The Office of the Child Advocate's Review of the Death of Bella Bond

October 28, 2015

At the request of Governor Charlie Baker, the Office of the Child Advocate (OCA) reviewed the involvement of the Department of Children and Families (DCF) and other state agencies and community providers in the short life of Bella Bond. OCA staff reviewed confidential records of DCF, which had been involved in 2012 and 2013, but had not received any 51A reports[1] of abuse or neglect between that time and Bella's Bond's death in 2015. The OCA reviewed confidential records and spoke with personnel of other agencies to gather information and learn from their insights. The scope of the OCA review is very different from the criminal investigation, which will address the individual responsibility of persons involved in Bella's death. The OCA review focuses on the role of DCF and other providers with the Bond family. This report also provides background information about Ms. Bond's history with DCF and other state and local agencies as context for the OCA's findings and recommendations.

The objective of this review was to identify areas for improvement in the Commonwealth's child welfare system. By looking at both DCF's handling of this family's case and the involvement of other parties, this review reinforces the safety and well-being of a child is the shared responsibility of the family, community, and entities responsible for providing assistance to children and families. It is not intended to place blame, but rather to gather and synthesize information from multiple sources.

Bella Bond was born to Rachelle Bond on August 6, 2012, and lived with her mother in Boston. For the first eleven months of her life, Bella and her mother lived in a family shelter with supports and supervision in place. After staying in another family shelter for three additional months, Ms. Bond and Bella moved into an apartment in October 2013 with assistance from a state-funded rental voucher program. They lived in this apartment for the next 20 months. At some point prior to Bella's death, Michael McCarthy moved into the apartment. Friends and neighbors of Rachelle Bond interviewed in news reports have stated Rachelle Bond was involved with illegal drugs during this time. Bella disappeared during May or June of 2015 and her body was found on Deer Island on June 25, 2015. Michael McCarthy and Rachelle Bond have been charged with criminal offenses related to Bella's death.

DCF Involvement:

Prior to Bella's birth in 2012, Ms. Bond had given birth to two older children more than ten years before. In separate cases involving each of these children, DCF removed the children from Ms. Bond's custody. Both cases ended with a termination of Ms. Bond's parental rights. After

[1] A report filed with DCF on behalf of a child that alleged abuse or neglect of a child is called a "51A" report. Any individual can file a report of abuse and neglect on behalf of a child. Section 51A of Chapter 119 of Massachusetts General Laws requires certain individuals, such as medical or school staff, to file a report with DCF when they have reasonable cause to believe that a child is a victim of abuse or neglect.

Bella's birth, Ms. Bond received services from DCF between August and December 2012, and between June and September 2013. Both cases were opened following allegations of neglect ("51A reports") which were investigated and supported, and both cases closed at the conclusion of a 45-day comprehensive assessment. No other 51A reports were filed with DCF after the case was closed in September 2013. DCF was aware of Ms. Bond's previous history with regard to losing her parental rights twice previously.

Other Agency Involvement:

Ms. Bond was incarcerated for several months during her pregnancy with Bella. After giving birth, she and Bella were discharged from the hospital to a family shelter where they received services from a home visiting program until May 2013. Subsequent to Bella's birth in 2012, Ms. Bond lived in two different family shelters where they received services from a home visiting service, a therapist and the shelter. Ms. Bond was also on probation during this period until May 2013. Therefore, several professionals saw Ms. Bond and Bella, some of whom were interviewed by DCF during its involvement in 2012 and 2013. When she moved into an apartment, these services and supports had ended. As a condition of the rental voucher program, she received housing stabilization services until October 2014.

Ms. Bond received housing services and public assistance from several state and federal programs. Bella received regular pediatric care through May 2014 and was up-to-date with her immunizations and on track with developmental milestones. She was due for an annual check-up at the time of her death. No one in any program or agency was found to have had contact for the eight months between October 2014 and June 2015 when Bella's body was discovered.

