post the publication of the report. The OCA does not have any statutory authority to oversee individual school districts but Fall River Public Schools has never denied any OCA request for information. This investigation status report details the work that the Commonwealth has done to close gaps in the state system of services to children since the publication of the OCA's report on March 31, 2021. Close to one year since the report was issued and already there has been sweeping changes that honor the life of David Almond.

This investigation status report lets the state agencies and entities identified in the investigation speak for themselves in outlining the work that they have done to implement the recommendations in the report. The OCA has reviewed the information herein and submits that the information is an accurate reflection of the work that has been done thus far.

Finally, we note that the OCA deals with the complexity of child abuse and neglect daily and is privy to private and terrifying situations in which children find themselves. Not all their names or stories can or should be told publicly. That David Almond and his brothers' story was told, and that his story has made such a sizable difference in the provision of state services to children, honors David, Michael, Noah, and Aiden and honors the lives and experiences of other children whose names are not publicized.

For more detailed information about the OCA investigation, including findings and recommendations, refer to the full investigation report, A Multi-System Investigation into the Death of David Almond.

OFFICE OF THE CHILD ADVOCATE ACTIVITIES

As noted above, after the publication of the OCA's investigative report on March 31, 2021, the OCA worked to collaborate on, and monitor, implementation of the recommendations in the report. In addition to that work, the OCA continued its own initiatives to improve the provision of state services to children.

OCA Complaint Line

One overarching theme that emerged from the investigation is that when a professional is concerned about DCF's decision making about an involved child or family and they question whether the DCF area office management is adequately responding to their concerns - they do not know whether they should, or how to report these concerns above the DCF area office director.

Since the beginning of the pandemic in March 2020 the OCA has reached out especially to legislators, service providers, advocates, caregivers and others who work with children and families to provide them with information about the OCA Complaint Line and ask them to alert the OCA if they have trouble accessing needed services or have a concern for a state agency's involvement with a child and family. The OCA staff will listen to a person's concerns and provide resources, information, and other options to assist in addressing the problems that are brought to our attention. We also track and analyze the information we receive from persons who contact us to inform our inter-agency work and make recommendations to improve services for children in the Commonwealth.

Immediately following the release of the investigative report on March 31, 2021, the OCA saw a 101% increase in the number of complaints filed in quarter four (April 1, 2021 – June 30, 2021) of FY21 compared to FY20.[7] Thus far in FY22, the OCA is experiencing a 54% increase in complaints compared to FY21. To meet the demand in both the volume and complexity of complaints, the OCA has increased the number of dedicated staff to our Complaint Line to ensure a timely and efficient response.

Mandated Reporting

Another overarching theme that emerged from our investigation is that sometimes, mandated reporters are hesitant to report concerns of abuse or neglect about a DCF involved family because (a) they already informed the ongoing social worker of their concerns, or (b) because they believe DCF must already be aware of the concern, or (c) they believe their report will be viewed as unimportant or duplicative by DCF and will be screened-out.

Prior to the release of the investigative report, the Child Advocate chaired the Mandated Reporter Commission (MR Commission) which was charged with reviewing the mandated reporter law and regulations for reporting child abuse and neglect and making recommendations on how to improve the response to, and prevention of, child abuse and neglect. The MR Commission was comprised

[7] Overall, there was a 31% increase in initial Complaint Line contacts from FY20 (328) to FY21 (430).

of statutory members who represented a broad range of public entities who have extensive experience with mandated reporting in the Commonwealth.

The MR Commission submitted its final report to the Legislature in June 2021.[8] The MR Commission's work concluded with the submission of the final report.

Informed by the work of the MR Commission, the OCA has undertaken a pilot project to design an evidence-based online training on mandated reporting of child abuse and neglect specifically for kindergarten through 12th grade educators. This online training is intended to cover aspects of mandated reporting of child abuse and neglect relevant to all mandated reporters in the Commonwealth, but also have information that is specifically designed to address common issues regarding educators' responsibilities and experiences with reporting. This will be a pilot project to determine the efficacy and value of evidence-based mandated reporter trainings. This training program will be standard-setting as the OCA does not know of any other state that is seeking to tailor the content of mandated reporter trainings this closely to profession-specific needs. The pilot project will be made available to a limited number of school districts and education entities in Massachusetts. If successful, the pilot program is intended to serve as a model for future profession-specific mandated reporter trainings in the Commonwealth.

Policy and Practice

In response to the numerous findings and recommendations in the investigative report, the OCA established monthly meetings with the DCF senior leadership team and quarterly meetings with the DESE senior leadership team. The purpose of these meetings is for the OCA to receive ongoing and updated information about the recommendation implementation and for the OCA to provide input and monitoring of each respective agency's efforts.

In addition to the monitoring of the investigative report recommendations the OCA has also worked on the following:

DCF Implementation Plan: In June 2021, DCF provided the OCA and the Legislature a detailed implementation plan outlining the steps and timeline for each recommendation. In addition to the OCA and DCF monthly meetings, DCF has provided the OCA quarterly written updates on the implementation plan.

Request for Response (RFR): In July 2021, DCF sought OCA input in a RFR for *DCF Parenting Capacity Evaluation*. DCF was seeking proposals from qualified bidders to conduct culturally competent and impartial parenting capacity evaluations. The OCA provided comprehensive input.

Policy Development: As a result of this investigation, the OCA is now intimately involved with DCF policy development. Since the release of the investigative report on March 31, 2021, the OCA provided detailed and ongoing input on the creation and drafting of updated DCF policies including *Education,*

[8] Mandated Reporter Commission Final Report | Mass.gov

Family Assessment and Action Planning and *Protective Case Practice*. The OCA also provided robust input in the newly developed *Disability Policy*.

Also, because of this investigation, the OCA actively provides input on the creation and drafting of DESE guidance for local school districts. This includes *Promoting Student Engagement, Learning, Wellbeing and Safety; Guidance on In-Person Learning and Student Learning Time Requirements; Joint DESE and DCF Advisory Regarding Mandated Reporting Responsibilities of School Personnel in cases of Suspected Child Abuse and Neglect; Guidance for Attendance Policies.*

Structured Decision Making (SDM): In July 2021, DCF engaged Evident Change[9] to lead the development of structured decision-making tools: *Safety Assessment* for parents/caregivers, *Safety Assessment* for substitute care providers and a *Reunification Assessment*. At DCF's invitation, the OCA is a member of the SDM Core Team whose role is to help develop priorities and provide input in the development and implementation of these critical tools.

Interstate Compact on the Placement of Children and Updated Information

The **Interstate Compact on the Placement of Children (ICPC)** is a statutory agreement that has been entered into by all fifty US states as well as Washington, D.C. and the U.S. Virgin Islands. The agreement governs the permanent placement of children from one state into another state. The purpose of the ICPC is to ensure that children who are "placed" out-of-state are cared for by safe caregivers in an environment that meets that child's needs. The ICPC also ensures that the individual or entity placing the child remains legally and financially responsible for the child following placement.

In September 2016, Mr. Almond was living in Massachusetts, and he was a respondent on a New York child abuse and neglect case regarding David, Michael, and Noah. At that time New York Family Court awarded full custody of David, Michael, and Noah to Mr. Almond. Mr. Almond was granted custody of the triplets after years of minimal to no contact with them. Since issuing the investigative report, the OCA spoke to the New York Office of Children and Family Services as well as an attorney at the local New York department of social services and gathered more information on what happened in this case regarding the ICPC.

The OCA's investigative report states that:

"There was no evidence available for the OCA to review that indicated Mr. Almond ever completed any service on his extensive New York service plan. There is also no evidence that New York OCFS ever initiated contact with Massachusetts DCF, or any other state entity, to determine if Mr. Almond had the means and ability to parent these children prior to the New York Family Court placing the children with him in Massachusetts. **This decision remains a mystery to the OCA as returning custody to Mr. Almond appears not to have been the appropriate legal action under the circumstances.**"

Since the investigative report was issued, we learned additional information and we are taking the opportunity here to correct this statement and provide further clarity. First, New York Office of Children

[9] Home | Evident Change

and Family Services (OCFS) is not the child protective entity that was responsible for this case in New York. OCFS is responsible for programs and services involving foster care, adoption and adoption assistance, child protective services including operating the Statewide Central Register for Child Abuse and Maltreatment, preventive services for children and families, services for pregnant adolescents, and protective programs for vulnerable adults. OCFS is also responsible for the functions performed by the State Commission for the Blind and coordinates state government response to the needs of Native Americans on reservations and in communities."[10] OCFS is also responsible for oversight and policy obligations. The initial report should have referenced the "local county department of social services" and not OCFS.

Also, since the investigative report was issued, we learned that there was apparently available evidence in New York that Mr. Almond was participating in drug testing, although we do not have documentation of that evidence, nor do we know if such drug testing was randomly done. There is no evidence we are aware of that Mr. Almond completed a parenting class or any other service.

Our understanding is that the local county department of social services in New York requested that Mr. Almond have a mental health evaluation, a substance abuse evaluation, and that there be an ICPC home study conducted in Massachusetts prior to the children being placed in Mr. Almond's care in Massachusetts. The judge in the NY case did not agree with the requests of the local county department of social services and discharged the children from foster care into the care of Mr. Almond in Massachusetts without an ICPC.

[10] About OCFS | About | OCFS (ny.gov)

RECOMMENDATION IMPLEMENTATION

The following sections provide the state agencies and entities identified in the investigation an opportunity to speak for themselves in outlining the work that they have done to implement the recommendations in the investigative report. As noted above, the OCA has reviewed the information herein and submits that the information is an accurate reflection of the work that has been done thus far.

DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families (DCF) is the designated child protective service agency for Massachusetts. DCF is the state agency responsible for receiving and responding to allegations of abuse and neglect, for providing services to children and their families that enable caregivers to safely care for their children, and when that is not possible, to assume custodial care as authorized by the courts. DCF provides services to more children and families than any other Executive Office of Health and Human Services child-serving agency. The Department ended Fiscal Year 2021 serving 93,802 families and young adults involved in 26,307 protective cases that included 44,465 children aged 0-17.[11] Of those 44,465 children, 36,000 are served at home.

DCF has one central office, five regional offices, and 29 area offices. The area offices are responsible for the intake and response of neglect and abuse allegations, and case management and decision-making about a family. The DCF Fall River Area Office is responsible for the oversight, monitoring, and management of the Almond family since their involvement began in August 2017.

The OCA identified several challenges with the Fall River Area Office case management and family engagement. The OCA determined there was an overall lack of clinical formulation[12] that resulted in the DCF Fall River Area Office inability to recognize that Mr. Almond and Ms. Coleman had done nothing to mitigate the risk they posed to the children. Additionally, the DCF Fall River Area Office lacked basic knowledge and understanding of Autism Spectrum Disorder and the individual needs of the triplets, which significantly impacted DCF's ability to make decisions in their best interest. As a result of these two key factors, the decision to reunify Aiden in July 2019 and David and Michael in March 2020 put the children at risk of future harm. Once David and Michael returned home in March 2020, the DCF Fall River Area Office did not adequately identify and adjust to the complications the COVID-19 pandemic presented for the family and the family's service provision. Mr. Almond and Ms. Coleman took advantage of the quarantine and social isolation effects of COVID-19 to keep the DCF case management team, the Fall River Public Schools, and service providers at arms-length.

[11] Massachusetts Department of Children and Families: Annual Report FY2021: https://www.mass.gov/doc/dcf-annual-reportfy2021/download

[12] A **clinical formulation** is the is the ability to synthesize information about a family to inform case planning and decision-making, and to create an achievable Family Assessment and Action Plan (FAAP) that is intended to promote the safety, permanency, and well-being of a child and family. For more information about the DCF Family Assessment and Action Plan (FAAP) visit: https://www.mass.gov/doc/family-assessment-action-planning-policy/download

As noted previously in this investigation status report, and as detailed more below, the OCA was invited by DCF to collaborate and consult on the implementation of the recommendations in the investigative report. The OCA is intimately involved and has been meeting with DCF monthly to discuss and provide input about implementation. The OCA was also invited by DCF to participate in other DCF initiatives aimed at improving practice, which the OCA accepted. The OCA wish to acknowledge DCF's transparency, collaboration, hard-work and expedited efforts towards the recommendation's implementation. It is exemplary of their unwavering commitment to improve the protection and safety net for all children in the Commonwealth.

As a result of the OCA's findings and recommendations, on March 7, 2022, the Department of Children and Families submitted to the OCA the following statement and information about their implementation of the recommendations:

The Department of Children and Families (DCF) submits an update of its implementation of the Office of the Child Advocate's (OCA) recommendations from the March 2021 report relating to the tragic death of David Almond. DCF has worked closely with the OCA on the implementation of the recommendations from the report, including increasing and promoting case communication and collaboration, focusing on sound clinical formulation, building additional capacity to serve the unique vulnerabilities and needs of children, especially those with disabilities, and keeping children visible in the community by partnering with providers and sister agencies. As stressors on the workforce continue due to COVID-19, the Department is committed to working with its partners in the Union to support their staff in the field and provide them with the training and learning they need to effectually incorporate policies into their everyday work. With input from the Union this sequential plan to implement new policies has been adjusted over time to optimize the learning and adoption of these policies. DCF social workers worked tirelessly during the latest Omicron surge to ensure the safety and wellbeing of the children in the Department's care. As outlined below, DCF has made significant progress on all recommendations and remains determined to address additional case practice and systemic reforms.

