INVESTIGATIVE REPORT

OFFICE OF THE CHILD ADVOCATE

DECEMBER 2025

A SYSTEMIC INVESTIGATION REGARDING THE DEATH OF A'ZELLA ORTIZ

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OCA
MASSACHUSETTS
Office of the Child Advocate

"There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace." – Kofi Annan

About A'zella Ortiz

The OCA's knowledge about A'zella Ortiz as a person is extremely limited. She did not attend childcare or activities and did not have any significant personal connections we know about other than her immediate family. She had an older sister and a younger brother; she was the middle child. She had an extremely strong bond with her siblings. She also had a love of the show CoComelon, a cartoon family that sings child-focused songs together.

A'zella's personality, interests, and life experiences are largely unknown to the Office of the Child Advocate (OCA). The record does not tell us much about this precious little girl. We dedicate space here in remembrance of her life, and to acknowledge her loss.

About the Office of The Child Advocate

The Office of the Child Advocate is an independent executive branch agency with oversight and ombudsperson responsibilities, established by the Massachusetts Legislature in 2008. The OCA's mission is to ensure that children receive appropriate, timely and quality state 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 Complaint Line serves as a resource for families who are receiving, or are eligible to receive, services from the Commonwealth.

Confidentiality

The OCA's enabling statute, MGL c. 18C, provides the OCA authority to investigate and ensure that high quality state services and supports are provided to safeguard the health, safety, and well-being of all Massachusetts children. The OCA is mandated to examine systemic issues related to the provision of services to children and provide recommendations to improve the quality of those services to give each child the opportunity to live a full and productive life.

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 their statutory duties. The Child Advocate's decision to publicly release the Office's findings and recommendations after reviewing a case is informed by weighing several factors including, but not limited to

(1) A child receiving state services has suffered a fatality (or is missing and presumed to be deceased).
(2) The actions or inactions of a state entity (or entities) over which the OCA has oversight authority were egregious and significantly contributed to the harm of the child.
(3) Substantiative and significant change in policy and practice – to include change in statute, regulation, budget, or administrative policy – is necessary to prevent future harm to children, and releasing confidential information will significantly increase the likelihood that the necessary changes will be made.

The OCA attempts to limit the release of confidential information, and many protected details are not included in this report. For more information, refer to OCA Protocol on the Public Release of Confidential Information.

Executive Summary

On October 17, 2024, the OCA received a critical incident report[1] from the Department of Children and Families (DCF)[2] about the death of A'zella Ortiz and the serious bodily and emotional injuries of her siblings, Luna and Mateo.[3] A'zella's cause of death was ruled by the Office of the Chief Medical Examiner to be multiple blunt force injuries from an unknown mechanism assaulted by others and the manner of death to be homicide.[4] At the time of the release of this report, A'zella's father, Francisco Ortiz, is in jail and facing criminal charges.

In alignment with the OCA's statutory oversight responsibilities,[5] the OCA determined that further investigation into this case was warranted to determine the factual circumstances regarding DCF's involvement with A'zella and her family prior to her death and whether the actions and services provided to the family were adequate, appropriate, in accordance with agency policies, and in compliance with state and federal law.[6]

The OCA identified this case for public release because it is illustrative of the concerns the OCA has raised regarding DCF risk assessment and case management in previously released investigation reports[7] and concerns presented to DCF on an ongoing basis through OCA oversight.

Due to supported allegations of neglect[8] of Luna, A'zella, and Mateo by their parents, Krystal Romero and Francisco Ortiz, DCF had served the family for a total of three years and eight months while the children remained in their parents' care. At the time of the critical incident, DCF was not involved with the family, as the DCF Worcester East Area Office[9] (DCF Area Office) had closed their case one year earlier, on October 20, 2023. The DCF case had closed as the DCF

[1] MGL c. 18C § 5. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C/Section5
[2] The Massachusetts Department of Children and Families is the state agency responsible for receiving and responding to allegations of child maltreatment, for providing services to children and their families that enable caregivers to safely care for their children, and, when that is not possible, for assuming custodial care as authorized by the Juvenile Court.
[3] The names Luna and Mateo are pseudonyms.
[4] Death certificates in Massachusetts are public documents: https://www.mass.gov/death-certificates
[5] MGL c. 18C. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C
[6] The scope of the OCA investigation is different from the criminal proceedings now underway in Massachusetts, which will address any individual responsibility for the death of A'zella and the harm to Luna and Mateo.
[7] Office of the Child Advocate. (2021). A Multi-System Investigation into the Death of David Almond. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocateinvestigative-reportmarch-2021/download; Office of the Child Advocate. (2022). A Multi-System Investigation Regarding Harmony Montgomery. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocate-investigative-reportharmony-montgomerymay-2022/download
[8] DCF's regulatory definition of neglect means failure by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition. This definition is not dependent upon location (i.e., neglect can occur while the child is in an out-of-home or in-home setting).
[9] The DCF Worcester West Area Office was responsible for the Romero Ortiz family's case between October 2018 and June 2019, when the family's DCF case closed. The DCF Worcester East Area Office was responsible for the Romero Ortiz family between September 2020 and October 2023, when the family's DCF case closed.

Area Office believed that the family was no longer in Massachusetts.[10] The children remained in their parents' care prior to the death of A'zella.

Although the ultimate tragic outcome of this case is rare, in other ways this case is like the vast majority of DCF cases. At the end of Fiscal Year 2025 (FY25),[11] 78% of families receiving services from DCF[12] were intact families, where there is an open DCF case due to child maltreatment but the concerns do not rise to the level requiring DCF to take custody of the children involved.

It is imperative that children are not removed from their caregivers unless it is necessary to safeguard them from substantial harm. While child safety is paramount, removal from the home can have profound consequences for the child's emotional well-being, family stability, and long-term outcomes. To ensure that children who come to DCF's attention and who are experiencing maltreatment can stay safely at home, DCF's intervention with intact families should be child centered, based on an accurate assessment of risk, results oriented, time limited, and serve to support and stabilize a family unit.

This investigation is intended to serve as an example of the potential negative consequences of DCF involvement with a family when there is no clear formulation of the risks to the family and the changes necessary to achieve safety for the children involved. It shows us that neglect is not trivial, that children in their home can be at very high risk, and that state intervention must be purposeful and as effective as possible.

Findings

The OCA finds that although the DCF case management team[13] in this case made strong and diligent monthly efforts to meet with and engage Ms. Romero and Mr. Ortiz, the DCF case management team did not have a comprehensive understanding of the strengths, dynamics, and needs of the Romero Ortiz family. During DCF's involvement with the family there was an increase in risk to the children. The intervention of the DCF case management team, though intended to provide support to the family, did not alleviate the initial concerns that brought the family to DCF's attention or the additional concerns that developed over time. Ultimately, the DCF case management team closed the case, believing the family was residing in New York,

[10] DCF reports critical incidents involving children in their custody, children and youth receiving services, and children and youth whose families had any DCF involvement within the preceding 12 months.
[11] July 1, 2024, to June 30, 2025
[12] Data provided by the Department of Children and Families on October 15, 2025.
[13] The chain of command in all 29 DCF area offices, in order of increasing authority, is the social worker, supervisor, area program manager, area clinical manager, and area director. In this report, references to the DCF Area Office, DCF Worcester West Area Office, or DCF Worcester East Area Office mean the social worker, supervisor, area program manager, area clinical manager, and area director. References to the DCF intake team mean the social worker and/or supervisor responsible for the screening of a report of abuse or neglect. References to the DCF response team mean the social worker and/or supervisor responsible for the investigation into allegations of abuse and/or neglect. References to the DCF case management team mean the social worker and/or supervisor responsible for this case when it was open for DCF services.

information that was later determined to be inaccurate. At the time the DCF case closed, it had been 114 days since the DCF case management team had last seen the children. A'zella's death followed approximately one year later.