Federal privacy laws prevented the OCA from obtaining information about any substance abuse treatment programs, or medical records related to Ms. Bond. Published media reports contained interviews with friends and neighbors regarding Ms. Bond's history of substance abuse and treatment but the OCA was unable to access any official information. Instead the OCA relied on information in the DCF case records, criminal and probation records, and information in the public domain (news reports) to discern the likelihood of substance abuse treatment. Therefore, we could not ascertain whether or not Bella was visible to the staff at any substance abuse programs.

It should also be noted that Ms. Bond received financial support and services from multiple state and local agencies for more than 15 years. Most of these interactions would not involve regular face-to-face contact where one might be able to make observations. In the past, Ms. Bond received Transitional Aid to Families with Dependent Children (TAFDC) and food stamps benefits when she had a child living with her. A Department of Housing and Community Development (DHCD) housing voucher paid a majority of the rent each month and payment was made directly to the landlord. DHCD also provided the assistance of a housing stabilization service for a year following moving to an apartment. Ms. Bond also received a monthly Supplemental Security Income (SSI)[2] check from the federal government and a smaller state payment. She also was eligible for MassHealth benefits. In addition, a Boston home visiting program was provided as a free, voluntary service after childbirth. It can be assumed that Ms.

[2] SSI pays monthly benefits to people with limited income or resources, and who are disabled, blind or age 65 or older.

Bond also received some substance abuse services over time. Her long benefit history is a constantly revolving door of times when her benefits would be terminated because of "whereabouts unknown," but then she would reappear and apply for reinstatement.

Rachelle Bond had a long history of ***involuntary*** involvement with local and state law enforcement agencies dating as far back as 1994, with arrests too numerous to list in this report. She was in state corrections facilities no fewer than 12 times, and also served time in county corrections programs. She was arrested in Suffolk County on several occasions in the past few years; however, her last sentence for six months was imposed in January 2012. She was only a few weeks pregnant when she went to jail that time. Her last probation ended in May 2013.

Findings Regarding DCF:

During Ms. Bond's involvement with DCF in 2012 and 2013, DCF received mixed messages about her ability to be an adequate parent to Bella. Both concerns and strengths about Ms. Bond were expressed to DCF staff. However, her past history of arrests, substance abuse, mental health issues, instability and the termination of parental rights for two other children should have triggered higher-level conferences at DCF, and closer attention. DCF's knowledge of her history should have also dictated the need to thoroughly check recent information from all known collaterals and not rely on Ms. Bond's own statements. Below are the OCA's findings:

A higher level of response to the 2012 and 2013 abuse and neglect reports was warranted by DCF.
Ms. Bond had previously lost custody of two older children and her parental rights were terminated by the court. Given this history and the current concern, DCF should have initiated an emergency investigation, rather than non-emergency investigation. A managerial review and legal consultation should have been conducted to determine whether Bella should have remained in her mother's care.

The risk assessments did not accurately reflect risk.
The DCF Risk Assessment tool is completed at the end of an investigation and, based on the information gathered during the investigation process, is meant to capture the degree of risk of abuse or neglect. In both 2012 and 2013, the investigators answered questions in ways that underestimated the risk to Bella. An accurate use of the risk assessment tool should have ranked the risk higher, which should have triggered a managerial review in 2012 and 2013 to discuss whether Bella should remain in her mother's care.

Current, relevant information should have been collected when assessing risk.
Following the investigation, the DCF caseworker is required to conduct an assessment of personal and family history and current functioning. DCF completed comprehensive assessments on Ms. Bond regarding her first child, her second child, and in 2012 and 2013 regarding Bella. During the 2012 and 2013 assessments, the caseworkers gathered minimal, if any, current family and personal history information from Ms. Bond. Rather, in 2012 and 2013 social workers largely copied information from a 2006 assessment report. Gathering

current family and personal history from Ms. Bond was critical to the social workers analysis of parental capacity, family functioning, identifying areas of need, and assessing risk to Bella. Absent this information, their assessment of risk to Bella could not be considered accurate or complete. Compounding the difficulty, the information appeared in the assessments as if it were current, when it was years old making it very difficult for the reader to determine whether the information was current or old. Having assessment information that clearly labels when the assessment information was entered originally would have avoided confusion and possible misinterpretations regarding risk.