RECOMMENDATION # 1: The DCF administration should revise the DCF *Supervision Policy* and workforce training curriculum to ensure all levels of the DCF workforce receive frequent and structured supervision that supports the development of task-oriented skills, but also the essential clinical formulation skills needed to accurately assess the safety and risks to a family.

ACTION TAKEN BY DCF #1: *The Department's first-ever Supervision Policy was established in 2016 as part of the first phase of the Department's agency reform. The goal of the policy was to strengthen regular supervisory support of social workers by reviewing casework activities, identifying practice areas requiring attention, and ensuring safe decision-making. This includes understanding parental history, the parent's ability to care safely for the child, and present factors affecting child safety such as substance use, mental health challenges, or domestic violence. Supervision and other supports assist frontline social workers in making informed decisions about their cases.*

Immediate Response & Staff Training – *Immediately following the death of David Almond, DCF senior leadership conducted a review of all cases open with the Fall River Area Office. While no child's safety*

was determined to be at imminent risk, approximately a dozen cases were referred to our substance abuse, mental health, domestic violence, and medical specialists for consultation. In conjunction with this October 2020 review, the Department took immediate action to conduct intensive supervision training at the Fall River Area Office on the fundamentals of supervisory practices to ensure that staff had the necessary tools to improve supervision procedures. The training of staff in the Fall River Area Office was completed in January 2021.

Following the local area office training, more than 300 supervisors statewide were trained on topics that covered assessing child safety, risk, and parent capacities, continuing our efforts to ensure consistent supervisory oversight for social workers across all offices.

Between February and April 2021, the DCF Child Welfare Institute (CWI), the unit responsible for the Department's professional development, also offered a re-training for all supervisors on assessing child safety, risk, and parent capacities.

***Revised Supervision Policy -** The revised Supervision Policy went into effect on August 31, 2021. In April 2021, DCF established a policy workgroup and conducted a comprehensive review of current policy, national standards, and best practices. In June 2021 the Department completed revising the Supervision Policy and negotiated the terms with SEIU Local 509. Staff statewide received training on the revised policy in the summer of 2021.*

The revised Supervision Policy adds the following requirements and guidance for staff:

- *Supervisory expectations for managers.*
- *Guidance on when social worker supervisors should notify managers of complex cases that may require additional review.*
- *Guidance on when staff should consult specialty social workers with expertise in a specific subject matter such as substance use, mental health, domestic violence, or disability.*
- *Involvement of Area Office leadership when differences arise regarding case direction among DCF social workers, managers, DCF staff, and other professional service providers.*

RECOMMENDATION # 2: The DCF *Ongoing Casework and Documentation Policy* and *Family Assessment and Action Planning Policy* should be revised to expand guidance and direction regarding social workers' contact with caregivers, service providers, educators, other professionals, and natural family supports.

***ACTION TAKEN BY DCF #2:** In order to make the best decisions for children, social workers must use all information available from every person who plays a role in the child's life including those at schools, courts, service providers, medical professionals, and law enforcement. Accessing this information requires strengthened communication with one another and, critically, an understanding of each other's role in child safety. By adding specific guidance and direction on effective case consultation and communication to the Protective Case Practice Policy (formerly called the Ongoing Case Practice Policy) and the Family Assessment and Action Planning Policy, the department is better able to ensure that*

social workers have vital input from specialists, collateral contacts, and service providers to make critical decisions about child safety, case direction (including reunification) and a family's service needs.

Area Clinical Review Team (ACRT) Pilot - *In May 2021, the Department piloted a new protocol to enhance ACRT, creating a structure that supports clinical decision-making and helps the department flag high-risk cases. The pilot was launched in five DCF Area Offices. ACRTs are convened when there is a complex case or a difference of opinion surrounding a case. These team meetings are conducted by area office leadership and consist of the casework management team and other subject matter experts, depending on case characteristics. The ACRT participants together take a comprehensive look at factors impacting child safety risks and disabilities, along with unresolved mental health, substance misuse, or domestic violence concerns.*

Initial Placement Reviews - *Once a child has been in care for six weeks, an Initial Placement Review occurs to ensure they are in the most appropriate placement setting that meets their needs, and immediate supports are identified and in place. In May 2021, the Department expanded its existing pilot on the Initial Placement Review process from 10 offices to 20, and by June 2021 the new Initial Placement Review process was implemented in all 29 DCF offices.*

Congregate Care Network – *DCF launched its new congregate care services network in January 2022. The Network uses multi-disciplinary team meetings with DCF senior managers and providers to identify and address issues that may arise while serving children in group care. In procuring these services, an emphasis was placed on providers' processes for conducting and sharing assessments, treatment planning, and incident reports for children in congregate care.*

Protective Case Practice Policy – *The revised Protective Case Practice Policy is scheduled to go into effect in April 2022. It requires social workers to make collateral contacts in conjunction with monthly visits and sets requirements for documenting case activities, including social worker dictation and referrals to services in the community, in the electronic case record. The Department developed initial training materials for the revised Protective Case Practice Policy in June 2021. Orientation for managers began in September 2021. Practice training conferences were held for managers in December 2021 and for supervisors in February 2022. The policy will take effect in April 2022.*

Family Assessment and Action Planning Policy – *The revised Family Assessment and Action Planning Policy is scheduled to go into effect in May 2022. The revised Family Assessment and Action Planning Policy adds guidelines for evaluating child safety risk for children with disabilities and requires social workers to conduct outreach to collateral contacts in conjunction with monthly home visits. Training and implementation of the updated Family Assessment and Action Planning Policy began in July 2021. The final technical training on the new policy will be held in April 2022.*

RECOMMENDATION # 3: The DCF administration should create guidance that provides: (1) specific criteria for when and why parental assessments are needed from external providers; (2) a standard process for parenting assessment referrals that includes relevant DCF and family history; and (3) a mandate that the DCF case management team provide the parenting evaluator specific

parental capacity questions that are related to the protective concerns of the case and the individual needs of both the children and caregivers.

ACTION TAKEN BY DCF #3: *Parental assessments are a valuable tool to help social workers understand parental capacities, particularly when a case involves a complex history or complex circumstances. These assessments can assist social workers in evaluating what they've learned from other service providers, what the social worker has observed, and taking all of that into account when determining a parent's ability to keep a child safe, and what services are needed to build parenting capacity. To strengthen and expand its parental assessments the Department developed best practice guidance for staff, and re-procured this provider-based service, enlisting providers to work with the Department to conduct these assessments.*

Parental Assessment Contracts - *In April 2021, DCF began a thorough review of its existing parental assessment contracts in preparation for developing a new procurement of these services that would codify recommendations outlined in the OCA's report. Revisions to the program design were incorporated into a new, stand-alone procurement for parenting capacity evaluation services (DCF's new name for parental assessments). The procurement was finalized and the new RFR was posted on July 30, 2021. DCF has received multiple qualifying bids from vendors and is in the process of negotiating contracts with selected providers. The anticipated start date of new parenting capacity evaluation services is April 2022.*

Practice Guidance on Parental Assessments – *While work on the new procurement proceeded, the Department moved quickly to develop and roll out practice guidance that implemented the OCA's recommendations on parental assessments, including specific criteria for when and why parental assessments are needed; standard practice for when DCF should request a parental assessment; and additional resources for special populations including individuals with disabilities. This practice guidance was adopted in May 2021 and implemented, in partnership with DCF lead agencies, throughout June and July 2021.*

RECOMMENDATION # 4: The DCF administration, in collaboration with their education experts, should conduct a comprehensive review of internal policies and procedures to determine how to effectively prioritize the educational needs of DCF involved children. Based on the results of this review, DCF should update or develop policies and procedures to ensure this examination promotes the educational success of DCF involved children.

ACTION TAKEN BY DCF #4: *Education is a critical piece in building a child's future and the Department values its collaboration with the Department of Elementary and Secondary Education (DESE) and local school districts to support children in foster care. Changes in federal education law have resulted in stronger collaboration among DCF, DESE, and school districts to improve school stability for children in foster care as outlined in joint guidance issued in January 2018. During the 2019-2020 school year DCF worked with DESE to conduct child specific problem solving and support for DCF foster children related to school enrollment, IEPs, Best Interest Determinations, etc. DCF and DESE coordinated 25 school reopening meetings during August and September of 2020 with about 230 school districts to support*

children and families at the start of the new school year. By creating appropriate supports for parents to address their child's educational needs and partnering with sister agencies like DESE, DCF creates opportunities for better outcomes for children, not only when it comes to their education but also their wellbeing.

Data Sharing Between DCF & DESE - *Consistent with the existing MOU with DESE, DCF receives routine data from DESE regarding children currently in the Department's custody which is uploaded into DCF's case record system. Data transferred from DESE to DCF includes Student Information Management System data, MCAS data, School Safety Discipline Reports, Student Course Schedule Reports, and attendance data. It is received according to designated marking periods. On June 30, 2021, DCF and DESE officially updated this MOU. DCF worked with DESE to achieve a critical deliverable, having attained a 98- 99% match for data elements using existing DCF-DESE data systems. A DESE-DCF workgroup continues its efforts to ensure the Department has access to timely attendance updates for all students who are in the legal custody of DCF.*

Access to Student Information & Records - *This collaborative work between DCF and DESE led to the development of new guidance released on October 21, 2021, entitled DCF's Access to Students' Education Records, which incorporated feedback from the OCA and other stakeholders. The joint guidance grants DCF social workers access to education records of students in DCF custody. The joint guidance specifies that when DCF has custody of a student, it is expected that the Local Education Authority will provide the assigned DCF social worker with access to that student's education records. Districts and schools that offer web-based or online access to student-specific data on attendance and education progress are directed to extend access to the DCF social worker. This includes providing social workers with a user profile, login credentials, information on how to access the portal, and guidance on how to use the system. Please see DESE recommendation #4 for more details.*

Legislative Report of School Attendance - *In January and April of 2021, DCF submitted mandated reports on attendance for children in DCF's custody to the Governor and the Legislature. The report provided data for children in DCF's custody for the 1st Marking Period of the 2020-2021 school year, a time frame spanning the start of the 2020-2021 school year (date dependent on school district) through October 1, 2020. This was the first Marking Period that required schools to make the distinction between in-person or remote attendance. The data showed that 42.9% of instruction for matched DCF children and youth (5,191) was conducted in-person, 54.6% remote, and 2.5% did not have the mode of instruction reported by the school district. Matched DCF students who participated in in-person instruction attended 93% of the time. Matched DCF students who participated in remote instruction attended 88% of the time.*

Education Advocates Contract - *In July 2021, DCF re-procured its contract for Educational Advocacy, a service where attorneys function as Educational Decision Makers when disputes arise regarding the education plan of DCF-involved children. These new contracts doubled the Department's capacity to provide education advocacy services for children in its care. By November 2021 the contracts were finalized, and four attorneys were onboarded. These attorneys are now also available to provide consultation to DCF staff and represent children at risk for expulsion.*

Mandated Reporter Guidance - *In May 2021, a Joint DESE/DCF Work Group was established to perform a comprehensive review of current guidance on mandated reporting responsibilities. By October 28, 2021, DESE and DCF issued the Joint DESE/DCF Advisory Regarding Mandated Reporting Responsibilities of School Personnel in Cases of Suspected Child Abuse and Neglect, which incorporates feedback from the OCA and other stakeholders. The updated joint advisory specifically explains to mandated reporters that even if there is current DCF or court involvement with a family or a child at the time of the suspected abuse or neglect, the mandated reporter must still make the required report if the reporter has reasonable cause to believe a child is being abused or neglected. DCF joined DESE in their statewide training for District Superintendents in August and September of 2021. See DESE's recommendation #6 for more details.*

Education Specialists - *In October 2021, DCF hired new Education Specialists in all five regions of the state to provide case consultation for staff, coordination among stakeholders, and support and training to enhance educational stability and success for all DCF school-aged children. These staff members provide specialized consultation to DCF social workers, supervisors, and managers.*

Education Policy - *The revised Education Policy went into effect on January 3, 2022. Between August and September 2021, DCF reviewed and updated its education policy to address children's educational needs and stability as part of reunification planning. Training on the policy occurred in November and December 2021. The revisions promote educational stability, academic performance, and reduction of school disciplinary actions for children and youth. It also includes specific guidance for children and youth in special education settings such as collaboratives, day educational settings, and residential schools.*

RECOMMENDATION # 5: The DCF administration should conduct a comprehensive review of DCF practices related to individuals with disabilities and develop a policy that promotes (1) workforce development and training; (2) evidenced-based best practices for effective case management and safety and risk assessment and planning; and (3) requirements for case documentation about an individual's disability.