While this investigation highlights the unique circumstances of A'zella and her family, the OCA findings mirror patterns identified in multiple other cases reviewed by the OCA, including investigations the OCA has released publicly.[14] Therefore, the OCA believes the issues observed in this case are not isolated, but instead are indicative of broader **DCF policy and practice gaps that require focused attention and improvement in two key areas:**

- **Ongoing and accurate assessment of risk**, particularly in the context of neglect and intact families; and
- The **establishment of a structured quality assurance framework to guide DCF's work with intact families.**

Recommendations

Based on these findings, the OCA recommends the following policy, practice, and quality assurance improvements to DCF:

- **Revise and update the DCF Case Closing Policy** to provide greater clarity and guidance with a particular focus on scenarios where a family has prolonged DCF involvement and/or their whereabouts are unknown.
- **Develop and implement a stand-alone policy about case consultations** with the already existing DCF clinical specialists that includes procedures to make sure the recommendations are addressed.
- **Strengthen the definition of "clinical formulation"** to ensure that it is child centered and guides assessment, casework, and decision-making.
- **Conduct a training needs assessment of the DCF workforce to systematically identify the knowledge, skills, and capacity gaps** with a particular focus on clinical formulation, child development and growth, parental engagement, substance use, and neglect.
- **Create and embed an understanding of chronic neglect into DCF casework,** recognizing that chronic neglect is a subset of neglect with its own unique characteristics and risks.
- **Establish a structured quality assurance framework** to guide DCF casework with intact families that is well researched, well resourced, and multifaceted.

[14] Office of the Child Advocate. (2021). A Multi-System Investigation into the Death of David Almond. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocateinvestigative-reportmarch-2021/download; Office of the Child Advocate. (2022). A Multi-System Investigation Regarding Harmony Montgomery. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocate-investigative-reportharmony-montgomerymay-2022/download

Conclusion

The mission of the Office of the Child Advocate is to ensure that children receive appropriate, timely and quality state services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children have an opportunity to thrive. One way we accomplish this is through advocacy for policy, practice, and legislative change that we believe will improve the state systems on behalf of all the Commonwealth's children.

This report asks that we, as a Commonwealth, seriously consider the investment needed to support and stabilize families so that children can remain safely at home, and to support DCF in their efforts to do so.

Introduction

On the evening of October 15, 2024, the Worcester Police Department received a 911 call concerning an unresponsive child. Worcester police responded to the home of Francisco Ortiz and found four-year-old A'zella Ortiz bruised, malnourished, and unresponsive. A'zella was transported to the hospital where she was pronounced deceased. A'zella's six-year-old sister Luna and two-year-old brother Mateo were also present in the home.[15] Luna and Mateo were found severely malnourished and dehydrated with multiple injuries that required hospitalization. The home was in a deplorable condition, with drug paraphernalia and a firearm within reach of the children. Luna and Mateo survived their injuries but required extensive medical intervention. On January 28, 2025, the Office of the Chief Medical Examiner ruled A'zella's cause of death multiple blunt force injuries from an unknown mechanism assaulted by others and the manner of death homicide.[16] At the time of the release of this report, Mr. Ortiz is in jail and facing criminal charges.

The Office of the Child Advocate's enabling statute, MGL c. 18C § 5, requires that executive branch 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.[17] On October 17, 2024, the OCA received a critical incident report from the Department of Children and Families[18] about the death of A'zella and the serious bodily and emotional injuries of her siblings, Luna and Mateo. **At the time of the critical incident, DCF was not involved with the family; DCF had closed their case one year earlier, on October 20, 2023.[19]**

Consistent with OCA practice, the OCA conducted an immediate administrative review of the critical incident report to learn more about the circumstances of the event and DCF's involvement with the family. The OCA learned that due to the neglect of Luna, A'zella, and Mateo by their parents, Krystal Romero and Francisco Ortiz, DCF had served this family for a total of three years and eight months while the children remained in their parents' care.

[15] Luna and Mateo are pseudonyms chosen by the OCA to protect the identities and privacy of A'zella's siblings, as their names have not been made public in the current criminal case surrounding A'zella's death.
[16] Death certificates in Massachusetts are public documents: https://www.mass.gov/death-certificates
[17] For the definitions of critical incident reports, refer to **Appendix A: Glossary of Terms**.
[18] The Massachusetts Department of Children and Families is the state agency responsible for receiving and responding to allegations of child maltreatment, for providing services to children and their families that enable caregivers to safely care for their children, and, when that is not possible, for assuming custodial care as authorized by the Juvenile Court.
[19] DCF reports critical incidents involving children in their custody, children and youth receiving services, and children and youth whose families had any DCF involvement within the preceding 12 months. In FY25, the OCA received 237 qualifying critical incident reports. Of those, 192 (81%) were reported by DCF and involved 280 incidents. The reason the number of reports does not equal the number of incidents is because a critical incident report can involve more than one qualifying incident. Most of the FY25 DCF-reported critical incidents were emotional injuries (150, 54%).

Following the OCA's administrative review and in alignment with the OCA's statutory oversight responsibilities,[20] the OCA determined that further investigation into this case was warranted to determine the factual circumstances regarding DCF's involvement with A'zella and her family prior to her death and whether the actions and services provided to the family were adequate, appropriate, in accordance with agency policies, and in compliance with state and federal law.[21]

The OCA takes confidentiality of children and their families very seriously and is the steward of the information our statute permits us to access. The death or harm to a child with a known history of child protection involvement is one that requires examination. Determining when such a case should become a public example of a need for systemic accountability is a complex process, and one that gives us pause. The case of A'zella and her siblings is a typical example of a fact pattern DCF regularly sees in child maltreatment involving neglect and chronic neglect, but it resulted in a particularly tragic and less common outcome. It is a case that highlights that neglect and abuse happen most often in the home and when DCF is not involved with a family. Most notably, for the OCA, it is a case that demonstrates how state intervention, when ineffective, can both prolong and fail to prevent harm to children. In this way, the case of A'zella and her siblings is both ordinary and extraordinary, both mundane and egregious, and an appropriate illustration of why **the OCA, in this report, recommends the development of a system-wide child protection framework that ensures that children can safely remain in their homes.**

The OCA identified this case for public release because it is illustrative of the concerns that the OCA has raised in previously released investigation reports and that the OCA raises on an ongoing basis through our oversight work. Luna, A'zella, and Mateo were not removed from their parents' custody prior to the death of A'zella, and the family came to DCF's attention due to neglect. Although the ultimate tragic outcome of this case is rare, in other ways this case is like the vast majority of DCF cases: At the end of FY25, 78% of families receiving services from DCF were intact families. Because the death of A'zella occurred approximately one year after DCF's involvement with the family, the connection to DCF's work with the family can appear tenuous. DCF has the challenging job of intervening to prevent harm to children and disrupting patterns of harm to children, and this case highlights one of the potential outcomes when that intervention is unsuccessful. It shows us that neglect is not trivial, that children in their homes can be at very high risk, and that state intervention must be purposeful and as effective as possible.

[20] MGL c. 18C. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C

[21] The scope of the OCA investigation is different from the criminal proceedings now underway in Massachusetts, which will address any individual responsibility for the death of A'zella and the harm to Luna and Mateo Ortiz.

This investigation is based on a review of confidential electronic records, as well as correspondence and interviews with individuals employed by DCF, the state agency responsible for providing services to A'zella and her family between October 2018 and October 2023.[22] **The focus of this investigation is on the DCF Worcester East Area Office (DCF Area Office) involvement with the Romero Ortiz family between September 2020 and October 2023, when the DCF Area Office closed the family's case.** It is during this time that A'zella and her siblings experienced neglect in the care of their parents that was chronic and cumulative over time, manifesting in missed health care appointments, failure to meet developmental milestones, poor nutrition, social isolation, unsafe housing, and parental substance use and disengagement that, once the DCF Area Office closed their case, escalated into life-threatening harm.[23]

The OCA finds[24] that the DCF Area Office made strong and diligent monthly efforts to meet with and engage Ms. Romero and Mr. Ortiz in addressing the routine and non-routine health care needs of their children and recommended services for the family. However, the OCA believes the DCF Area Office did not have a comprehensive understanding of the strengths, dynamics, and needs of the Romero Ortiz family. This lack of a comprehensive understanding of the family led to, and supported, an improper assessment of the risks to the children, inconsistent management oversight and accountability, and a lack of identified benchmarks to measure family progress toward safety and stability. As a result, warning signs were missed, and necessary interventions did not occur.