Ms. Bond's ability to parent was not appropriately assessed.
The concerns about Ms. Bond's ability to parent her older children were the same concerns raised in 2012 and 2013 regarding Bella. The 2012 and 2013 social workers were aware Ms. Bond lost permanent custody of her other two children, and the reasons why. Ms. Bond was struggling with the same issues that had troubled her in prior years. The caseworkers did not take into consideration the totality of Ms. Bond's current and prior functioning, parenting, substance abuse and lifestyle choices, or her ability to demonstrate insight and ability for change. Ms. Bond's parenting capacity was not fully assessed and therefore a safe determination could not be made that Ms. Bond was able to care for Bella and make decisions in her best interest.

Insufficient information was gathered from family service providers.
Information gathered from professionals delivering support and services to a family provides an important perspective about a parent's ability to care for their own needs, and the needs of their children. In both 2012 and 2013, DCF missed opportunities to gather pertinent information from professionals providing services to the family, and they did not properly consider the little information they did receive when making their final determination of risk to Bella. DCF relied on Ms. Bond's own statements in some cases and did not delve deeper by contacting professionals or agencies with whom she should have been working.

Decisions to close the 2012 and 2013 DCF cases were premature.
When DCF makes a determination to discontinue their work with a family, the decision must be based on a synthesis of information. Some information may conflict with other sources and a clear path may not emerge to determine current risk to a child or predict future risk of harm. During our review, it became evident this occurred with the Bond family when DCF made the decision to close the cases. In 2012 and 2013, DCF observed Bella to be happy and well-cared for by Ms. Bond, and professionals working with the family consistently communicated these same observations to DCF. Ms. Bond was trying to be a good mother to Bella, despite her history and current issues. Ms. Bond was functioning marginally well under the supervision of the family shelter and her probation officer. Both provided her not only the support and resources she need to care for Bella, but were able to hold her accountable for her actions. Knowing Ms. Bond was under the consistent supervision of the shelter and her probation officer, it is reasonable to conclude DCF closed the 2012 and 2013 case with a false sense of security that these entities would contact DCF should there be a future concern for the safety and well-being of Bella. When the case closed in 2013, however, Ms. Bond had terminated the voluntary services that provided support to her and had been discharged from probation. DCF should have checked the status of these services.

She was working with a housing specialist to find an apartment and leave the shelter, which had provided oversight and eyes on Bella. None of this information was reflected in the 2013 assessment conclusion, which copied information from the 2012 assessment. Therefore the case closing was based on faulty information. No managerial oversight of the decision to close the case is indicated in the DCF record. A month after the case closed, Ms. Bond and Bella moved to an apartment without supportive services in place other than monthly visits from the housing specialist. Given the long history and totality of factors, DCF should not have closed the case at the end of the assessment, which it might not have if the current status of services had been checked.

In 2013, a mandatory managerial review ("Tiered Review") was not properly conducted.
During 2013, Acting Commissioner Olga Roche instituted a statewide case review of the safety of children from birth through age five receiving services from DCF while in the home of their parents or guardians. One-year-old Bella met the criteria for a Tier II case review beginning in September 2013 for children Bella's age. DCF closed the Bond family's case in September 2013 before the case review was conducted. The OCA learned DCF conducted the case review of the Bond family as a closed case in October 2013. Because the 2013 assessment contained cut-and-pasted information from prior years and was inaccurate, the managers conducting the review did not have current or accurate information to assess risk to the family, and therefore could not fulfill its intended purpose.