ACTION TAKEN BY DCF #5*: Immediately following David Almond's tragic death, the Department identified the need for additional expertise in the field of disabilities. Staff has been hired as resources to the field for consultation on cases with complex family dynamics impacted by disabilities where children are especially vulnerable. The creation of the Disability Policy to ensure that DCF-involved parents with disabilities are provided an equal opportunity to benefit from and participate in DCF services, programs, and activities is consistent with the requirements of the Americans with Disabilities Act (ADA).*

Disability Coordinators - *In December 2020, the department appointed Disability Coordinators in each regional counsel office and one in DCF's central office in the General Counsel's office, as part of the DOJ Agreement to identify regional points of contact for ADA accommodations for parents and caregivers.*

Case Reviews *– Between June and August 2021, in preparation for new policy development, DCF conducted a continuous quality improvement (CQI) review of a sample of cases involving children with disabilities based on criteria and definitions used by the children's bureau, DESE, and DCF*

Health/Behavior conditions data. The review helped to ensure that the new policy was informed by an understanding of the unique concerns of children with disabilities in child welfare. Research shows children with disabilities carry an even higher risk of being abused or neglected by a caregiver and the risks differ based on the child's disability. Children with disabilities have greater needs and require specialized services or educational supports often obtained through tireless advocacy. Financial stress and feeling isolated or overwhelmed can frustrate even the most resourced, dedicated, and knowledgeable of parents.

Disability Training & Disability Policy – *The new Disability policy took effect on January 18, 2022. In April 2021 disability training was provided to DCF legal staff on Title II of the ADA and sec. 504 for child welfare. A policy workgroup was established during this time, which completed a comprehensive review of national best practices involving accommodations policies and children with disabilities in child welfare to prepare for writing the Department's first Disability Policy. In May 2021, DCF submitted to DOJ and implemented revisions to the Family Assessment and Action Planning, Family Resource, and Permanency Planning policies to ensure that each policy addresses ADA principles.*

DCF's i-FamilyNet case record system was updated in September 2021 and now requires the documentation of disabilities. By October 2021, DCF developed and implemented a training plan to support practice improvement for agency staff working with individuals with disabilities. Online training on the intersection of the ADA and Child Welfare was made available to all staff on October 31, 2021. With final input from the U.S. Department of Justice and other disability specialists, the Department finalized its new policy and began training in December 2021.

Director of Disability Services - *On December 6, 2021, the Department hired a new Director of Disability Services. Duties of this position include accessing and overseeing timely one-on-one case consultations and ensuring that staff has in-house access to an expert with a thorough understanding of the complex dynamics of families impacted by disabilities where children are especially vulnerable. The Department also developed positions for regional disability specialists and, as of the beginning of March 2022, all five regions were conducting interviews. Their primary role is to act as a consultant to DCF's regional and area office staff; to build capacity and expertise in the field; and to create linkages to the provider community that services the disabled population, particularly in the areas of parenting children with Autism, Intellectual Disabilities or Developmental Disabilities. The Department hopes to onboard these specialists in the spring of 2022.*

RECOMMENDATION # 6: The DCF administration should develop a reunification policy that includes, at a minimum (1) an assessment of safety and risk using a research or analytical based or actuarial tool that is used prior to a child's return and as a support in DCF's reunification decision-making; (2) area office management administrative case record review prior to any internal case review meeting (e.g. Foster Care Review, Permanency Planning Conference); (3) area office management consultations with the DCF case management team, educational provider, probation officer, relevant service providers and subject matter experts prior to any internal case review meeting; (4) area office management discussions with the caregiver(s) to elicit their input and participation in formulating a reunification transition plan that takes into

considerations their strengths and needs; and (5) a documented family-centered transition plan that takes into consideration the individual needs of the child and caregiver, outlines the pre-and-post reunification caregiver expectations, and the DCF oversight and monitoring of the family to ensure child safety.

ACTION TAKEN BY DCF #6: *DCF developed a new stand-alone Reunification Policy that will strengthen the department's practice and reinforce critical steps in the process to achieve successful reunifications. The new policy emphasizes that reunification is a process and not simply a decision that:*

- *Prioritizes safety. The period when a child transitions home is one of heightened risk and stress for both children and parents, so it's important to continuously assess child safety and risk during this time, paying special attention to a child's vulnerability and factors that can increase stress.*
- *Begins before a child enters care. The department explores potential caregivers and supports for a child anytime we work with a family. If family separation becomes necessary to keep a child safe, our work to explore safe reunification begins immediately.*
- *Involves gathering information from multiple sources that informs our understanding of a parent or caregiver's progress towards providing a safe environment for their children, including safety and risk present in a family.*
- *Demands active collaboration with parents/caregivers, children, placement providers, and collaterals to help determine a family's readiness for reunification.*
- *Requires a plan and the ability to adjust that plan, as needed. It is common for clinical challenges to arise as the department works towards reunification. These challenges are expected and are opportunities for readjusting our plan and goals through team decision-making.*

Immediate Response: Implemented Reunification Reviews & Interim Reunification Policy - *In March 2021, DCF began routine reunification-focused meetings between DCF managers, staff, and contracted providers. In May 2021, the Department implemented an Interim Reunification Policy which calls for tri-level (social worker, supervisor, and manager) reviews of all cases with an anticipated reunification date that is within 120 days. This team-based review approach emphasizes improved parental capacities, rather than completion of tasks in an action plan, to determine if reunification is safe and appropriate. Subsequent to each review, legal and clinical managers are required to address disagreements and approve case recommendations.*

Reunification Conferences - *DCF developed and hosted multiple Statewide Reunification Conferences for supervisors and area program managers throughout the spring and early summer, beginning in May 2021, at which the Interim Reunification Policy was introduced and officially rolled out in the days that followed. This Interim Reunification Policy formally established the new reunification review process DCF developed in March, and it was implemented at all area offices across the state by the end of June 2021. This review process ensures that managers are actively involved in evaluating the family's readiness to reunify.*

Reunification Policy - *The new policy is scheduled to go into effect in April 2022. Beginning in April 2021, a policy workgroup was established to conduct a comprehensive review of national standards and best*

reunification practices in child welfare. Once research and review had been completed, the workgroup proceeded to draft, negotiate and finalize DCF's new Reunification Policy in September 2021. Technical policy training is scheduled for completion in March 2022.

In addition to the themes outlined above, the new Reunification Policy focuses on assessing indicators of a parent's capacity to safely care for a child, such as mental health, coping skills, and sobriety. The policy requires:

- *A reunification plan for every child and a reunification review at the managerial level before a child can return home.*
- *Social workers to contact collaterals who work with parents and children or see them regularly (e.g., service providers, schools, and family members) and to document the conversations in the electronic case record system before meeting with their supervisors to discuss and finalize the reunification plan.*
- *Social workers, supervisors, and managers to consider whether the parent has the capacity and willingness to make appropriate educational decisions for the child upon reunification. If it is determined the parent does not, the clinical team must consider retaining custody after the child is reunified and ensuring the Educational Decision Maker (EDM) continues in their role or a new EDM is established.*
- *DCF staff directly involve parents and other family members in reunification planning to help prepare parents to transition back to a full-time caregiving role. Once the child returns home, social workers will conduct in-person visits according to the specific needs of the family and maintain regular contact with collaterals.*

RECOMMENDATION # 7: The DCF administration should review their current processes for safety assessment and develop an evidenced-based process for assessing safety that includes (1) a structured framework for examining the potential safety of a child within a family unit; (2) the actions that should be taken because of the safety assessment; (3) how the findings will be communicated to the family; and (4) how and when safety assessment should be used as a tool for monitoring.

ACTION TAKEN BY DCF #7: *Risk assessment helps analyze the strengths of the family, and the needs of the family, in order to keep children safe. Therefore, the review to determine if reunification should occur should include the use of an evidence-based reunification assessment tool. Based on the outcome on the risk assessment tool, along with information about the family history, and participation in the services outlined in the action plan, DCF can determine whether the caregivers have shown measurable progress and change to mitigate the abuse and neglect concerns that initially led to the removal of the child from their care. If this progress and change have been shown, and reunification is deemed appropriate, DCF can develop and document realistic and individualized pre-and-post reunification transition plans.*

Initial Re-Training - *Between October 2020 and January 2021, more than 300 supervisors in all 29 DCF area offices participated in mandatory training on assessing child safety, risk, and parenting capacities and were retrained on the department's existing risk assessment and reassessment tools. The risk*

assessment and reassessment tools work similarly to the instruments used by the criminal justice system to predict the likelihood of reoffending. In child protection, DCF seeks to identify children who are more likely to be abused or neglected again to engage families in ongoing services to reduce the potential for future harm.

***Assessment Tools** – Beginning in May 2021, DCF began the development of an RFR for new Structured Decision-Making (SDM) tools, DCF looked to hire a vendor to design, validate and implement nationally recognized, research-based actuarial tools, including a reunification tool. This research-based actuarial tool will be used to assess child safety and risk before reunification, using the same evidence-based approach as introduced in DCF's Protective Intake Policy. The tool will incorporate specific factors in child welfare cases in Massachusetts, validated by DCF data.*

In July 2021, DCF contracted with Evident Change, a nationally recognized leader in child safety and risk assessment. DCF and Evident Change conducted a series of five core team meetings with internal and external stakeholders to inform the development of the SDM tools. As a part of discovery activities, the Department concurrently worked with Evident Change to identify administrative data elements required for informing SDM tool development. DCF policies were also forwarded to Evident Change to inform SDM tool development. Evident Change is now engaged in SDM discovery activities. These include DCF policy and practice review, data analysis of the de-identified administrative data, and focus groups with DCF social workers, supervisors, managers, specialists, and external stakeholders to better understand policy and practice—especially as they relate to the assessment of safety. Findings from these in-depth discovery activities will inform SDM tool design and these activities are anticipated to be completed by August 2022.

Timelines for completion of work products:

- *SDM Safety Assessment and Substitute Care Provider Safety Assessment design is anticipated to be completed in September 2022.*
- *SDM Reunification Assessment design and customization are scheduled to be completed by February 2023.*
- *SDM Assessment Curriculum development and training is anticipated to be completed by June 2023.*

RECOMMENDATION # 8: The DCF administration should develop guidance and training for the DCF workforce that sets standards clarifying (1) which families are appropriate for virtual home visits; (2) when a family previously approved for virtual home visits must be transferred to in-person visitation only; (3) how to recognize warning signs and assess safety and well-being of a child during virtual home visits; and (4) indicators of child abuse and neglect during virtual home visits.

***ACTION TAKEN BY DCF #8:** In March 2021, DCF offices reviewed high-risk families who had received only virtual visits since the early stages of the COVID-19 pandemic and prioritized these families to be seen in person. The Department fully resumed routine in-person visits for all families, effective April 26, 2021.*

Currently virtual visits may only be used to supplement in-person visits. An updated Virtual Home Visit Guidance has been implemented which addresses best practices in post-COVID-19 use of telehealth strategies in child protection. The guidance offers detailed tips and reminders to social workers on what elements they should examine most closely to assess the safety of the child and some strategies on how best to do this virtually. This may include physical appearance, emotional and mental presentation of the child and caregivers, their interactions with others, the condition of the surrounding environment/home, and any significant deviation from previous patterns/observations (i.e. home looks significantly more cluttered, caregiver looks more disheveled, etc.). The Department developed a web-based training for staff on the content of this guidance and reinforced a focus on indicators for when a child may be abused or neglected.

RECOMMENDATION # 9: The DCF administration must enhance its quality assurance infrastructure to provide additional levels of qualitative monitoring and to create feedback loops that promote a culture of continuous learning.

ACTION TAKEN BY DCF #9: *The Department's CQI unit was established in 2015 and conducts numerous focused reviews each year to examine practice collaboratively with DCF Offices. The CQI unit develops and utilizes case review modules to assess fidelity of practice to DCF policies. Findings are shared with agency leadership at the area, regional, and central office levels to ensure the policy is reflected in practice and to inform refinement of policy and guidance as needed. The CQI unit develops regional and area office expertise on the methods and tools of CQI. In addition to the Department's internal CQI function, the federal government requires that states participate in additional quality assurance reviews called the Child and Family Services Reviews (CFSR). From July 2017 through December 2021, 630 cases were reviewed. With the expansion of the CQI Unit, starting in January 2022, 100 randomly selected cases will be reviewed every 6 months.*

Case Review Protocols - *From May to July 2021, the Department implemented case review tools for conducting focused quality of practice reviews to expand Area Office and Regional CQI capacity. Activities on this effort included:*

- *The Administration for Children and Families-Children's Bureau (ACF-CB) Onsite Review Instrument (OSRI) is used by the CQI Unit to conduct ongoing comprehensive quality of practice case reviews (including interviews as per the CFSR model).*
- *The ACF-CB Online Monitoring System's (OMS) built-in reports were leveraged to provide focused feedback to the area, regional, and central office leadership with the first batch of OMS reports shared with field leadership in mid-July 2021.*
- *Cross-training of the area and regional office staff completed on the existing set of CQI-focused case review modules [e.g., Intake/Response, Family Assessment and Action Planning (FAAP), Case Closing, Supervision]; the Department also began a process to identify the next group of key staff members to prioritize for training on these modules.*
- *CQI Unit then developed CQI-focused modules for new and updated policies upon rollout.*

Topic Specific Case Reviews - *From July to September 2021, the Department established a CQI review framework for selecting cases for review and providing feedback on cases with children and families with disabilities, substance use disorders, and mental health concerns. Activities on the effort included:*

- *Developed processes and methods for completing CQI review on cases with children and families with disabilities, substance use disorders, and mental health concerns. Definitions were outlined to clarify the criteria for cases to be selected at random and case reviews were conducted.*
- *CQI Unit selected random cases that fit the criteria determined above and case reviews were conducted.*
- *After the distribution of those findings, subsequent reviews were completed on a subset of the original cases selected.*

During this same period the CQI unit and Office of Management Planning and Analysis (OMPA) worked with regional and area office leadership to utilize a statewide protocol for facilitating the use of CQI-related data when reviewing cases with supervisors and social workers.