The OCA recognizes that there was a significant gap of time of almost a year between the DCF Area Office closing the family's case on October 20, 2023, and the death of A'zella and physical injuries to Luna and Mateo on October 15, 2024. The OCA additionally recognizes that during this gap of time, no report of abuse or neglect was filed with DCF about Luna, A'zella or Mateo.[25]

While this investigation highlights the unique circumstances of A'zella and her family, the OCA findings in this case mirror patterns identified in multiple other cases reviewed by the OCA, including investigations the OCA has released publicly.[26] Therefore, the OCA believes the issues

[22] The DCF Worcester West Area Office was responsible for the Romero Ortiz family's case between October 2018 and June 2019, when the family's DCF case closed. The DCF Worcester East Area Office was responsible for the Romero Ortiz family between September 2020 and October 2023, when the family's DCF case closed.
[23] For more detailed information, refer to the **Background** section of this report.
[24] For more detailed information, refer to the **Findings** section of this report.
[25] MGL c. 119 § 51A. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/section51a
[26] Office of the Child Advocate. (2021). A Multi-System Investigation into the Death of David Almond. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocateinvestigative-reportmarch-2021/download; Office of the Child Advocate. (2022). A Multi-System Investigation Regarding Harmony Montgomery. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocate-investigative-reportharmony-montgomerymay-2022/download

observed in this case are not isolated but instead are indicative of broader **DCF policy and practice gaps that require focused attention and improvement in two key areas:**

1. **Ongoing and accurate assessment of risk,** particularly in the context of neglect and intact families.
2. The **establishment of a structured quality assurance framework to guide DCF's work with intact families.**

As such, the OCA recommends[27] the following policy, practice, and quality assurance improvement to DCF:

- **Revise and update the DCF Case Closing Policy** to provide greater clarity and guidance with a particular focus on scenarios where a family has prolonged DCF involvement and/or their whereabouts are unknown.
- **Develop and implement a stand-alone policy about case consultations** with the already existing DCF clinical specialists that includes procedures to make sure the recommendations are addressed.
- **Strengthen the definition of "clinical formulation"** to ensure that it is child centered and guides assessment, casework, and decision-making.
- **Conduct a training needs assessment of the DCF workforce to systematically identify the knowledge, skills, and capacity gaps,** with a particular focus on clinical formulation, child development and growth, parental engagement, substance use, and neglect.
- **Create and embed an understanding of chronic neglect into DCF casework,** recognizing that chronic neglect is a subset of neglect with its own unique characteristics and risks.
- **Establish a structured quality assurance framework** to guide DCF casework with intact families that is well researched, well resourced, and multifaceted.

By using A'zella and her family's DCF involvement as an example, the OCA hopes these recommendation can lead to a strengthened child protection system – one where DCF social workers are supported, supervised, and held accountable for accurate family assessments, meaningful family engagement, and the timely identification of, and response to, the needs of a child with the goal of that child safely remaining at home.

The Importance of Family Preservation

Most families involved with DCF are those whose children remain at home, including Luna, A'zella and Mateo's family prior to A'zella's death.[28] At the end of FY25, DCF was serving 60,609 families and young adults involved in 17,853 open cases, which included 28,975 children ages 0-

[27] For more detailed information, refer to the **Recommendations** section of this report.
[28] Luna and Mateo were removed from the care and custody of Ms. Romero and Mr. Ortiz immediately following A'zella's death. As of the release of this report, they remain in DCF custody.

17. Of those 28,975 children, 78% (22,656) were maintained at home with services as needed.[29] **It is imperative that children are not removed from their caregivers unless it is necessary to safeguard them from substantial harm.** While child safety is paramount, removal from the home can have profound consequences for the child's emotional well-being, family stability, and long-term outcomes. The goal of child protection must always be to strengthen families whenever safely possible – not to separate them.[30]

Keeping families together in the context of neglect and substance use is complex, requiring child protection systems to balance child safety with the goal of keeping families intact whenever possible. Substance use can impair a caregiver's ability to meet a child's basic needs, often interlacing with issues such as poverty, trauma, and mental health challenges. Effective family preservation efforts therefore demand coordinated responses to address the root cause of neglect, provide intensive and sustained support, and recognize the importance of maintaining family bonds while ensuring that children are protected and caregivers receive the help needed to achieve stability. Critical to this effort is the need to respectfully engage families.

To ensure that children who come to DCF's attention and who are experiencing maltreatment can stay safely at home, DCF's intervention with intact families should be child centered, based on an accurate assessment of risk, results oriented, time limited, and serve to support and stabilize a family unit. This investigation is intended to serve as an example of the potential negative consequences of DCF involvement with a family when there is no clear formulation of the risks to the family and the changes necessary to achieve safety for the children involved.

The Impact and Prevalence of Neglect

Child neglect is defined in DCF regulation as the failure by a caretaker to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care.[31] Neglect is the most frequent form of child maltreatment, both nationally and in the Commonwealth. According to

[29] Data provided by the Department of Children and Families on October 15, 2025.
[30] Federal and state laws require that DCF make "reasonable efforts" to preserve intact families and prevent removal of children. *See* 42 USC § 671(a)(15)(B); 45 CFR § 1356.21(b); MGL c. 119 § 1; MGL c. 119 § 29C; 110 CMR 1.00 *et seq.* Accessed December 9, 2025.
https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section671&num=0&edition=prelim
https://www.ecfr.gov/current/title-45/subtitle-B/chapter-XIII/subchapter-G/part-1356/section-1356.21
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section1
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section29C
https://www.mass.gov/law-library/110-cmr
These efforts must be made prior to DCF's decision to petition for custody of a child except in circumstances where the abuse and neglect is particularly egregious. *See* M.G.L. c. 51A § 29C. Accessed December 9, 2025.
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section29C.
Specific circumstances that do not require DCF to make reasonable efforts prior to removal can be found here.
[31] MGL. c. 18B. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18B; 110 C.M.R. 2.00. Accessed December 2, 2025. https://www.mass.gov/regulations/110-CMR-200-glossary.

the National Child Abuse and Neglect Data System (NCANDS),[32] in federal year 2022,[33] child protective services across the nation identified an estimated 559,899 children as victims of substantiated maltreatment. Of these cases of maltreatment, 74.3% involved neglect.[34] At the end of FY25,[35] of the 17,853 open DCF cases in Massachusetts, neglect was a factor in approximately 86% (15,339) of those cases.[36]

Neglect has immediate effects on the child and family as well as long term and potentially lifelong effects.[37] As described by the Center on the Developing Child at Harvard University,

> Safe, stable environments are essential for young children's development and lifelong well-being. Science has shown that early exposure to maltreatment or neglect can disrupt the development of healthy brain architecture, affecting learning, problem-solving, and relationships. Chronic neglect is particularly damaging, with research showing it leads to more widespread developmental impacts than abuse despite receiving less attention in policy and practice.[38]

Chronic neglect refers to cases in which there are multiple incidents of neglect in multiple domains rather than single instances of neglect.[39] Chronic neglect often overlaps with poverty, mental health issues, substance use disorders, and other challenges.[40] Chronic neglect may be identified by its duration and frequency resulting in families experiencing repeated maltreatment reports or many referrals to services over a long period of time. Chronic neglect happens when a child's healthy developmental needs are not met on a recurring or enduring basis.[41]

The seriousness as well as the prevalence of neglect, nationally and in Massachusetts, underscore the need for a focused and strategic response to neglect. The unique nature of chronic neglect requires a specific approach to identification and intervention, particularly

[32] National Child Abuse and Neglect Data System (NCANDS) is a voluntary data collection system that gathers information from all 50 states, the District of Columbia, and Puerto Rico about reports of child abuse and neglect.
[33] Federal year 2022 spans October 1, 2021, to September 30, 2022. This is the most current available NCANDS data.
[34] The Children's Bureau. (2024). National Child Abuse and Neglect Data System (NCANDS). Accessed December 2, 2025. https://acf.gov/cb/data-research/ncands
[35] July 1, 2024, to June 30, 2025.
[36] Data provided by the Department of Children and Families on October 15, 2025.
[37] For more information: https://developingchild.harvard.edu/resource-guides/guide-neglect/
[38] Center on the Developing Child. (n.d.). A Guide to Neglect. Accessed December 2, 2025. https://developingchild.harvard.edu/resource-guides/guide-neglect/
[39] The Children's Bureau. (2019). Chronic Child Neglect. Accessed December 2, 2025. https://www.govinfo.gov/content/pkg/GOVPUB-HE-PURL-gpo156923/pdf/GOVPUB-HE-PURL-gpo156923.pdf
[40] The Children's Bureau. (2019). Chronic Child Neglect. Accessed December 2, 2025. https://www.govinfo.gov/content/pkg/GOVPUB-HE-PURL-gpo156923/pdf/GOVPUB-HE-PURL-gpo156923.pdf
[41] The Children's Bureau. (2019). Chronic Child Neglect. Accessed December 2, 2025. https://www.govinfo.gov/content/pkg/GOVPUB-HE-PURL-gpo156923/pdf/GOVPUB-HE-PURL-gpo156923.pdf

because it necessitates a shift from assessing individual incidents of neglect to patterns of behavior. Determining where risk exists in neglect cases is complex, and families experiencing neglect often have intersecting risk factors that are common across both fatal and non-fatal child protection cases, making it difficult to distinguish which families are at the highest risk.