The lack of sufficient management structure contributed to the poor case judgment.
In 2010, the DCF Regional Offices were reduced from six to four and the director of area positions reduced from 29 to 15. After 2010, DCF area offices were combined with each director of areas supervising two offices. There were fewer regional clinical staff and due to attrition and reassignment, and there were fewer area program managers to provide close review of cases and clinical consultations. The number of families being overseen by the area offices reporting to the director where the Bond family case resided was approximately 1,800 during the 2012-2013 timeframe. These changes could have accounted for some of the problems identified in this report.

The OCA also searched past caseload reports for the area office in which the Bond family case was located. Monthly weighted caseloads during the August-December 2012 case ranged from 15.57 to 16.77 cases per social worker. During the June-September 2013 case, weighted caseloads were between 15.47-16.52 per worker. Weighted caseloads were under 17 for each of the months the Bond family case was open in 2012 and 2013. These findings indicate that high caseloads do not account for some of the issues identified in this report.

Other Findings:

Information sharing between state agencies could help reduce risk to children.
Better information sharing between agencies could help reduce risk to children, but this involves important questions of privacy and civil liberties. Sharing electronic information between state information technologies to identify families exhibiting multiple known risk factors would also add a level of safety by using multiple sources that can provide reliable data. The technology

already exists for DCF, MassHealth and the Department of Transitional Assistance (DTA) to share certain information. The conversation to strike the right balance between sharing information and protecting children should continue.

Recommendations:

The death of Bella Bond is one of several tragedies over the past two years that have cast a spotlight on DCF and the difficult nature of their work with children and families. Ms. Bond's struggles are shared among the thousands of parents receiving services from DCF who wrestle with substance abuse, mental health issues, violence, and housing and income instability. Ms. Bond's path was complicated by having lost custody of her two older children and having been convicted of crimes and incarcerated. Nonetheless, her first year with Bella in the family shelter was relatively stable. With the support of the shelter staff, her probation officer, and other services, she was able to care for Bella's basic needs and remain out of jail. But these services are not designed to stay in place indefinitely, and after Ms. Bond moved to an apartment the outside services ended. Within twenty months, her old patterns reemerged and things fell apart, and no one from the community was watching out for Bella.

The OCA observations and findings about DCF policy and case practice are consistent with recent reviews conducted by the OCA[3] and DCF[4]. As a result of the lessons learned in these recent reviews, DCF is vigorously rebuilding their management structure, revising their supervision and clinical oversight; issuing new policies for intake, assessment, service planning and case closing; enhancing their training of staff, and implementing a robust system of quality assurance. The OCA will monitor DCF's development, implementation and progress in all of these areas, and makes the following recommendations:

1. DCF intake policy must mandate that when a report of abuse or neglect is filed concerning a parent whose parental rights were terminated on other children, this report will be screened in for an investigation, and a managerial case review and legal consultation will occur.

2. DCF shall develop a protocol that provides expectations and guidance about completing the risk assessment tool. The protocol should clearly identify action steps to be taken depending on whether the results show a child is at low, moderate or high risk of abuse or neglect. If the result shows a child is at high risk, the protocol should mandate that a managerial case review and legal consultation occur.

[3] OCA review concerning Jeremiah Oliver, released January 23, 2014. OCA review concerning Chase Gideika, released May 2, 2014.
[4] DCF review concerning Jeremiah Oliver, released December 30, 2013. DCF review concerning Jack Loiselle, released September 4, 2015. DCF review concerning the foster home of Kimberly Malpass, released September 30, 2015.

3. The DCF assessment policy should mandate that information collected from prior assessments needs to be properly labeled with the date of the prior assessment clearly identified.

4. DCF should enhance their electronic record keeping system (iFamilyNet) to include the capacity to date stamp information that is copied from one report to another. This feature would prevent old information from appearing as current information in reports.

5. The DCF case practice policy should include guidance about working with parents who have a history of substance abuse, including how to assess for current substance use, the appropriateness of the parent relapse prevention plan, and the parent's ability to safely care for their child.