CQI Specialists & Managers - *In June 2021, to build even greater CQI capacity, the Department began the process of hiring for several new positions in the CQI Unit. All of these new positions have been filled except one, which is currently in the final stages of the onboarding process. The status/onboarding timeframe of each new hire is as follows:*

- *5 CQI Specialist positions (Social Worker III):*
  - *Southern Region – onboarded Jul-2021*
  - *Western Region – onboarded Oct-2021*
  - *Northern Region – onboarded Oct-2021*
  - *Boston Region – onboarded Nov-2021*
  - *Central Region – final onboarding steps underway; anticipated start date in Mar-2022*
- *2.0 CQI Quality Manager positions (M-V):*
  - *QM #1 – onboarded Jan-2022*
  - *QM #2 – onboarded Feb-2022*

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION AND FALL RIVER PUBLIC SCHOOLS

Under Massachusetts law, children ages six to 16 are required to attend school.[13] The Department of Elementary and Secondary Education (DESE) implements state education policy as set by the Board of Elementary and Secondary Education.

The OCA investigated how the guidance provided to districts and within districts affected David and Michael and determined that the safety net meant to protect these students and provide them with the opportunity to be educated failed. Fall River Public Schools failed to provide David and Michael with a free and appropriate public education (FAPE) during the period discussed in the investigative report because David and Michael never received any academic instruction or related special education service. This failure to provide these students with the education that they were entitled to is a direct result of the complexities that the COVID-19 pandemic presented. This situation occurred despite the belief of the Fall River Public Schools administration that they were following the DESE guidance provided to the district. The disconnect between the guidance that DESE provided and the lack of the implementation of any education service provision suggested that there must be a statewide reevaluation of what the baseline requirements are for students to receive education in the Commonwealth and the resources and legal authority for DESE to enforce those baseline requirements on a timely basis.[14] As a result of these findings, the OCA outlined seven recommendations to remedy that failure.

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

As noted previously in this investigation status report, and as detailed more below, the OCA was invited by DESE to collaborate and consult on the implementation of the recommendations in the report. The OCA availed itself of every opportunity to consult and has been meeting with DESE quarterly to discuss implementation as well as other issues relevant to education in the Commonwealth. The OCA notes that DESE expedited the recommendations implementation and did so with sincere commitment to the themes that the investigative report highlighted.

On February 16, 2022, the Department of Elementary and Secondary Education submitted to the OCA the following statement and information about their implementation of the recommendations:

DESE has implemented all the recommendations as detailed below and greatly appreciates the feedback and support that the OCA has provided to DESE throughout this process. Student safety and well-being are of paramount importance to DESE, and we are committed to continuing to work collaboratively with the OCA and other stakeholders on continuing to improve safety and well-being of Massachusetts

[13] M.G.L. c. 76 § 1. Children in Massachusetts ages six to 16 are required to attend school in Massachusetts.

[14] The DESE Public School Tiered Focused Monitoring System reviews school districts every three years. More information is available at: Public School Tiered Focused Monitoring System - Office of Public School Monitoring (PSM) (mass.edu)

students through a variety of means, including guidance, technical assistance, professional development opportunities, and grants.

RECOMMENDATION # 1: Educators must be adequately trained on DESE and Fall River Public Schools (FRPS) expectations for education during the shifting scenarios of COVID-19 and given specific training on how to identify student safety concerns during the provision of virtual and/or remote education.[15]

During the spring of 2021, the most important step that DESE took was to require school districts to provide full-time, in-person education to K-12 students across the state. DESE provided significant support to school districts to facilitate safe in-person learning for students, including establishing a statewide school-based COVID-19 testing program and a Rapid Response Team to answer questions and provide support to school and district leaders to maintain in-person learning. The vital shift to full-time, in-person education has allowed educators to more quickly identify and address student safety concerns.

In addition to returning students to full-time, in-person learning, DESE also launched a reusable eLearning module for educators across the state to help them identify student safety concerns during in-person learning and remote learning in the extremely limited circumstances in which it may be used. The reusable eLearning module is based on DESE's updated Promoting Student Engagement, Learning, Wellbeing and Safety guidance, which was improved with input from the OCA and stakeholders across the state and shared widely through webinars and the Commissioner's Weekly Update. Both the reusable eLearning module and the guidance document contain sections that specifically highlight how to identify student safety concerns during remote learning. In the guidance and the reusable eLearning module, DESE reminds educators that a daily visual "live check-in" is required for students learning through the remote model of instruction and provides guidance on how to conduct the live check-in in a manner that is respectful of the student's individual needs. In addition to the reusable eLearning module and the updated guidance document, DESE also created ready-made slides that schools and districts can easily use locally to remind educators about ways to identify student safety concerns, including any safety concerns about students who may be learning remotely.

Based upon the feedback from the OCA and other key stakeholders, DESE has made its resources more readily accessible through various means and more easily understood by school administrators and educators. DESE has made available to school and district administrators and educators a wide range of professional development opportunities intended to help them identify and address concerns about student safety and well-being, whether students are learning in-person or remotely. For example, in the fall of 2021, DESE offered a mental health six-part series through the Partnerships in Education and Resilience (PEAR) that focused on Reimagining Belonging; Connection and Reconnection: Structure, Agreements, and Rituals; Relationships and Identity; Understanding the Moment from a Mental Health Perspective; How Do We Know What Students are Going Through; and A New Vision of the Three Tiers of Support: During the Pandemic and Beyond. Similarly, DESE is offering Youth Mental Health First

[15] DESE assumes that the OCA will obtain an update from FRPS as to FRPS' implementation of the recommendations that were specifically directed to it.

Aid (YMHFA) training sessions to school administrators, educators, and other school staff who want to better recognize, support, and refer to professional mental health services, if needed, students who may be experiencing mental health challenges or who may be in crisis.

RECOMMENDATION # 2: Districts should explicitly link attendance in remote and hybrid models to the actual participation of students in their education and follow all established policies and procedures for investigating and addressing attendance issues. Districts should require some visual observation of students who are being educated remotely as a requirement of attendance.

As described above, DESE has adopted a requirement for a daily visual "live check-in" for students learning through a remote or hybrid model of instruction in the rare instances where such models are permitted. DESE also requires teachers and administrators to communicate regularly with any students learning through a remote or hybrid model, as well as with the students' parents. 603 CMR 27.08(3)(b)4. DESE also requires districts to have in place procedures for tracking participation and attendance of students learning through a remote or hybrid model. 603 CMR 27.08(3)(b)1. DESE has also issued Guidance for Attendance Policies, which reflects contributions and feedback from the OCA and other key stakeholders. The Guidance for Attendance Policies discusses in detail written attendance policies, procedures, and best practices for preventing and addressing attendance issues. It also provides districts with resources, such as the Attendance Plan Reflection Tool for Local Education Agencies, which is designed to assist districts with assessing and improving their attendance policies and practices. DESE has shared the Guidance for Attendance Policies with districts through the Commissioner's Weekly Update and is also in the process of discussing it with school personnel across the state.

In its reusable eLearning module, Promoting Student Engagement, Learning, Wellbeing and Safety guidance, and related slides, DESE discusses the importance of using attendance as a tool for engagement and safety, including by establishing and following policies and protocols that convey the importance of regular attendance and engagement, outline circumstances for when schools will check-in with students and families, how this will take place and be documented, and establishing clear expectations about when the school must have direct contact with students. In addition to emphasizing to schools and districts the importance of establishing policies and procedures for investigating and addressing attendance issues, in the spring of 2021, DESE also publicly published the attendance data it had collected up to that point in the school year so that schools and districts could use it to address attendance issues before the school year ended.

In the spring of 2021, DESE in partnership with TNTP, a national education nonprofit that has extensive experience supporting school districts for more than two decades, also released the School Leader Edition of the Acceleration Roadmap and the Classroom Educator Edition of the Acceleration Roadmap. The Acceleration Roadmap discusses in detail the importance of fostering a sense of belonging and partnership with students and families. The Acceleration Roadmap also provides links to resources that are designed to help educators target supports to groups of students who need additional help to overcome barriers to attendance and participation. DESE continues to provide targeted professional development opportunities for school leaders and classroom educators about the Acceleration Roadmap strategies, which include setting of clear expectations for student participation and engagement,

monitoring and following up on attendance data. DESE has posted the Acceleration Roadmap webinars that have taken place thus far on its website, as well as the dates of future webinars. DESE and TNTP also offer drop-in professional development workshops for school leaders.

RECOMMENDATION # 3: Districts, including FRPS, should have written policies or procedures that require documentation of educator concerns for student and family safety and such documentation should be reviewed by all appropriate staff during any critical transition.

In DESE's updated Promoting Student Engagement, Learning, Wellbeing and Safety guidance and reusable eLearning module, DESE instructs districts to create communications plans and make them readily available to staff to help maintain strong, consistent, and ongoing communications about students' needs. DESE provided school districts with sample questions for creating individualized communications plans, and described various means for documenting, tracking, and addressing concerns about student and family safety. For students with more intensive needs, DESE discussed the importance of relying on the Student Support Team to collaboratively identify intervention strategies that maximize school, family, and community-based supports, including establishing supportive relationships that students can rely on when experiencing challenges. DESE also discussed the importance of ensuring that information about the student's attendance status is shared among those who are engaged with the student, such as the classroom teacher, special education team, and Student Support Team, as absenteeism can often be a key sign of challenges and must be addressed promptly.

In addition, on October 28, 2021, DESE and DCF published the updated Joint DESE/DCF Advisory Regarding Mandated Reporting Responsibilities of School Personnel in Cases of Suspected Child Abuse and Neglect, which incorporated feedback from the OCA and other stakeholders. The updated joint guidance recommends that schools and school districts develop written reporting protocols, both for efficiency and so that school administrators and other relevant individuals are informed about children who may be at risk. The updated joint advisory explains that once a protocol is developed, the school or school district administration is responsible for ensuring that school staff know, understand, and follow the protocol throughout the year. During its webinars about the joint mandated reporting advisory, DESE provided school districts with information about the Massachusetts Children's Trust Designing & Implementing a School Reporting Protocol. DESE discussed the key considerations for designing a reporting protocol, training staff on it, and the role of child protection teams in communicating concerns about student safety and well-being at critical transitions.

To assist school districts in establishing comprehensive systems for addressing student safety and well-being concerns, DESE offers a variety of Multi-Tiered Systems of Support Academies, including an academy specifically focused on helping schools "develop the skills, knowledge, and internal capacity necessary to provide a system of integrated student support for all students" and establishing "a solid and comprehensive tracking system that is streamlined for scalability" across schools.

DESE has also made available a variety of grant programs to help school districts support and improve student safety and well-being, including a grant specifically targeted to adapting, expanding, and strengthening multi-tiered systems of support to respond to the social-emotional and behavioral health

needs of students, families, and educators and to build strong partnerships with community-based mental health agencies and providers.

DESE's Statewide System of Support Regional teams also provide comprehensive assistance to districts and schools that is differentiated by need, including structured opportunities for teachers, administrators, and district leaders to engage in activities including coaching, action research, facilitated work teams, professional communities of practice, and resource networking.

RECOMMENDATION # 4: DCF and DESE should collaborate to determine operating guidelines for information sharing that respects confidentiality but communicates clearly the challenges faced by the family to facilitate student safety and education.

On October 21, 2021, DESE and DCF issued a joint guidance document entitled DCF's Access to Students' Education Records, which incorporated feedback from the OCA and other stakeholders. The joint guidance facilitates access by DCF social workers to education records of students in DCF custody. The joint guidance specifies that when DCF has custody of a student, it is expected that the DCF social worker assigned to the student will have access to that student's education records. The joint guidance document further explains that "DCF social workers should be provided with access of the same type and degree as parents to online portals" and "other communication protocols used by districts and schools to share education records and data about individual students." Moreover, the joint guidance specifies that "districts and schools that offer web-based or online access to student-specific data on attendance and education progress should extend such access to the DCF social worker." DESE and DCF have been discussing this joint guidance during trainings and networking sessions, which have been attended by nearly 300 participants from school districts and DCF. During the networking sessions, participants had opportunities to share challenges and solutions for improving communications between districts and social workers. Increased sharing of education records, school attendance data, and other information in a manner consistent with confidentiality is one important way that school districts and DCF are promoting student safety and well-being together.