A'zella and her siblings experienced neglect that escalated into chronic neglect. Physical abuse, as far as we can know, occurred after the DCF Area Office's involvement with the family and co-occurred with the chronic neglect. Physical abuse and chronic neglect led to the death of A'zella and profound physical and developmental impacts on Luna and Mateo. **By using this case as an example, the OCA brings necessary attention to the broader challenges DCF faces in working with families who come to their attention due to neglect, the complexity of working with families experiencing chronic neglect, and the persistent difficulty of accurately assessing risk to children.**

The Role of Substance Use

Luna (born in 2018), A'zella (born in 2020) and Mateo (born in 2022) were all "substance exposed newborns"[42] to marijuana, leading to supported allegations of neglect of Ms. Romero and Mr. Ortiz and DCF intervention after each of their births. This means that each of the children tested positive for marijuana upon their birth. The OCA recognizes that marijuana is legal in Massachusetts and that many people, including many parents, use the substance in a manner that does not impact their ability to adequately care for their children. In this case, however, the DCF Area Office identified that marijuana use by Ms. Romero and Mr. Ortiz impacted their ability to adequately care for the children and that parental substance use was a risk to the children's well-being.

Ms. Romero and Mr. Ortiz are among the thousands of parents in Massachusetts and nationally who wrestle with substance use and substance use disorder. The prevalence of substance use in the population of families served by DCF is high, with it being a factor in 65% (11,520 of 17,853) of DCF open cases at the end of FY25.[43] Substance use is also a prevalent concern identified in publicly released OCA investigations,[44] as well as in the critical incident reports the OCA receives from DCF.[45] A child witnessing a life-threatening or fatal overdose is the leading cause of

[42] This is the term used at the time of birth of each of the children. The current term is "infant with prenatal substance exposure (IPSE)." See **page 17** for more information about the recent developments in allegations related to infants born with prenatal substance exposure.
[43] Data provided by the Department of Children and Families on October 15, 2025.
[44] Office of the Child Advocate. (2021). A Multi-System Investigation into the Death of David Almond. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocateinvestigative-reportmarch-2021/download; Office of the Child Advocate. (2022). A Multi-System Investigation Regarding Harmony Montgomery. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocate-investigative-reportharmony-montgomerymay-2022/download
[45] In FY25, the OCA received 237 qualifying critical incident reports. Of those, 192 (81%) were reported by DCF and involved 280 incidents. The reason the number of reports does not equal the number of incidents is because a critical incident report can involve more than one qualifying incident. Most of the FY25 DCF reported critical incidents were emotional injuries (150, 54%).

reported emotional injury critical incidents to the OCA, accounting for 54% of critical incidents reported to the OCA in FY25.[46]

Substance use disorders are complex brain diseases that profoundly impact the way people think, feel, and act. In the case of marijuana use, because of its relatively recent legality in Massachusetts and its more long-standing social acceptance, it can be difficult to weigh as a risk to parental capacity or care of children. DCF is required to identify if substance use is a barrier to adequate caregiving and to assist the family in addressing this barrier. Any substance, regardless of its use and legality, can present a barrier to adequate caregiving. The recommendations in this report take into consideration the OCA's continued recognition of the complexity of substance use disorder and the other challenges parents face in providing their children with a safe and supportive home.

An Act Relative to Substance Exposed Newborns

The OCA strongly supported An Act Relative to Substance Exposed Newborns, which was signed as part of a larger omnibus package in December 2024.* Prior to this new law, health care professionals were mandated to file a report of abuse or neglect (51A) with DCF whenever an infant was born substance-exposed, even though data showed that about half of these cases did not present substantial risk of abuse or neglect.^ The new law replaces this blanket reporting requirement with a dual notification system: providers will send de-identified notifications to DPH of every infant born with prenatal drug exposure and will only file a 51A report with DCF when they have reasonable cause to believe that the infant is at substantial risk of abuse or neglect including whether ongoing parental substance use may endanger the child.~ The law also strengthens perinatal support systems, enhances data collection, and requires reporting on impacts such as child safety, service gaps, and racial disparities. Together, these changes aim to protect infants while reducing stigma and encouraging parents with substance use challenges to seek treatment and support.

* An Act relative to treatments and coverage for substance use disorder and recovery coach licensure. H.5143. 193 (2023-2024). Accessed December 2, 2025. https://malegislature.gov/Bills/193/H5143
^ MGL c. 119 § 51A. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/section51a
~ MGL c. 32A § 17Q. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIV/Chapter32A/Section17Q

[46] The Office of the Child Advocate. (2024). Office of the Child Advocate Annual Report FY2024. Accessed December 2, 2025. https://www.mass.gov/doc/oca-annual-report-fiscal-year-2024/download

The Role of the Covid-19 Pandemic[47]

The Romero Ortiz family came to the attention of DCF for the second time[48] in September 2020, during the Covid-19 pandemic and the Massachusetts state of emergency. The state of emergency in Massachusetts ended in June 2021, and the DCF Area Office involvement with the family ended in October 2023. The Romero Ortiz family sometimes reported that the pandemic, including concerns about transmission of the Covid-19 virus, was a barrier to their engaging in medical care for their children and their participation in other services. Though this was not consistently presented as a barrier, it was a very real challenge for families during the pandemic to safely take part in services.

In this case, Ms. Romero and Mr. Ortiz's concerns about how to engage in services safely during the pandemic were not meaningfully addressed by the DCF case management team. Additionally, Ms. Romero and Mr. Ortiz's pattern of refusal to engage in services did not consistently identify Covid-19 as the barrier, and the pattern of non-engagement continued after the height of the pandemic passed.

The pandemic created an unprecedented strain on the Commonwealth's children and families as well as the public and private entities that provide support to them. The OCA does not underestimate the difficulty of working with a family that presents numerous barriers, whatever they may be, to meaningful change. In this report, the OCA asserts that barriers must be meaningfully addressed when presented so that progress can be made in providing a safe environment for children.

OCA Acknowledgement

The OCA wishes to acknowledge with gratitude the individuals from DCF who provided information for this investigation for their cooperation. The OCA recognizes that DCF employees have one of the most difficult jobs in the Commonwealth. The complexity and risks to personal safety and well-being, as well as the responsibility to keep children safe, is unlike any other. This report does not lay blame on any individuals employed by DCF and does not seek to rely too heavily on the power of hindsight. This report identifies where the Commonwealth can engage families in a more focused way and can identify and mitigate risks to children so that they can remain safe in their homes.

[47] On March 10, 2020, Governor Charlie Baker declared a state of emergency in response to the Coronavirus outbreak. The state of emergency and all Emergency and Public Health Orders issued pursuant to the emergency terminated on June 15, 2021.
[48] The Romero Ortiz family's first DCF involvement was between October 2018 and June 2019.

Background

The Department of Children and Families is the state agency responsible for receiving and responding to allegations of child maltreatment, for providing services to children and their families that enable caregivers to safely care for their children, and, when that is not possible, for assuming custodial care as authorized by the Juvenile Court. DCF provides services to more children and families than any other Executive Office of Health and Human Services child-serving agency. DCF has one central office, five regional offices, and 29 area offices. The area offices are responsible for the intake and response to abuse and neglect allegations as well as case management and decision-making about a family.

The DCF Worcester West Area Office was responsible for the Romero Ortiz family's case between October 2018 and June 2019, when the family's first DCF case closed. The DCF Worcester East Area Office was responsible for the Romero Ortiz family between September 2020 and October 2023, when the family's second DCF case closed.

Romero Ortiz Family Child Protection History

A'zella Ortiz was born in Massachusetts in September 2020 to Krystal Romero and Francisco Ortiz. Ms. Romero and Mr. Ortiz have three children together of which A'zella was the middle child. A'zella's older sister, Luna, was born in October 2018, making her 7 years old at the time this report was published, and her younger brother, Mateo, was born in October 2022, making him three years old at the time of this report.

The Romero Ortiz family first came to the attention of DCF in October 2018 when the DCF Worcester West Area Office[49] received a report on behalf of Luna alleging "neglect – substance exposed newborn" upon her birth. Ms. Romero reported using marijuana during her pregnancy, and Mr. Ortiz reported using marijuana daily throughout Ms. Romero's pregnancy. As a result of the parents' substance use prior to the birth of Luna, the DCF response team supported an allegation[50] of "neglect – substance exposed newborn,"[51] opened a case to assess the sobriety of the parents and the safety of Luna,[52] and offered services to the family. In June 2019, the DCF Worcester West Area Office closed the case and ended their involvement with the family, as

[49] The chain of command in all 29 DCF area offices, in order of increasing authority, is the social worker, supervisor, area program manager, area clinical manager, and area director. In this report, references to the DCF Area Office, DCF Worcester West Area Office, or DCF Worcester East Area Office mean the social worker, supervisor, area program manager, area clinical manager, and area director. References to the DCF intake team mean the social worker and/or supervisor responsible for the screening of a report of abuse or neglect. References to the DCF response team mean the social worker and/or supervisor responsible for the investigation into allegations of abuse and/or neglect. References to the DCF case management team mean the social worker and/or supervisor responsible for this case when it was open for DCF services.
[50] For the DCF definition of supported allegations, refer to **Appendix A: Glossary of Terms**.
[51] For the DCF definition of substance exposed newborn, refer to **Appendix A: Glossary of Terms**.
[52] For the definition of a DCF open case, refer to **Appendix A: Glossary of Terms**.

Luna was up to date with routine pediatric medical care,[53] meeting all developmental milestones, and Ms. Romero and Mr. Ortiz reported no longer using marijuana since the birth of Luna.

The family came to the attention of DCF for a second time in September 2020 when the DCF Worcester East Area Office[54] (DCF Area Office) received a report alleging "neglect – substance exposed newborn" of A'zella.[55] A'zella was born with marijuana in her system, and Ms. Romero reported using marijuana during her pregnancy and had limited prenatal care. During the investigation, the DCF response team learned that two-year-old Luna was behind in her routine pediatric medical care and that there had been a recent police response to the home due to a verbal argument between the parents.[56] Ms. Romero reported that she used marijuana socially, and Mr. Ortiz reported that he smoked marijuana three to four times a week outside the home. The DCF response team supported allegations of neglect on behalf of both children by Ms. Romero and Mr. Ortiz, determining further DCF intervention was necessary to address the parents' marijuana use and its impact on their ability to care for Luna and A'zella. The DCF Area Office opened a case and started a family assessment.

In January 2021, the DCF case management team **completed their family assessment,** which concluded there was heightened concern for the impact of Ms. Romero's and Mr. Ortiz's marijuana use on their parenting abilities, that Luna and A'zella remained behind in routine pediatric medical care, and that the children had not received early intervention evaluations.[57] The DCF case management team determined that the family would benefit from continued DCF intervention and developed an **action plan**.

The action plan tasked Ms. Romero and Mr. Ortiz with ensuring Luna and A'zella were medically up to date, following through with early intervention evaluations for both children, and meeting

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[53] American Academy of Pediatrics. (2019). *The Well-Child Visit: Why Go and What to Expect*. American Academy of Pediatrics. Accessed December 9, 2025. https://publications.aap.org/DocumentLibrary/Solutions/Toolkits/Well_Child_Visit_Why_What_en.pdf; American Academy of Pediatrics. (2025). *AAP Schedule of Well-Child Care Visits*. American Academy of Pediatrics. Accessed December 9, 2025. https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx

[54] The Romero Ortiz family moved to a new apartment after their case closed with the DCF Worcester West Area Office. When a report of neglect was filed in 2020 following A'zella's birth, the case was assigned to the Worcester East Area Office, as the family's new address fell within their coverage area.

[55] There was no DCF involvement with the Romero Ortiz family between June 2019 and September 2020.

[56] Through this investigation, the information available to the OCA does not indicate that domestic violence was an area of concern identified by the DCF Area Office.

[57] **Early Intervention (EI)** is a voluntary program that is free of charge to caregivers for children birth to three who have developmental delays or are at risk of a developmental delay. EI services are meant to help support families and caregivers and to enhance the development and learning of infants and toddlers through individualized, developmentally appropriate activities within the child's and family's everyday life. Any Massachusetts family with a child under three may be eligible for EI services if the child is not reaching age-appropriate milestones, is diagnosed with certain conditions, and/or has a medical or social history which may put the child at risk for a developmental delay; Massachusetts Department of Public Health. (n.d.). About Massachusetts Early Intervention (EI). Accessed December 2, 2025. https://www.mass.gov/info-details/about-massachusetts-early-intervention-ei

with the DCF case management team once a month. Neither parent was tasked with participating in substance use services despite the DCF case management team identifying this as an area of concern impacting Ms. Romero's and Mr. Ortiz's parenting abilities. Ms. Romero was individually tasked with ensuring Luna and A'zella always had a sober caregiver. Mr. Ortiz was individually tasked with refraining from parenting if using marijuana as a stress reducer, and to make a parenting plan to ensure Luna and A'zella had a sober caregiver.

Between January 2021 and May 2021, the DCF case management team made strong efforts to meet with the family, often making multiple attempts to reach the family through text messages, telephone calls, and unannounced visits to the home. Although the family was often unresponsive to the DCF case management team's outreach, the diligent efforts of the DCF case management team resulted in the required completed home visits each month. Also, during this time frame, **the risk factors identified by the DCF case management team remained the same and included parental marijuana use, the children's isolation in that they rarely left the home, and a general lack of follow-through by the parents with medical care and early intervention evaluations of Luna and A'zella.**

In June 2021, the DCF case management team conducted an internal **Continuous Quality Improvement (CQI)** review[58] on behalf of the Romero Ortiz family. Areas of concern identified were Ms. Romero's and Mr. Ortiz's marijuana use, an observation that the family often slept late with young children in the home, that they frequently did not allow the DCF case management team into the home, and that there was an April 2020 police response to the home for a domestic dispute. The concerns identified for the children included that they were behind in routine pediatric medical care and had not received early intervention evaluations to identify if they had any developmental needs that required[59] services, particularly noting that Luna was aged two and a half and not speaking. The CQI review determined that Ms. Romero and Mr. Ortiz had not followed through with obtaining services for their children, consistent with prior determinations made during the investigation following the birth of A'zella in September 2020 and at the conclusion of the family assessment in January 2021**.**

Between July 2021 and October 2021, the DCF case management continued to make strong efforts to meet with the family, making multiple attempts each month. As a result of this effort, the DCF case management team completed the required home visit each month. Ms. Romero and Mr. Ortiz reported using marijuana and storing it within the home away from the children.

[58] This case was identified for a CQI review by the DCF Worcester East Area Office due to the presence of multiple risk factors. The review was completed by the DCF case management team and discussed with the DCF management team. This type of case review was standard practice within the DCF Worcester East Area Office at the time of the Romero Ortiz family's involvement.
[59] Through this investigation, the information available to the OCA does not indicate that domestic violence was an area of concern identified by the DCF Area Office.

In July 2021, the DCF case management team made a third referral for Luna and A'zella to receive early intervention evaluations because Ms. Romero and Mr. Ortiz did not follow through with the previous two referrals. An early intervention evaluation was also recommended for Luna by the children's pediatrician due to concern of a speech delay. In August 2021, at the request of Ms. Romero, the DCF case management team made a no-cost childcare referral for Luna and A'zella. Neither Ms. Romero nor Mr. Ortiz followed up on the early intervention or childcare referrals. In October 2021, Luna turned three years old and was no longer eligible for an early intervention evaluation or services.[60] Though there was no evaluation of Luna to diagnose a developmental delay, she remained non-verbal at three years old when her eligibility for early intervention services lapsed.