RECOMMENDATION # 5: DESE and the DCF administration should collaborate and determine how districts should ensure DCF has access to regular attendance updates for all students who are in the legal custody of DCF.

On July 30, 2021, DESE and DCF updated their joint memorandum of understanding to enable DCF to regularly provide DESE with information about students in its custody and care and DESE to regularly provide DCF with detailed data relating to those students. Data transferred from DESE to DCF includes Student Information Management System data, MCAS data, School Safety Discipline Reports, Student Course Schedule Reports, and attendance data.

RECOMMENDATION # 6: Joint DESE and DCF guidance on mandated reporting responsibilities should be updated to include that child abuse and neglect reports should be filed even during open DCF cases or when there is court involvement with the family. The DCF administration should critically review their internal practice and culture to eliminate any negative response to any mandated reporter seeking to file a report on an open case.[16]

On October 28, 2021, DESE and DCF issued an updated version of the Joint DESE/DCF Advisory Regarding Mandated Reporting Responsibilities of School Personnel in Cases of Suspected Child Abuse and Neglect, which incorporated feedback from the OCA and other stakeholders. The updated joint advisory specifically explains to mandated reporters that even if there is current DCF or court involvement with a family or a child at the time of the suspected abuse or neglect, the mandated reporter must still make the required report if the reporter has reasonable cause to believe a child is being abused or neglected. The updated advisory further explains that "[e]ven if the reporter has raised concerns to the child's DCF social worker, the reporter must still make the required report." During its webinars about the updated joint advisory, DESE specifically highlighted those portions of the advisory. DESE has made available a recording of its webinars about the updated joint advisory on its website for schools and districts to use.

FALL RIVER PUBLIC SCHOOLS

As noted previously in this report, the OCA does not have an oversight role over any local education agency including Fall River Public Schools. However, Fall Rivers Public Schools cooperated fully with the OCA's investigation and has never denied the OCA information or updates regarding their work related to this case. The OCA acknowledges the difficult and important work that Fall River Public Schools has completed in the wake of David Almond's death.

On February 16, 2022, the Fall River Public Schools submitted to the OCA the following statement and information about their implementation of the recommendations:

Since the release of the internal review and the OCA report, Fall River Public Schools has worked diligently to improve upon a number of district policies and procedures to ensure that we are meeting the needs of our most vulnerable students. We have adopted, or are in the process of adopting, all of the recommendations contained in both the OCA report and the internal report.

Our School Committee established a commission to review all policies and procedures related to the findings of the investigative reports and made a full presentation with the recommendations to the School Committee last summer. The "Almond Commission", comprised of members representing Fall River Public Schools, the Department of Children and Families Regional Office, the Fall River Police Department, the Fall River Juvenile Court, engaged in a process of examination and reflection which resulted in a set of recommendations that will further contribute to the district's response to this tragic incident. Overall, the Commission found that the written policies and procedures that were in place at the time of the incident were sufficient and the focus of improvement should be centered on

[16] DESE assumes that the OCA will obtain an update from DCF as to DCF's implementation of the recommendations that were specifically directed to it.

strengthening implementation across the district. In some cases, the Commission found that some of the district's procedures first need to be documented and disseminated to ensure consistency across the system. The inquiry focus on structure and implementation resulted in rich discussions and an expressed desire to deepen overall collaboration between several of the city agencies that interact with children and families in the city of Fall River.

In addition to providing clearer guidance on mandated reporting, the Student Services department has strengthened its relationship with the Fall River area office of the Department of Children and Families. The leaders of both organizations communicate with each other regularly to collaboratively problem-solve difficult cases.

The FRPS staff have been directed to file a 51A report of abuse and/or neglect, in addition to notifying the assigned DCF social worker. We have communicated this expectation with our building leadership, and this has been communicated with staff as well. In June 2021, we partnered with the Children's Advocacy Center (CAC) to provide district-wide professional development session on mandated reporting and standard operating procedures within the chain-of-command, as well as the signs and signals of child abuse and neglect provided by district staff, legal counsel, and the Child Advocacy Center of Fall River.

FRPS has adopted new student information system (SIS) that will provide greater real-time communication to families in multiple languages and live "flagging" ability to alert us to negative attendance trends. While FRPS continues to navigate the challenges posed by the Covid-19 pandemic, our return to full in-person instruction has enabled us to monitor and provide "just in time" interventions for students who are at-risk of becoming or are chronically absent.

The FRPS community has learned a great deal from David Almond's tragic death. At FRPS, it is our collective hope that the improvements we have made to our school system and the strengthened partnerships with other local agencies will prevent other vulnerable students from falling through the cracks.

THE MASSACHUSETTS JUVENILE COURT

The Massachusetts Juvenile Court Department oversees statewide civil and criminal matters involving children including youthful offender, care and protection, and delinquency cases. A Care and Protection petition is the beginning of a legal case in which a Juvenile Court judge determines whether a child is at risk of being, or has been, abused or neglected by a parent or caregiver. If a Juvenile Court judge determines that a child is at risk of abuse or neglect, or has been abused or neglected, then the Court may find that a child needs care and protection and has the authority to determine the permanent legal custody of that child.

On October 5, 2017, Care and Protection Petitions were filed with the Bristol County Juvenile Court Department regarding David, Michael, and Noah, as well as their younger half-sibling Aiden.

In July of 2019 David, Michael, and Noah were formally found by the Court to need care and protection and remained in DCF legal custody. That same month, Aiden was reunified with Mr. Almond and Ms. Coleman. In January of 2020, the Care and Protection petition as it related to Aiden was dismissed. David, Michael, and Noah remained in congregate care placement.

On March 13, 2020, only David and Michael were reunified with their father Mr. Almond and his non-marital partner Ms. Coleman. DCF retained legal custody of David and Michael at that time. On the next court date, July 17, 2020, the DCF Fall River Area Office recommended the return of David and Michael to the legal custody of their father and for Noah to remain in the care of DCF, a plan that was agreed upon by all attorneys and which the Court approved.

In this investigation, the OCA found the length and time of the litigation and custodial decisions colored the substantive issues in this case. The length of time that the children spent in care prior to a hearing on the merits resulted in a loss of momentum in the legal case and resulted in a lack of attention to the original concerns that brought the case to the Juvenile Court. The investigation also found that the Juvenile Court and the attorneys involved did not adequately weigh or monitor the risks to the children due to the lack of a clinical formulation for the family. Finally, the investigative report found that critical information, including information about the children's schooling and information about other persons in the family home, were not presented to the Court.

As a result of the investigative report findings, the OCA made seven recommendations aimed at improving the Juvenile Court system. As noted previously in this investigation status report, the OCA does not have any oversee authority of the judicial branch. We continue to have a positive relationship with the Judiciary and appreciate their forthright cooperation with our requests for information. The OCA has not played an active role in the implementation of these recommendations in the judicial branch, but we have been kept appraised of their efforts both through their proactive outreach to our office and upon our requests for meetings.

On February 16, 2022, the Juvenile Court submitted to the OCA the following statement and update about their implementation of those recommendations:

In the year since the Office of the Child Advocate (OCA) released multi-system recommendations in its investigative report regarding the case of David Almond, the Juvenile Court has continued strengthening its efforts to prioritize the safety, stability, and permanency of children. The Court has worked collaboratively and in partnership with child-serving stakeholders and leadership dedicated to addressing the complex challenges inherent in the work of child welfare. Discussion among department, agency, and judicial leadership continues to focus on the need for judges to receive information critical to decisions about custody of children and the ability of court participants to provide information according to their respective roles.

RECOMMENDATION # 1: The Juvenile Court should conduct an analysis of the speediness of Care and Protection proceedings and the effect that speediness may have on the outcome of the cases and the safety and welfare of the children involved.

*The Massachusetts Juvenile Court launched the **Pathways**[17] initiative in 2019, implementing a differentiated case flow management statewide to improve legal permanency by ensuring fair, just, and prompt resolution of cases through individualized assessment of each case, each child, and each family. Integral to the **Pathways** approach is comprehensive, timely and continual child-centered case assessment, including ongoing assessment of reasonable timeframes for addressing gaps between caregivers' skills and abilities and subject children's needs.*

*A series of bench cards, detailed below, facilitate this judicial inquiry, including an "Essential Questions to Ask at Each Hearing to Promote Permanency" bench card (see Appendix A) that continues to be widely disseminated and referenced among court participants such as the Department of Children and Families (DCF) and the Committee for Public Counsel Services (CPCS). Additionally, **Standing Order 5-21: Return of Custody in Care and Protection Proceedings**, which was issued in December 2021 by the Administrative Office and the Chief Justice of the Juvenile Court, directs judges to "be mindful and vigilant of the duration for a child awaiting permanency in all cases." (See Appendix B)*

*In conjunction with supporting case-specific assessments of factors impacting care and protection case outcomes, **Pathways** furthers differentiated case flow management by developing and sustaining dynamic and responsive multi-disciplinary systems to serve children and families. The Administrative Office of the Juvenile Court works directly with judicial leadership in each of the 11 Court divisions to support case flow management particularized to the current needs, resources, challenges and opportunities in each court and each community. The Administrative Office and Juvenile Court judges engage in cross-sector coordination by convening systems partners to address barriers to permanency, safety, and stability for children and ultimately enhance the capacity of our communities to serve children and families at risk.*

[17] *Pathways* also brings together multidisciplinary teams of stakeholders to address issues and outcomes in that court division, identifying challenges and needs while prioritizing inquiry by judges to elicit information necessary for effective decision-making and charging attorneys with providing that specific information crucial to differentiated case management.

As the timeliness of a care and protection proceeding is interrelated to other factors affecting the safety and wellbeing of a child, the Juvenile Court has partnered with the Community Justice Project of the Executive Office of the Trial Court (EOTC) to develop Massachusetts Upstream and map the child welfare landscape from a prevention and intervention-based perspective, bringing together multi-disciplinary community stakeholders to identify resources and gaps in resources, systems, and processes in order to reduce the likelihood and duration of involvement in the child welfare system and Juvenile Court. (See Appendix C)

RECOMMENDATION # 2: The Court should hold DCF responsible for linking the family's action plan to the clinical needs of the family. The Court should require that DCF update all parties and the Court on the clinical needs of the family at each court date.

The "Essential Questions to Ask at Each Hearing to Promote Permanency" bench card, which has been referenced and utilized by clinical and legal participants in preparation for and presentation in court hearings, specifically directs inquiry about "the collaboratively developed plan to return the child safely home", also known as the action plan. These "Essential" questions are designed to be asked at each hearing to elicit information regarding specific barriers to reunification for that child and efforts undertaken by DCF to decrease the child's time in foster care.

RECOMMENDATION # 3: The Court should specifically inquire about school success at each court date where the well-being of a child is being discussed.

The "Pathways Essential Questions to Promote Education Stability" bench card was introduced in October 2020 (see Appendix D). This bench card facilitates inquiry into school success at each hearing so that participants address the educational circumstances of the child at the earliest meaningful opportunity in the court process and each time thereafter. This inquiry is particularly important as the educational landscape has changed over the past several years during the Covid-19 pandemic.

RECOMMENDATION # 4: The court should revisit, on the record, the reason the children were brought into the care and custody of DCF at the beginning of the case before determining whether care and custody should be returned.

*Following a thorough, responsive, and public process, the Juvenile Court issued **Standing Order 5-21: Return of Custody in Care and Protection Proceedings** concerning the return of custody to a parent, custodian, or guardian. Among the extensive factors for judges to identify and consider when making such determinations, the **Standing Order 5-21** specifies "the original danger(s) that led to the removal of the child."*

The Administrative Office of the Juvenile Court also released, in April 2021, the "Assessing Danger, Risk, and Safety" bench card, developed in partnership with the non-profit organization Evident Change. This bench card supports judges in assessing danger, risk, and safety throughout care and protection cases, including by directing at each court event inquiry into the original danger that led to the case and whether other dangers have been identified (see Appendix E). The Chief Justice of the Juvenile Court

mandated judicial education on "Assessing Danger, Risk and Safety" at a training held virtually in April 2021.

RECOMMENDATION # 5: The Court should be permitted to assign court investigators to provide court investigation reports at times other than at the onset of a Care and Protection case. The Court should appoint guardian ad litem to evaluate the interests of the child(ren) prior to transfers of custody.

*Juvenile Court **Standing Order 5-21: Return of Custody in Care and Protection Proceedings** outlines that a judge may order an updated court investigation or appoint guardian ad litem (GAL) or Court Appointed Special Advocate (CASA) prior to issuing the custody order to a parent, custodian, or guardian.*

RECOMMENDATION # 6: The Court should consider placing legal conditions on the reunification of any children and on any custodial changes. The court should indicate their reasoning for placing conditions or not placing conditions on the record at relevant court hearings.