In November 2021, the DCF case management team made an unannounced home visit due to multiple unsuccessful attempts to see the family that month. The DCF case management team heard a child crying inside the home and despite repeated knocking on the door, no one answered. The DCF case management team contacted the Worcester Police Department for assistance. In response to the Worcester police, Mr. Ortiz eventually opened the door, as he had been present when the DCF case management team sought access, and allowed them and the Worcester police inside the home. Ms. Romero was not home. Mr. Ortiz reported that he did not open the door because it lacked a peephole and he wasn't expecting any visitors. When he realized the police were at the door, he felt he needed to open it. The DCF case management team observed the home to smell like dirty diapers with trash throughout the home. Mr. Ortiz was unable to provide the DCF case management team with an update on childcare or the status of an early intervention evaluation for A'zella and routine pediatric medical care for both children, stating it was typically Ms. Romero's responsibility. The DCF case management team documented concerns that Ms. Romero and Mr. Ortiz were still not following through with services despite having two young, non-verbal children at home. As an intervention, the DCF case management team decided to again offer referrals to childcare for both children and an early intervention evaluation for A'zella.

In late December 2021, the DCF Area Office received a report of neglect from a non-mandated reporter on behalf of Luna and A'zella. The report alleged that the family was having difficulty paying rent, and that the children were frequently overheard crying in the apartment with no response at the door. It was also alleged that the apartment smelled like marijuana, and that Ms. Romero and Mr. Ortiz were routinely sleeping and inattentive toward their children. This

[60] Although Luna was no longer eligible for services through Early Intervention, the DCF case management team could have referred Ms. Romero and Mr. Ortiz to their local public school to request a special education evaluation. Had this occurred, the school district could have conducted a multidisciplinary evaluation of Luna to determine if she qualified for services. If found eligible, Luna could have received an Individualized Education Plan with services tailored to support her growth and development. For more information on this process, refer to the Federation for Children with Special Needs.

report was **screened out**[61]because Mr. Ortiz reported to the DCF case management team that he was not sleeping while in a caregiving role for the children.

The DCF case management team went to the family's home several days later and overheard the television playing; however, there was no answer at the door. Mr. Ortiz allowed the DCF case management team into the home two weeks later. **The DCF case management team did not address the allegations in the screened out report with Mr. Ortiz despite the concerns aligning with the risk factors present since DCF involvement began in September 2020.** Mr. Ortiz reported to the DCF case management team that he was the primary caregiver of Luna and A'zella, as Ms. Romero was frequently not home.

In January 2022, an **internal DCF management meeting** was held to discuss escalating concerns about the family due to the December report of neglect, Ms. Romero's sporadic presence in the home, and the DCF case management team having difficulty entering the home each month. The risk factors in the family were again identified, including that Luna and A'zella were two young, isolated, children at home now with Mr. Ortiz as the only primary caregiver. The DCF management team issued several recommendations to the DCF case management team, including contacting kin[62] and the children's pediatrician, requesting an internal consultation with the DCF substance use specialist, assessing Mr. Ortiz's substance use more thoroughly, helping Mr. Ortiz arrange childcare, obtaining additional information as to why Ms. Romero was out of the home, and working with both parents to better understand the caregiving responsibilities for Luna and A'zella.

During the January 2022 home visit, the DCF case management team gave Mr. Ortiz a one-month deadline to contact the children's pediatrician to secure a speech evaluation for Luna and informed Mr. Ortiz that they would make a parent aide referral on his behalf. **Mr. Ortiz did not meet this deadline.** Mr. Ortiz reported to the DCF case management team that Ms. Romero was not living at home consistently and not predictably present and he did not know the reasons for this change in the parental relationship. The DCF case management team noted that Luna, who was three years old, did not respond to their attempts to engage her and instead would stare at the television. Luna also cried when Mr. Ortiz left the room, a behavior not observed by the DCF case management team up until this date.

Between January 2022 and April 2022, the DCF case management team continued to have difficulty entering the home because of unresponsiveness to their outreach, but due to their diligent efforts they met with the family in their home each month. Mr. Ortiz remained the main caregiver of the children as Ms. Romero's presence in the home and caregiving remained inconsistent. Mr. Ortiz declined childcare, citing Covid-19 concerns. Mr. Ortiz did not follow

[61] For the DCF definition of screened out, refer to **Appendix A: Glossary of Terms**.
[62] For the DCF definition of kin, refer to **Appendix A: Glossary of Terms**.

through with routine pediatric medical care for both children, a speech-evaluation for Luna, or an early intervention evaluation for A'zella, citing reasons related to transportation or the stress associated with being the primary caregiver of the children. Mr. Ortiz declined the parent aide service, stating that he did not want a service provider other than the DCF case management team in his home. He also acknowledged marijuana use, stating he would call the paternal grandmother or 911 in an emergency if he was under the influence. However, Mr. Ortiz also acknowledged that the paternal grandmother was not a strong support for him, stating she was unresponsive to his requests for help.

At this point, the DCF case was open for 19 months and Luna and A'zella remained behind in routine pediatric medical care, had not been evaluated for developmental needs despite concerns about both children being non-verbal, and were not visible in the community to anyone other than the DCF case management team during monthly home visits. The DCF case management team recognized that limited visibility for children in this age range is a risk factor for child maltreatment.[63]

Shortly after the March home visit, the **DCF case management team met with the DCF substance use specialist** as recommended by the DCF management team in January. The DCF substance use specialist noted concern with Ms. Romero's actions of leaving the home for periods of time and identified this as an area that required further assessment and exploration, as it could be an indicator of ongoing substance use. The DCF substance use specialist also recommended the DCF case management team continue to assess Ms. Romero's and Mr. Ortiz's marijuana use and contact and engage with the paternal grandmother, as she was reportedly an occasional caregiver for the children.

In May 2022, the DCF case management team conducted an unannounced home visit and found Ms. Romero at home with Mr. Ortiz, Luna, and A'zella. Ms. Romero and Mr. Ortiz reported to the DCF case management team that they were co-parenting well and always ensured there was a sober caregiver for the children. **This was the first time since September 2021 that the DCF case management team had met with Ms. Romero, a period of approximately eight months.**

Between June 2022 and September 2022, the DCF case management team met with the family each month, except August.[64] Mr. Ortiz reported that, while Ms. Romero helped with the care of the children, he remained the main caregiver and it was stressful. Mr. Ortiz also reported working full-time to support the family, using the paternal grandmother and family members for

[63] U.S. Centers for Disease Control and Prevention. (2024). Risk and Protective Factors. Accessed December 2, 2025. https://www.cdc.gov/child-abuse-neglect/risk-factors/index.html

[64] The DCF case management team did not meet with the family in August 2022. Despite the numerous efforts by the DCF case management team to reach Mr. Ortiz, he was unresponsive, citing the demands of his work and home life as the reason.

childcare when needed. Mr. Ortiz acknowledged marijuana use by both him and Ms. Romero, indicating that he would not allow Ms. Romero around the children under the influence. Neither parent had followed through with routine pediatric medical care for the children.

In October 2022, Ms. Romero gave birth to a son, Mateo. Following Mateo's birth, another report was filed with the DCF Area Office alleging the neglect of Luna and A'zella and "neglect – substance exposed newborn" of Mateo by Ms. Romero. Ms. Romero admitted to using marijuana daily throughout her pregnancy. **The DCF case management team was not aware that Ms. Romero was pregnant prior to this report. Their last contact with her was in May 2022, approximately five months earlier.**

During the DCF response team's investigation into the allegations, Ms. Romero reported that she did not want to return to Mr. Ortiz's home with Mateo upon discharge from the hospital, but rather she wanted to live with a friend. There was a consultation with the DCF legal team at the time of Mateo's birth. The DCF response team and DCF case management team did not seek custody of Mateo, instead they jointly developed a safety plan with Ms. Romero and Mr. Ortiz. The safety plan required Ms. Romero to refrain from using substances, engage in mental health services, follow through with services recommended by the DCF case management team, keep Mateo medically up to date, and have supervised visits with A'zella and Luna. Mr. Ortiz was required to ensure that Ms. Romero would not reside in the home, not allow Ms. Romero to care for A'zella or Luna unsupervised, ensure that A'zella and Luna were medically up to date and receive dental care, follow through with a childcare referral, and ensure he and his supports, such as paternal grandmother and paternal aunt, meet with the DCF case management team.

It is unclear why Ms. Romero was allowed to care for her newborn son but her access to Luna and A'zella was restricted to only supervised visits. It is also unclear why Ms. Romero was not allowed to live with Mr. Ortiz, Luna, and A'zella.

During the investigation, the DCF response team and DCF case management team conducted a joint home visit. Mr. Ortiz reluctantly allowed the DCF teams into the home, which was noted to be messy, with trash and debris on the floor. Mr. Ortiz reported that he was the primary caregiver, as Ms. Romero did not live in the home and would sporadically come to the home for a few hours at a time. Mr. Ortiz further reported that he last smoked marijuana two years prior. **This was inconsistent with Mr. Ortiz's prior reports to the DCF case management team about his marijuana use**.