*Juvenile Court **Standing Order 5-21: Return of Custody in Care and Protection Proceedings** details how temporary and permanent custody orders returning custody to a parent, custodian, or guardian must be in writing and must specify conditions set or reasons why conditions are not necessary in the case. The **Standing Order 5-21** lists conditions that the court may consider setting, but is not limited to setting, when applicable.*

RECOMMENDATION # 7: During the continued COVID-19 pandemic, the Court should make specific inquiries into DCF safety assessments prior to the reunification of any children or changes to custody. The Court should also specifically inquire of the attorney for the child what particular concerns COVID-19 presents for a specific child; attorneys representing children should make inquiries independent of DCF to be able to adequately answer this question.

*As noted above, integral to the **Pathways** approach of differentiated case flow management is comprehensive, timely and continual child-centered case assessment, including ongoing assessment of reasonable timeframes for addressing gaps between caregivers' skills and abilities and subject children's needs. The bench cards and **Standing Order 5-21** detailed previously and attached here support Juvenile Court judges in making specific inquiry regarding the safety and well-being of the child, including inquiry about any assessments made by DCF, concerns or efforts of the child's attorney, and circumstances caused by the COVID-19 pandemic or any other illness.*

*Finally, crucial to the success of the Juvenile Court's efforts to improve outcomes for children is cross-systems coordination. The **Pathways** initiative serves as an organizational umbrella for programming and projects that address barriers to safety, stability, and permanency for children through case flow management and systemic strategies such as "Massachusetts Upstream."*

"Massachusetts Upstream" engages judges as convenors and leaders in the child welfare landscape to enhance the safety net for children and families by collaboratively identifying resources and gaps and facilitating community-based actions for change. The systems, communities, and partners engaging in

"Massachusetts Upstream" are poised to address the complex needs of vulnerable children, particularly those living in families affected by substance use disorder and mental or behavioral health issues. This mapping serves as a needs assessment for the $1.5 million grant from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), recently awarded in December 2021, to implement and expand Family Treatment Court best practices throughout Massachusetts Juvenile Courts and to establish dedicated Family Treatment Court sessions where appropriate. The Juvenile Court is also partnering with the Trial Court to build the "Massachusetts Juvenile Court Virtual Resource Hub" which is intended to support and elevate the level of practice and engagement in Juvenile Court processes, prioritizing user experience. The goals of the "Virtual Resource Hub" include improving case outcomes for children and their families, increasing access to justice, and empowering participants to make informed and meaningful decisions by providing a centralized, accessible, accurate, and current source to learn about the Juvenile Court system and proceedings, find relevant law and documents, and access community resources. Such efforts reflect the Juvenile Court's multi-disciplinary and differentiated approach to case flow management, which is signature of the ***Pathways*** *initiative and centers on individualized assessment of each case, each family, and each child. (See Appendix F)*

THE MASSACHUSETTS PROBATION SERVICE

The Massachusetts Probation Service (MPS) serves many functions across its various roles in the Commonwealth. MPS works with the courts, state agencies, and individuals. In Care and Protection proceedings, the assigned Probation Officer's role is to verify compliance with court orders on the case, report to the Court regarding the status of those court orders and monitor the well-being of the children in the case. The level and frequency of the Probation Officer's contact with the children and the family in a Care and Protection case is determined by the placement of the children: whether the children are placed by DCF in foster care or other residential program, or whether the children are in the home with their caregivers. A Probation Officer has the power to bring an open court case into court before the regularly scheduled court dates, also known as "advancing the case," if the Probation Officer finds that any of the parties on the case are not complying with court orders or if there is a threat to a child's health or welfare. The assigned Probation Officer is also required to review criminal offender information (which includes CORI information, juvenile record information, and out of state information) for each household member every month and bring that information to the attention of the court. MPS also maintains ongoing contact with DCF about the family and the risks to the children.

In this investigation, the OCA found the role of the MPS in the Care and Protection of David and his siblings was not leveraged by the Court or the DCF Fall River Area Office. The Court chose not to place any legal conditions on the custodial changes in this case. When the assigned Probation Officer raised concerns about the family to the DCF Fall River Area Office, they were downplayed and dismissed. MPS did not bring these concerns to the attention of the Court between court dates.

As a result of these findings, the OCA made three recommendations aimed at improving the MPS. As noted previously in this investigation status report, the OCA does not oversee the judicial branch in any way including MPS which is a judicial branch department. We continue to have a positive relationship with the judicial branch and appreciate their forthright cooperation with our requests for information. The OCA has not played an active role in the implementation of these recommendations in the judicial branch but we have been kept appraised of their efforts both through their proactive outreach to our office and upon our requests for meetings.

On February 15, 2022, the MPS submitted to the OCA the following statement and information about their implementation of those recommendations:

On March 31, 2021, the Office of the Child Advocate (OCA) released its Findings and Recommendations stemming from the multi-system investigation into the death of David Almond of Fall River. Subsequent to the issuance of the OCA Report, the Massachusetts Probation Service joined efforts with the Juvenile Court Department and the Department of Children and Families to review the findings in the report and to implement its recommendations. This effort included a joint committee, created in July 2021, comprised of subject matter experts on staff in both the MPS and DCF focused on those finding and recommendations common to both agencies. An operational MOU is in development and should be finalized in the very near future.

Summarized below are the responses to the three findings and recommendations specific to the Massachusetts Probation Service. These responses reflect the full collaboration and cooperation among the three entities - AOJC, DCF and MPS - as well as the hard work, focused commitment, and professionalism of all of the staff who have worked directly in this effort.

RECOMMENDATION # 1: MPS should institute policies and procedures to ensure that Probation Officers are prepared to present detailed recommendations to the Court concerning conditions to be placed on custodial arrangements if the Court is inclined to place such conditions on custodial arrangements.

*The Administrative Office of the Juvenile Court (AOJC) developed **Standing Order 5-21: Return of Custody in Care and Protection Proceedings** to address the return of custody in care and protection proceeding. In section IV. of that order it requires that at the conclusion of a 72-hour hearing where custody is returned to the parent, custodian, or guardian a temporary order shall be in writing with "conditions" unless the court determines that conditions are not needed in the case.*

MPS will continue to conduct supervision and visits in accordance with our standards unless otherwise ordered by the court.

RECOMMENDATION # 2: MPS and DCF should discuss gaps in information sharing and develop a Memorandum of Understanding (MOU) that outlines the basic information that should be shared and how such information should be shared.

Together, the MPS and DCF have been developing a detailed MOU that outlines basic information sharing including guidelines for what information at what stage of the case should be shared between the two agencies. Drafting has been ongoing since the summer of 2021 and is in its final stages. We expect an MOU to be signed by both Commissioners in the very near future.

RECOMMENDATION # 3: The Juvenile Court and MPS should jointly investigate whether there is a culture of discouraging Probation Officers from advancing cases.

*In support of child welfare and the work of the MPS and system stakeholders, AOJC issued **Standing Order 5-21: Return of Custody in Care and Protection Proceedings**. **Standing Order 5-21** specifically requires the MPS to advance a case if there is belief a child's safety may be in danger or at risk and/or the parent, custodian, or legal guardian is not complying with the conditions of a temporary custody order. This order makes clear that Probation Officers have both standing and responsibility to advance cases of concern. This Order will be supported with staff education.*

*Additionally, the MPS is working with AOJC to finalize a case advancement form relative to **Standing Order 5-21**. The Form will have a section where Probation Officers can seek to advance a case and a section in which court investigators, CASAs, or GALs, will be able to notify the MPS of concerns.*

OTHER RELEVANT INFORMATION

Recommendation #5 under the Juvenile Court Recommendation includes the recommendation that "The Court should appoint a guardian ad litem to evaluate the interests of the child(ren) prior to transfers of custody." The report noted that:

> This specific case has shown that the Court would have benefitted from an on-the-record unequivocal statement, outside of the typical adversarial posture of the legal case that addressed the status of the children regarding the possible ongoing danger and risks that the children faced when returned home. The Court would have also benefitted from updated reports on the children's condition once returned home to minimize risk to the children and ensure an immediate response to new or renewed danger. (page 95 INVESTIGATIVE REPORT (mass.gov))

On February 18, 2022 Governor Baker filed "An Act Making Appropriations for Fiscal Year 2022 to Provide for Supplementing Certain Existing Appropriations and for Certain Other Activities and Projects." This bill includes a section that would mandate the appointment of a guardian ad litem (GAL) in every Juvenile Court proceeding in which it is alleged that a child has been subjected to abuse or neglect. The GAL provides children in DCF custody an independent advocate responsible for considering only the child's best interests. The bill included an accompanying appropriation request of $50 million to support the recruitment, training, and compensation of additional GALs.

The language of the proposal sets out clear and comprehensive expectations for what guardian ad litem must consider when determining what the best interest of the child is in each case. This proposal goes beyond the report's recommendation as the proposal requires the guardian ad litem to be assigned throughout the life of a case, not just prior to the transfer of custody. The OCA feels that this proposal is in the spirit of the OCA recommendations and the OCA supports this proposal. The OCA believes the Court will benefit from always having an on-the-record statement about the possible ongoing danger and risks that a child faces, including the particular strengths and vulnerabilities of that individual child, and that such information is critical to consider whenever any legal decision is being made about a child's life. Such information is also critical to consider when determine how legal decisions will be executed, including transition planning.

For more information, refer to Appendix G.

CONCLUSION

David Almond's untimely death, and the situation he and his brothers Michael and Aiden endured prior to David's death, as well as Noah's experiences, has inspired extensive change in policy and practice in the Commonwealth. The OCA believes that the investigative report, the recommendations in the report, and the implementation of those recommendations will directly affect the way that state services are provided to children and families in the Commonwealth. This is the highest calling of the OCA: to make changes on the ground that affect the real lives of children. We often operate at the policy level and we specialize in the complex interplay of multiple state agencies and entities. However, our sights are always on the street-level experience of children and families and the safety and support that those children and families need to be successful and to thrive.

To that end, the OCA not only continues to grieve David's death, but we also carry the weight of the trauma and struggles Michael, Noah, and Aiden have because of their experiences. Michael, Noah, and Aiden experienced extreme abuse and neglect while in the care of Mr. Almond and Ms. Coleman. They were not provided with the love, safety, support, and guidance every child is entitled to experience. The severity of their trauma is somewhat unfathomable and will remain with them throughout their lives.

The OCA has continued to closely monitor the state services provided to Michael, Noah, and Aiden. We have ensured that they have been provided the opportunity to start to heal from the abuse they endured, grieve the loss of David, and that they have been provided safe and stable living environments that will aide in this process. Through our monitoring of Michael, Noah, and Aiden this past year, we are reassured that the state agencies and entities involved fully recognize their responsibility to these children and are committed to ensuring they each have the services and support they need. The OCA's responsibility to the long-term well-being of Michael, Noah, and Aiden, and the state entities' efforts to support them and sustain the change implemented because of the recommendations will remain a top priority for our office.

The OCA recognizes that the hard work of child protection is an unending task and that tragedies behind closed doors can't always be prevented. The OCA's investigative report asked the Commonwealth to rise to the challenge in new and complex ways - and the Commonwealth did rise. There will always be more work to be done, there will be more policies to write and implement, more nuances to understand, more challenges, such as Covid-19, to overcome, and more children to protect. David's story is one of many, but we can say here that David's life and his death has impacted us all and for that the OCA feels both grief and gratitude.

APPENDIX A: ESSENTIAL QUESTIONS TO ASK AT EACH HEARING TO PROMOTE PERMANENCY

Essential Questions to Ask at Each Hearing to Promote Permanency

1. *What measures have been taken to prevent the placement of the child in foster care or to decrease the child's time in foster care?*

2. *What are the specific issues or barriers preventing the child from being returned home today?*

3. *What is the collaboratively developed plan to return the child safely home?*

4. *What efforts has the Department undertaken to place the child with a fit and willing relative?*

5. *How are the Department, parents, and others supporting stability (placement, school, and otherwise) for the child?*

6. *What other efforts must be made to support the child and promote timely permanency in the event that the issues or barriers cannot be ameliorated?*

APPENDIX B: JUVENILE COURT STANDING ORDER 5-21

Juvenile Court Department

Standing Order 5-21

Return of Custody in Care and Protection Proceedings

I. Purpose

The purpose of this standing order is to provide a uniform practice on the issuance and oversight of temporary custody orders granted by the Juvenile Court returning custody of a child to a parent, custodian, or guardian in a care and protection proceeding.

II. Applicability

This standing order is applicable to temporary orders returning custody of a child to a parent, custodian, or guardian in a care and protection proceeding.

Commentary

Temporary custody orders returning custody of a child to a parent, custodian, or guardian may be issued as the result of a hearing held pursuant to G.L. c. 119, §§ 24 or 25. *See Care and Protection of Manuel*, 428 Mass. 527 (1998). The Juvenile Court may also issue a temporary custody order as the result of a hearing on the merits or a review and redetermination hearing pursuant to G.L. c. 119, § 26.

III. Definitions

For this standing order the terms below shall have the following definitions:

"Danger" means imminent threat of serious harm.

"GAL Evaluator" means a category of guardian ad litem (GAL) that the court may appoint, pursuant to the *Juvenile Court Uniform Practice and Procedure Regarding the Appointment of Guardians Ad Litem*, to report on a narrowly defined issue where the judge deems an updated court investigation is not appropriate and where the appointment does not fall into one of the other categories of GAL appointments.

"Hearing on the Merits" means the trial held pursuant to G.L. c. 119, § 26, where the court determines whether the Department of Children and Families (the Department) has met its burden in proving that the child is in need of care and protection. The hearing may result in, but is not limited to, granting temporary or permanent custody to a non-custodial parent, returning temporary custody to a parent, custodian, or guardian, returning permanent custody to a parent, custodian, or guardian, granting permanent custody to the Department or the issuance of a decree terminating parental rights.

"Non-custodial parent" means the biological or legal parent of the child who did not have physical or legal custody of the child prior to the child's removal by the Department.

"Non-party" means a person who is not a party to the care and protection proceeding but may be granted temporary or permanent custody of the child, also known as a "third party custodian." See Note to Rule 9 of the *Juvenile Court Rules for the Care and Protection of Children.*

"Parent, custodian, or guardian" means the party or parties in the care and protection proceeding who had custody of the child immediately prior to the filing of the care and protection petition.

"Review and redetermination hearing" means the hearing held pursuant to G.L. c. 119, § 26(c) where a party may petition the court not more than once every 6 months for a review and redetermination of the current needs of the child whose case has come before the court, with the exception of a parent whose parental rights have been terminated by the court.

"Risk" means warning sign of a possible danger.

"Safety" means actions of protection taken by a caregiver that address danger to the child and are demonstrated over time.

"72 Hour Hearing" means the hearing held pursuant to G.L. c. 119, § 24 after the court grants temporary custody to the Department following an emergency or ex parte hearing.

IV. Return of Custody Following a Temporary Custody Hearing (G.L. c. 119, § 24, "72 Hour Hearing")

Any temporary custody order issued at the conclusion of the 72 Hour Hearing that returns custody of the child to the parent, custodian, or guardian shall be in writing with conditions, unless the judge determines that conditions are not necessary in a specific case. The judge shall set forth, in writing, the reasons why conditions are not needed in the case. The order shall be issued on a form approved and promulgated by the Chief Justice of the Juvenile Court. The temporary custody order shall remain in effect until the status hearing held pursuant to Rule 14 of the *Juvenile Court Rules on Care and Protection Proceedings*. At the status hearing, the court shall review with the parties the factors set forth in Section V. of this standing order. Probation shall be present at the status hearing unless otherwise directed by the court.

The court may in its discretion set a date for review of the order prior to the scheduled status hearing date.

V. Return of Custody Assessment

A. Assessment Factors. The court shall consider the following factors when determining whether to issue a temporary custody order to a parent, custodian, or guardian:

1. Dangers and risks, if any, to the child:

a. Identification of the original danger(s) that led to the removal of the child; identification of any additional danger(s); existence of any current danger(s).

b. Identification of any current risk(s).

2. Reasons court is being asked to issue the return of custody order:

a. The actions or services the parent, custodian, or guardian participated in, completed, or anticipate completing that demonstrate or create safety for the child. This may include a review of the action plan developed by the Department for the parent, custodian, or legal guardian that provides for services tailored to meet the underlying needs of the parent, custodian, or guardian and their compliance with such plan.

b. The opportunities the parent, custodian, or guardian has taken to demonstrate that they currently have the skills to address the dangers and risks that led to the child's removal.

3. Assessment of child's educational needs.

4. Assessment of the child's mental health care and needs, if applicable.

5. Assessment of child's physical health care and needs, if applicable.

6. Assessment of the status of child's siblings if not part of the motion requesting return of custody:

a. Plan for facilitation of sibling visits, if applicable and appropriate.

b. Siblings' current placements if not with the child who is the subject of the motion requesting a return of custody.

7. Plan for facilitation of non-custodial parent visits if applicable and appropriate.

B. Updated Court Investigation/GAL Evaluator Report. Prior to the issuance of a temporary custody order to the parent, custodian, or guardian, the court may order an updated court investigation or appoint a GAL Evaluator to report back to the court on specified issues regarding the child. The updated court investigator report or GAL Evaluator report shall be filed with the court no later than 60 days from the date of appointment. The GAL Evaluator appointment letter shall outline the GAL Evaluator's authority and scope of appointment.

Commentary

General Law c. 119, § 24 requires the appointment of a court investigator in all care and protection matters upon the issuance of the precept and notice to the parents regarding the care and protection petition. Rule 11 of the *Juvenile Court Rules for the Care and Protection of*

Children requires that the court investigator report be filed within 60 days of the initial appointment unless otherwise ordered by the court. This section of the standing order follows the same timeframe for any updated court investigator report ordered by the court.

VI. Issuance of the Return of Custody Order

A. Return of Custody Order. All temporary or permanent custody orders returning custody to the parent, custodian, or guardian, shall be in writing and on a form approved and promulgated by the Chief Justice of the Juvenile Court.

1. Temporary Return of Custody Order. Any temporary custody order issued to a parent, custodian, or guardian shall remain in effect until a date as determined by the judge that is consistent with the needs of the child and family, the circumstances of the case and that is within time standards as set forth in Juvenile Court Standing Order 2-18.

B. Conditions. The court shall set conditions in writing addressing the child's care and safety when issuing any temporary custody order pursuant to this standing order, unless the judge determines that conditions are not necessary in a specific case. The judge shall set forth, in writing, the reasons for why conditions are not needed in the case.

The court may consider setting, but is not limited to, the following conditions when applicable:

1. The Department and Probation to have access to the child at home.

2. Parent, custodian, or guardian to cooperate with the reunification portion of the Department's Family Assessment and Action Plan, if applicable.

3. Parent, custodian, or guardian to maintain all of the child's medical, dental, psychological/psychiatric and educational services and appointments. If the child has a physical disability, the parent, custodian, or guardian to maintain all services and accommodations necessary for the child. The Department shall provide the parent, custodian, or guardian the information they need to maintain the child's appointments, services, and accommodations, as well as any other necessary supports.

4. Parent, custodian, or guardian to maintain a safe home environment.

5. Parent, custodian, or guardian to remain drug and alcohol free if there is a substance use issue as determined by the Department.

6. Parent, custodian, or guardian and child to meet with the Department social worker and/or Probation.

7. Parent, custodian, or guardian and child to meet with the GAL Evaluator as ordered if one is appointed by the court.

8. Parent, custodian, or guardian and child to meet with the Court Investigator as ordered if one is appointed by the court.

Commentary

Supervision and visits by probation shall be conducted in accordance with Probation Standards unless otherwise ordered by the court.

C. GAL Evaluator and CASA. Upon the issuance of a temporary custody order to the parent, custodian, or guardian, the court may appoint a GAL Evaluator for the purpose of oversight regarding one or more specific conditions set by the court in the custody order. The GAL Evaluator shall be authorized by the court to contact the child's school, the child's medical providers and any other service providers to request information regarding the child to assist with the oversight of the specific conditions. The GAL Evaluator appointment letter shall outline the GAL Evaluator's authority and scope of appointment.

The court may appoint a court appointed special advocate (CASA) if the program is available in that court division. The CASA shall be authorized by the court to contact the child's school, the child's medical providers and any other service providers to request information regarding the child to assist with the oversight of the specific conditions. The court shall provide the CASA with an appointment letter outlining the scope of the appointment or may modify an existing appointment letter if the CASA was previously appointed on the case.

Commentary

Though the court may appoint a GAL Evaluator or CASA for the purpose of oversight of one or more conditions, probation is expected to oversee the conditions as required under the Probation Standards or as otherwise ordered by the judge.

D. Notification to the Court Regarding the Condition of the Child. During the pendency of the care and protection matter, if Probation or the Department believes that the child's safety may be in danger or at risk and/or the parent, custodian, or legal guardian is not complying with the conditions of the temporary custody order, Probation or the Department shall file a notice to advance the case before the court with a copy to all parties on the case.

A court investigator, CASA, or GAL who has been appointed to the care and protection matters shall notify Probation in writing if they believe that the child's safety may be in danger or at risk and/or the parent, custodian, or legal guardian is not complying with the conditions of the temporary custody order. The court investigator, CASA or GAL shall detail their concerns in the written notification to Probation. The notification shall be emailed or submitted to the Chief Probation Officer of the appropriate Juvenile Court division. Probation shall then file a notice to advance the case before the court, providing a copy to all parties on the case of the notice which would include the concerns regarding the child.

Upon receipt of the notice to advance, a hearing for all parties may be scheduled at the discretion of the presiding judge. If the judge determines that a hearing shall be held, the clerk's office shall notify the parties of the scheduled date.

This section does not preclude probation from communicating with the Department pursuant to G.L. c. 119, § 51A. The Department retains its authority under G.L. c. 119, § 51B, to take the child into immediate temporary custody if the Department has reasonable cause to believe that removal is necessary to protect the child from abuse or neglect.

Commentary

Though Probation may advance the case on behalf of a court investigator, CASA, or GAL, probation is not responsible for presenting information on their behalf at the hearing if one is held by the court.

VII. Review of Temporary Return of Custody Order

For temporary custody orders, it is recommended that the court review the order as it relates to the child's health, safety, and well-being with the parties at each hearing following the issuance of the order. Part of the review may include one or more of the following depending upon the circumstances of the case: (1) a report from the GAL Evaluator or CASA, if appointed at the time of the issuance of the return of custody order; (2) a report from Probation and the Department regarding any home visits conducted in-person or virtually with the child, if applicable; (3) updated criminal activity record information (CARI), including but not limited to any information regarding G.L. c. 208, G.L. c. 209A or G.L. c. 258E orders and G.L. c. 123, § 35 orders, for the parent, custodian, or guardian provided to the court by Probation, if applicable. The court shall order from Probation the CARI of any person living in the home over the age of 14; and/or (4) a review of any G.L. c. 119, § 51A reports the Department has received regarding the parent, custodian, or guardian while the return of custody order has been in place regardless of whether the G.L. c. 119, § 51A reports were screened in or out by the Department.

VIII. Temporary Custody Orders Issued to Non-Parties

All temporary custody orders issued to a non-party in a care and protection case shall be in writing with conditions, unless the judge determines that conditions are not necessary in a specific case. The judge shall set forth, in writing, the reasons for why conditions are not needed. The court shall review the assessment factors outlined in Section V. with the non-party with a focus on the non-party's ability to address the clinical, medical, and educational needs of the child while the child is in their custody as well as review any issues regarding safety, risk, and danger specific to the non-party and their care of the child. In addition, the court shall order from Probation a CARI on all individuals over the age of 14 living in the home. The court shall not issue a temporary custody order to a non-party prior to the completion of a home study conducted by probation or other person, or agency designated by the court, as required by G.L. c. 119, § 26(b)(2)(i).

Commentary

The court should be mindful and vigilant of the duration for a child awaiting permanency in all cases and in particular when a child remains in the temporary custody of a non-party and shall set dates for trial accordingly.

General Law c. 119, § 26 sets forth the following: "The department shall file a petition or a motion to amend a petition to dispense with parental consent to adoption, custody, guardianship or other disposition of the child if: …(iii) the child has been in foster care in the custody of the state for 15 of the immediately preceding 22 months. Under this paragraph, a child shall be considered to have entered foster care on the earlier of: (a) the date of the first judicial finding, under section 24 or this section, that the child has been subjected to abuse or neglect; or (b) the date that is 60 days after the date on which the child is removed from the home… The department need not file such a motion or petition to dispense with parental consent to the adoption, custody, guardianship or other disposition of the child if the child is being cared for by a relative or the department has documented in the case plan a compelling reason for determining that such a petition would not be in the best interests of the child or that the family of the child has not been provided, consistent with the time period in the case plan, such services as the department deems necessary…Unless the court enters written findings setting forth specific extraordinary circumstances that require continued intervention by the court, the court shall enter a final order of adjudication and permanent disposition, not later than 15 months after the date the case was first filed in court. The date by which a final order of adjudication and permanent disposition shall be entered may be extended once for a period not to exceed 3 months and only if the court makes a written finding that the parent has made consistent and goal-oriented progress likely to lead to the child's return to the parent's care and custody."

IX. Placement of Child with Parent, Custodian, or Guardian by the Department

Under G.L. c. 119, §§ 21, 24 and 26, the Department may place a child with the parent, custodian, or guardian from whom the child had been removed while maintaining temporary or permanent custody of the child in anticipation of a return of custody. The Department shall notify the court, all parties and Probation in writing at least 48 hours prior to placing the child with the parent, custodian, or guardian, or, unless emergency circumstances preclude notification, the court and all parties shall be notified on the next business day. The Department shall provide an update to the court and all parties on the child's status and condition as well as the Department's progress toward a permanent transition for the child at every scheduled hearing or earlier as determined by the judge.