The DCF response team contacted the children's pediatrician and learned Luna and A'zella were behind in medical care. Luna, four years old, had not been seen by a medical provider since March 2021 (19 months earlier) and at that time was noted to be non-verbal with a

speech delay. A'zella was seen by the pediatrician in September 2022 but prior to this visit had not been seen since July 2021 and had 18 cancellations. **The pediatrician noted concerns that A'zella, age two, did not speak, had dental needs, and was bowlegged. The pediatrician made numerous medical and developmental specialist referrals to address these concerns but neither parent followed through with these recommended evaluations or services.**

The DCF response team and DCF case management team held a consultation with the DCF substance use specialist in October 2022, which was the second one since the case opened in September 2020. It was recommended that the DCF case management team contact the paternal grandmother, ensure that childcare is in place, and that a support and stabilization team work with the family. It was also recommended that the DCF case management team assess the specifics of Ms. Romero's marijuana use and involve Ms. Romero's friend, who was the owner of the residence where Ms. Romero resided with Mateo, to ensure that the safety plan was followed. At the conclusion of the investigation, the DCF response team supported allegations of neglect by Ms. Romero on behalf of all three children.[65]

Between October 2022 and January 2023, the DCF case management team met with the family monthly in their home. **In October, Mr. Ortiz brought Luna and A'zella to the pediatrician, and they were brought up to date with routine pediatric medical care**. The pediatrician made a referral for Luna to receive a developmental evaluation given her speech delay and Ms. Romero's concern that Luna was exhibiting behaviors she attributed to autism spectrum disorder. **There is no information available to the OCA to support that Luna received any evaluation.** In December, Ms. Romero moved back into the home and both she and Mr. Ortiz reported co-parenting well. This was a violation of the agreed-upon October 2022 safety plan, which required that Mr. Ortiz and Ms. Romero live separately and that her contact with Luna and A'zella would be supervised.

In January 2023, the DCF case management team documented concerns that the family continued to be difficult to meet with each month, requiring significant efforts by the DCF case management team. Mateo, three months old, had missed scheduled routine pediatric medical care appointments, there were no childcare or early intervention services in place, and the parents had not followed through with obtaining an evaluation for Luna to address her developmental delays. The DCF case management team decided to request a legal consultation. **There is no evidence that this legal consultation occurred.**

Between February 2023 and June 2023, the DCF case management team met with the family in their home. Ms. Romero continued to occasionally leave the home to stay with a friend,

[65] There were no allegations of abuse or neglect against Mr. Ortiz.

resulting in Mr. Ortiz being the primary caregiver. The parents continued to report that they used marijuana, storing it away from the children and always ensuring the children had a sober caretaker. Ms. Romero and Mr. Ortiz both expressed concern about Luna's speech delay, the possibility of other developmental delays, and a desire for an evaluation to identify and address her needs. The DCF case management team made numerous developmental evaluation referrals on behalf of Luna and was thorough in making sure Ms. Romero and Mr. Ortiz had the necessary information to follow through with these referrals. However, Ms. Romero and Mr. Ortiz did not follow through with these referrals and Luna did not receive any evaluation or any services.

In July 2023, the DCF case management team learned from the children's pediatrician that Mateo was seen in March 2023 but was again behind in routine pediatric medical care. On this same day, the DCF case management team texted Ms. Romero and Mr. Ortiz that they needed to make an immediate plan for Mateo to see the pediatrician because, at approximately nine months old, he had missed multiple prior appointments. Ms. Romero told the DCF case management team that they were unexpectedly visiting family in New York and would be back in a couple of days. Ms. Romero scheduled a home visit with the DCF case management team for when they arrived home.

Shortly after Ms. Romero reported being in New York, also **in July 2023, the DCF Area Office received a maltreatment report from a non-mandated reporter alleging neglect of Luna, A'zella, and Mateo by Ms. Romero and Mr. Ortiz.** The report alleged that Ms. Romero and Mr. Ortiz were using substances, had not paid rent in years, and were in the process of being evicted. It was also alleged that Ms. Romero and Mr. Ortiz would "pass out" and leave the children unattended, soiled in feces and urine for long periods of time. Further concern was expressed regarding loud arguments coming from the home and the condition of the home, as it was observed to have urine-soaked mattresses and feces stains. The DCF case management team had last seen the family in the home in June, one month prior.

The DCF intake team screened out this report because the Romero Ortiz family was no longer living in this residence.[66] The DCF case management team was tasked with ensuring appropriate support was in place for the family. Several concerns outlined in this report were the same concerns relayed to the DCF intake team in a previous report filed in December 2021. The report filed in July 2023 highlighted additional new concerns with the Romero Ortiz family regarding housing instability, poor condition of the home, and loud arguments coming from the home. **Mr. Ortiz and Ms. Romero were no longer responding to the DCF case management**

[66] This is an inappropriate reason for screening a report out and the screening out of this report violates the DCF Protective Intake Policy.

team's attempts to meet with them, and the DCF case management team did not know the family's current whereabouts.

Ms. Romero and Mr. Ortiz did not respond to the DCF case management team's attempts to meet with the family in August 2023. Due to the parents' lack of response, the DCF case management team attempted to locate the family through a social media search, requested police responses to their home, and contacted several of the family's relatives and friends. Ms. Romero eventually responded to the DCF case management team via telephone, reporting that the family was staying in New York with the maternal grandmother until they were able to enter a shelter placement in Massachusetts. At that time the DCF case management team appeared to believe that they did not know the maternal grandmother's address in New York, even though **the maternal grandmother's address, including an apartment number, had been provided to the DCF case management team in March 2022 during a DCF search for family members.**

In **September 2023**, approximately three months since the DCF case management team had last seen the children and approximately one month after they had the last phone contact with Ms. Romero, the DCF case management team spoke with Ms. Romero again over the telephone**. Ms. Romero said they were staying with the maternal grandmother in New York for an undetermined amount of time and agreed to a video call with the DCF case management team within the hour so Luna, A'zella, and Mateo could be viewed via phone. Ms. Romero did not follow through with this agreement.** Later that day, the DCF case management team planned to continue the outreach efforts to the family. That plan included conducting additional attempts to video call with Ms. Romero to view the children, obtaining the maternal grandmother's address in New York (the DCF case management team had an address in their records), filing a report of neglect with New York Child Protective Services (NY CPS), and preparing to close the Massachusetts DCF case.

One week later, the DCF case management team attempted to contact Ms. Romero three times, but she did not answer their calls. The following week, the DCF case management team attempted again to contact Ms. Romero and contacted NY CPS to share that the Romero Ortiz children were behind medically and had all been prenatally exposed to marijuana. **These were the only concerns reported to NY CPS despite three years of documented neglect related to Ms. Romero's and Mr. Ortiz's ability to care for the children. The call to NY CPS occurred approximately two months after the July 2023 screened out report alleging serious concerns and approximately one month after the DCF case management team had last successfully contacted the family. The children had not been seen by the DCF case management team physically or on video for approximately three months.**

NY CPS informed the DCF case management team that there was not enough information provided by the DCF case management team to register a report of concern[67] and suggested the DCF case management team request a courtesy visit by the New York State Police to the maternal grandmother's home to confirm the family's location and well-being of the children. The DCF case management team called the New York State Police, but the police refused to do a well-being check because the DCF case management could not identify an apartment number where the family was staying. The DCF case management team had an apartment number in their record, but it appears they were unaware of it at the time they spoke to the New York State Police.

The DCF Area Office closed the family's case in October 2023. The DCF case management team believed Ms. Romero and the three children were in New York at the time of case closing, but information gathered over a year later shows that the family was in Worcester, Massachusetts, at the time. Information gathered after A'zella's death confirmed that the Romero Ortiz family stayed in New York for only three weeks – not the approximately three months that the DCF case management team thought – before returning to Worcester to reside with the paternal grandmother. **The last time the DCF case management team saw Luna, A'zella, and Mateo before closing the case was 114 days prior, in June 2023, one month prior to the last maltreatment report.**

The Critical Incident Post-DCF Involvement

On October 15, 2024, a little less than one year after the DCF case management team closed the Romero Ortiz family's case, Mr. Ortiz contacted 911 for medical assistance. Luna, A'zella, and Mateo were found by emergency services in the care of Mr. Ortiz, in an apartment in Worcester, Massachusetts, where the family had been residing with the paternal grandmother. A'zella, four years old, was found by emergency services to be unresponsive, cold to the touch, and with significant head trauma and bruising. A'zella was transported to a medical facility where she was pronounced deceased.