X. *Pathways* Essential Questions

At all stages of a care and protection matter and in accordance with the purpose of this standing order, ***Pathways*** Essential Questions, including those to Promote Permanency and those to Promote Educational Stability, shall be reviewed by all parties and content of the Juvenile Court's ***Assessing Danger, Risk, and Safety*** Benchcard shall be addressed by the judge. Such ***Pathways*** resources support fair, just, and prompt resolution of cases through individualized

assessment of each case, each child, and each family in furtherance of the initiative's goal of improving legal permanency, addressing barriers to permanency, safety, and stability for children, and developing dynamic and responsive systems for children and families.

Commentary

Pathways materials, including the Essential Questions, are available through the First Justice of each Juvenile Court division.

Date: December 10, 2021

Effective Date: December 30, 2021

/s/ Amy L. Nechtem

Amy L. Nechtem

Chief Justice of the Juvenile Court

APPENDIX C: CROSS-SYSTEMS MAPPING TO SUPPORT HEALTHY FAMILIES

UPSTREAM brings together local stakeholders to collectively:

- Create a map of the child welfare landscape
- Identify local resources and gaps in services
- Determine priorities for change
- Develop an action plan
- Enhance collaboration among community partners and across systems
- Reduce risk of child welfare system involvement for children and families
- Support safe, nurturing and permanent homes for children

UPSTREAM MASSACHUSETTS

Cross-Systems Mapping to Support Healthy Families

Upstream Massachusetts is a child welfare mapping initiative led by the Juvenile Court Department and developed in collaboration with the National Center for State Courts. The project is designed to help communities work across systems to strengthen families and support safe, nurturing, and permanent homes for children.

Upstream brings local stakeholders together for a series of action-oriented working meetings using a tool informed by the *Sequential intercept Model*.* Stakeholders engage in a facilitated process to collectively map the local child welfare landscape, identify resources and gaps in services, agree on priorities, and create an action plan to enhance collaboration within and across systems.

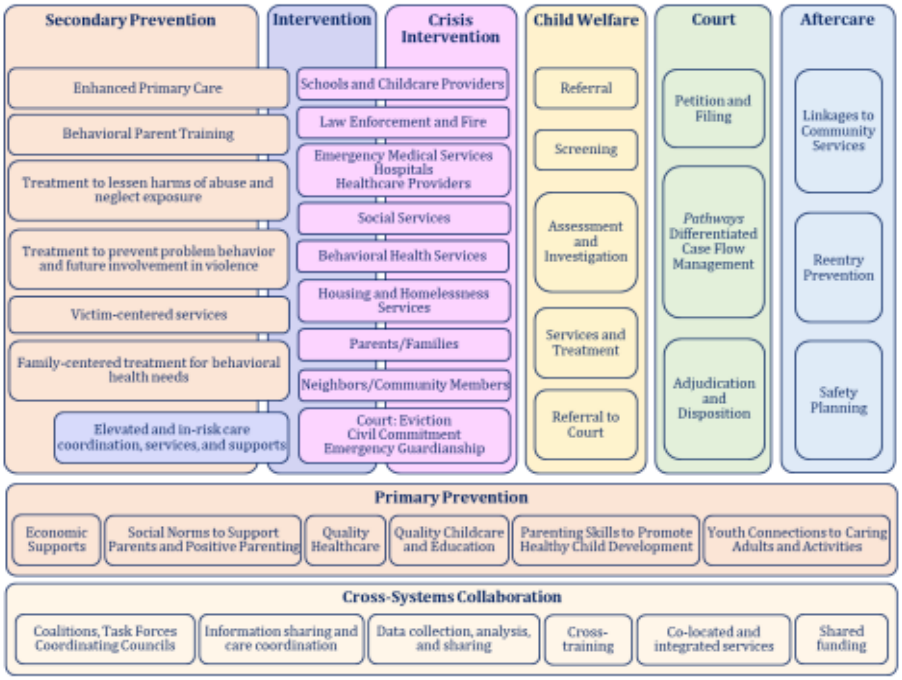
Vision

- Strong families
- Safe, stable, and nurturing homes
- Community-based, coordinated, and comprehensive prevention and intervention networks

Mission

- Support data-driven, evidence-based, and culturally appropriate practices
- Facilitate and enhance collaboration and coordination among partners and across systems
- Reduce the risk of child maltreatment, family disruption, and trauma

CHILD WELFARE LANDSCAPE



For more information please contact Tess Jurgensen at tess.jurgensen@jud.state.ma.us

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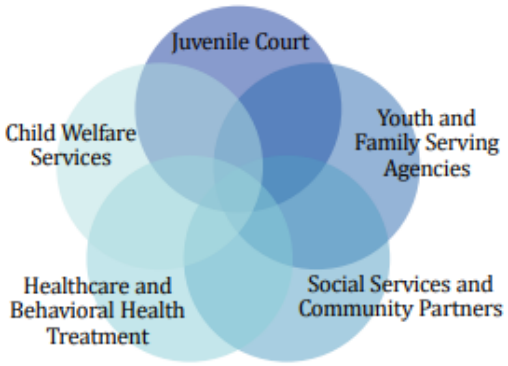
**Please see the Trial Court's Community Justice Project website for more information about Sequential Intercept Mapping.*

Upstream at the Local Level

Key Components

Planning

- Assemble cross-systems county-level planning group
- Inventory local resources and key stakeholders
- Facilitate focus groups and key informant interviews across systems
  - Child welfare, courts, schools, law enforcement, attorneys and advocates, healthcare, youth and family services, social services, behavioral health treatment and recovery support providers
- Begin data collection and disseminate community self-assessment
- Identify gaps and organize along child welfare landscape



Summit

- Convene key stakeholders
- Review data and risk and protective factors
- Review and refine gap analysis according to child welfare landscape
- Collectively agree on priorities for change
- Develop action plan

Post Summit

- Compile comprehensive report of findings
- Develop map of regional resources organized by child welfare landscape
- Convene quarterly meetings of all partners to implement Summit action plans and address priorities for change
  - Working group/subcommittee to integrate family treatment court best practices and/or session based on needs assessment

Timeline

Convene county-level planning group

Conduct resource and key stakeholder inventory

Facilitate focus groups and key informant interviews

Begin data collection and disseminate the Community Self-Assessment

*Convene stakeholders at the **Upstream** Summit*

Compile findings and prepare report

Schedule quarterly meetings

Implement action plans

DRAFT UPDATED 2.2022

APPENDIX D: ESSENTIAL QUESTIONS TO ASK AT EACH HEARING TO PROMOTE EDUCATIONAL STABILITY

Essential Questions to Ask at Each Hearing to Promote Educational Stability

1. *Is the child enrolled in school and if so, is the child regularly attending either in-person or virtually?*

2. *If the child is in DCF custody, what are the specific barriers preventing the child from remaining in the school of origin?*

3. *What has been done to ensure the child has all technological, adaptive, or other resources needed to participate successfully in school in-person or remotely?*

4. *What has been done to ensure the child has appropriate transportation to school, if needed?*

5. *Is the child in need of or receiving special education services or testing?*

6. *Who is the educational decision-maker for the child, and is it appropriate or necessary for the Court to appoint a GAL?*

APPENDIX E: ASSESSING DANGER, RISK AND SAFETY

Assessing Danger, Risk and Safety

*In making assessments, **always consider implicit or explicit biases***

- **Danger** is imminent threat of serious harm
- **Risk** is determined by elements associated with likelihood of future system involvement → risk can be a warning sign of possible danger and may never be eliminated
- **Safety** refers to actions of protection taken by a caregiver that address any current danger to the child; protective factors are elements associated with positive outcomes → remember that services are not the same as safety
- While attorneys advocate clients' positions, the **Judge** must pose questions and facilitate discussion to move the case toward permanency and assure the safety of the child.

Questions to be asked at each court event:

- What was the original **danger**? Have other dangers been identified? What danger exists now, if any?
- What **risks** exist at this time?
- How do actions or services participated in, completed, or anticipated demonstrate or create **safety**? Has the parent been provided opportunities to demonstrate skills?
- Before the next court event: **Who** will be observing and **what** will they be watching for? **How** will they report a decrease in safety, increase in risk, or return of danger? **What** is needed to achieve the permanency plan safely?

This content has been developed in consultation with and adapted from materials by Evident Change (www.evidentchange.org), in partnership with Casey Family Programs (www.casey.org).

APPENDIX F: PATHWAYS

Pathways

Improving permanency for children in Massachusetts

What is the Massachusetts Juvenile Court's *Pathways*?

Pathways is a court-wide differentiated case management initiative for improving legal permanency by ensuring fair, just, and prompt resolution of cases through individualized assessment of each case, each child, and each family along with development of dynamic and responsive multi-disciplinary systems to support children and families.

The ***Pathways*** model is designed to be particularized to the resources, challenges, and opportunities within each community and court division. Grounded in principles from the ***Pathways*** and collective impact models, the ***Massachusetts Upstream*** project is underway to identify resources and gaps, community priorities, and actions needed for change in the state and local child welfare landscapes.

Launched in April 2019, ***Pathways*** is supported by the Casey Foundation, the National Center for State Courts (NCSC), and Court Improvement Program (CIP) funds.

Core elements of *Pathways*

- Creation and dissemination of resources to assist with comprehensive, timely and continual child-centered case assessments including reasonable timeframes for addressing gaps between caregivers' skills and abilities and children's needs
- Multi-disciplinary and cross-sector coordination within an organizational umbrella to address barriers to permanency, safety, and stability for children and to increase capacity of the child welfare community
- Utilization and development of metrics to enhance data-driven case flow management strategies
- Judicially-led programming that convenes partners in current and innovative work in child welfare
- Training and education in substantive issue areas impacting permanency outcomes as well as prevention and intervention frameworks

APPENDIX G: GUARDIAN AD LITEM PROPOSAL IN H.4479

SECTION 12. Chapter 119 of the General Laws is hereby amended by inserting after section 29 the following section: -

Section 291/2. (a) In any proceeding filed pursuant to clause (3) of subsection (a) of section 23 or section 24 of this chapter, section 3 of chapter 210 or any other proceeding determining custody of a child receiving services from the department in which it is alleged that the child has been subject to abuse or neglect, the court shall appoint a qualified guardian ad litem to advocate for the best interests of the child unless the court, after making written findings, determines for good cause shown that the appointment is unnecessary. The guardian ad litem must have professional experience in the field of child welfare or the field of child mental health and must be a licensed social worker, a registered nurse or a licensed attorney. An attorney serving as counsel for the child, pursuant to section 29 or otherwise, shall not serve in the same proceeding as guardian ad litem.

(b) The guardian ad litem shall be an independent advocate for the best interests of the child, considering the child's safety, well-being, and permanency. In determining the best interests of the child, the guardian ad litem must consider, without limitation, the following factors: (i) the physical safety of a child, taking into account any medical conditions or disabilities the child may have; (ii) a child's need for permanence, stability and continuity of relationships; (iii) a child's age and sense of time; (iv) a child's level of maturity; (v) a child's language, culture and ethnicity; (vi) the degree of a child's attachment to family members, including siblings; and (vii) a child's sense of belonging and identity.

(c) The duties of the guardian ad litem shall include: (i) investigating and collecting relevant information about the child and reporting to the court factual information regarding the best interests of the child; (ii) maintaining regular in person contact with the child, and in a manner appropriate to his or her developmental level, meeting with, interviewing or observing the child prior to all hearings; (iii) appearing at all hearings to be heard by the court; and (iv) advocating for the child's best interests with clear and specific recommendations based upon an independent investigation that the court shall consider in making findings and rulings in any proceeding. The guardian ad litem shall report to the court and all parties in writing prior to all hearings. All reports shall be provided at least 72 hours in advance of the hearing for which the report is prepared. The guardian ad litem shall appear at all hearings and be provided the opportunity to be heard. Any report filed by the guardian ad litem shall be considered evidence pursuant to section 21A of chapter 119.

(d) The department shall provide the guardian ad litem with a copy of the case file and shall provide the guardian ad litem with periodic updates. Upon presentation of the order of appointment by the guardian ad litem, any state agency, school, health care provider, including behavioral health provider, insurance carrier or managed care entity, police department or other law enforcement agency shall permit the guardian ad litem to inspect and copy any records relating to the child or children involved in the case, notwithstanding any general or special law to the contrary, unless such access is otherwise

specifically prohibited under federal law. The guardian ad litem shall seek necessary consents where federal law prohibits disclosure of relevant records without such consent.

(e) The rate of compensation to all guardian's ad litem who are appointed pursuant to this section, payable by the commonwealth, shall, subject to appropriation, be equivalent to the rate of compensation payable to counsel appointed or assigned to care and protection cases pursuant to section 11 of chapter 211D.