Luna and Mateo were found severely malnourished, dehydrated, and covered in feces and urine. Luna, six years old, was non-verbal, tested positive for fentanyl, and had numerous bruises and severe dental decay causing her significant pain. Mateo, two years old, had a skull

[67] The standard in New York is reasonable cause to suspect that a child has been abused or maltreated. "Maltreated child" means a child less than 18 years of age whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of their parent or other person legally responsible for their care to exercise a minimum degree of care in supplying the child with adequate food, clothing, shelter, or education in accordance with the provisions of part one of article 65 of the Education Law, or medical, dental, optometrical, or surgical care, though financially able to do so, or offered financial or other reasonable means to do so. NYS Soc. Serv. Law § 413(1)(a). Accessed December 9, 2025. https://www.nysenate.gov/legislation/laws/SOS/413

fracture and numerous bruises. Both children required inpatient hospitalization and significant medical intervention.

A'zella's autopsy was completed in 2025, and her cause of death is multiple blunt force injuries from an unknown mechanism assaulted by others, and the manner is homicide. As a result of A'zella's death and the severe and chronic neglect of Luna and Mateo, Mr. Ortiz is currently facing charges of murder, improper storage of a firearm, and three counts of permitting bodily injury to a child and reckless engagement of a child. He is currently in state custody while his criminal case proceeds. Ms. Romero and Mr. Ortiz have an open case with the DCF Area Office due to supported allegations of abuse and neglect for both Luna and Mateo filed at the time of A'zella's death. The DCF Area Office also supported allegations of abuse and neglect against the paternal grandmother who lived in the same residence.

As a result of this investigation, the OCA has learned about the impact of Mr. Ortiz and Ms. Romero's severe and chronic neglect of Luna and Mateo. Both children are severely delayed in their physical, social, and developmental growth, which will take years of intensive, multi-disciplinary services to remedy. Both children have begun these services and have shown significant growth since coming into DCF's custody in October 2024.

Findings

The following findings are based on the OCA's comprehensive review of case records, interviews, and relevant documentation related to the Romero Ortiz family's involvement with the DCF Worcester East Area Office (DCF Area Office) between September 2020 and October 2023, when the DCF Area Office closed the family's case. The purpose of this section is to present information and analysis and to identify key areas where practice, policy, or systemic factors may have contributed to missed opportunities for intervention.

While this case reflects the unique circumstances of one family, the findings also highlight broader patterns observed in similar cases reviewed by the OCA, including previous publicly released investigations.

THEME: The DCF Area Office did not have an adequate clinical formulation of the Romero Ortiz family, which resulted in a miscalculation of the family dynamics, strengths, and needs, and ineffective DCF intervention.

Child protective work is grounded in the mission of preserving families while ensuring the safety, well-being, and permanency[68] of children. To achieve this goal, child protection workers must develop a **clinical formulation** – the process by which they assess a family's dynamics, strengths, and challenges related to child safety to guide their case planning, interventions, and decision-making. A solid and accurate clinical formulation is child centered, demonstrates an understanding of the presenting concerns, and weighs protective factors with risks and safety. **Clinical formulation is not stagnant; it must continually evolve based on available information throughout the life of a family's DCF case and is essential to informing any necessary shifts in priorities and interventions.**

In Massachusetts, DCF case management teams are required to develop clinical formulations about each family assigned for case management.[69] While DCF case management teams are responsible for developing the clinical formulation about a family, DCF management teams are responsible for

What Are Protective Factors?

Protective factors are characteristics or strengths of individuals, families, communities, or societies that act to mitigate risks and promote positive well-being and healthy development. Most often, we see them as attributes that help families to successfully navigate difficult situations.

Center for the Study of Social Policy. (n.d.). Protective Factors Framework. Accessed December 2, 2025. https://cssp.org/ideas-in-action/our-work/projects/protective-factors-framework/

[68] For the DCF definition of permanency, refer to **Appendix A: Glossary of Terms**.
[69] Massachusetts Department of Children and Families. (2021). DCF Family Assessment and Action Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download

recognizing when case management teams need support to form an accurate clinical formulation. The DCF case management team assigned to the Romero Ortiz family did not develop an adequate clinical formulation of the family and did not get the management support needed to develop the clinical formulation essential to the accurate assessment of safety and risks to Luna, A'zella, and Mateo. The following findings illustrate how the absence of an adequate clinical formulation about the Romero Ortiz family resulted in numerous missed opportunities for the DCF case management team to support, intervene, and safeguard the children from immediate and prolonged neglect and harm.

FINDING #1: The DCF Area Office completed a structured decision-making risk assessment tool in accordance with the DCF Protective Intake Policy but did not evolve or adjust their casework when the results of the tool showed increased risk to the children.

Per the DCF Protective Intake Policy, prior to concluding an investigation into allegations of abuse or neglect, a DCF response team is required to complete a **DCF structured decision-making risk assessment tool**[70] based on the information gathered during the investigation. **The DCF structured decision-making risk assessment tool is an actuarial assessment that estimates the likelihood of future maltreatment and assists DCF response teams in determining which cases should be continued for ongoing DCF services and which may be closed at the end of an investigation.** The use of the risk assessment tool is mandatory during an investigation and requires DCF response teams to answer a series of questions based on family history and current concerns.

In compliance with this policy, the DCF response teams completed three formal risk assessments on behalf of the Romero Oritz family

- **October 2018**: The risk assessment tool was completed at the end of the DCF response teams' investigation into allegations of "neglect – substance exposed newborn" due to Luna's exposure to marijuana. The family scored **low risk** of future maltreatment.
- **September 2020**: The risk assessment tool was completed at the end of the DCF response teams' investigation into allegations of "neglect – substance exposed newborn" due to A'zella's exposure to marijuana. The family scored **moderate risk** of future maltreatment.
- **October 2022**: The risk assessment tool was completed at the end of the DCF response teams' investigation into allegations of "neglect – substance exposed newborn" due to

[70] For information about Structured Decision Making: https://www.cebc4cw.org/program/structured-decision-making/ and https://evidentchange.org/assessment/structured-decision-making/

Mateo's exposure to marijuana. The family scored **very high risk** of future maltreatment, the highest score possible on the risk assessment tool.

While the Protective Intake Policy requires DCF response teams to complete the risk assessment tool, the DCF Supervision Policy requires that DCF case management teams seek consultation from DCF clinical specialists when "a case is determined to be high risk through discussions in supervision, the use of a structured decision-making tool (e.g. risk assessment), and presents with multiple risk factors."[71] These risks include caregiver substance use, domestic violence, mental or behavioral health, and/or medical needs of a child.[72]

The DCF case management team, in collaboration with the DCF response team, consulted with the DCF substance use specialist at the time the family scored as very high risk following Mateo's birth. The DCF substance use specialist issued several recommendations that directly related to the concerns identified in the family's risk assessment score, including offering family childcare and in-home support and stabilization services.[73] The DCF case management offered the recommended services to Ms. Romero and Mr. Ortiz, however, Ms. Romero and Mr. Ortiz refused to engage in the services identified to support the family and alleviate risk in the home.

The DCF risk assessment scores indicated a clear progression of risk to the children. Despite the escalation in risk to the children and the parents' refusal to engage in services to alleviate that risk, the DCF case management team did not reevaluate their clinical formulation of the family to determine if alternative support or intervention was required to successfully engage the family in reducing risk to the children. As a result, the children remained chronically neglected in the care of Ms. Romero and Mr. Ortiz, with the impacts of such neglect having profound consequences on their short- and long-term well-being.

FINDING #2: The DCF Area Office did not use the Family Assessment and Action Plan (FAAP) as a tool to effectively assess the family or hold Ms. Romero and Mr. Ortiz accountable for addressing the needs of the children.

DCF social workers, under the support of a supervisor and other DCF area office managers, use the clinical formulation about each family to inform and create a Family Assessment and Action Plan with a family. The **family assessment** and resulting action plan is developed in partnership with the family and identifies the "goals and areas of focus related to what must be accomplished to maintain child safety, achieve the child's permanency plan, and close the

[71] Massachusetts Department of Children and Families. (2021). DCF Supervision Policy. Accessed December 2, 2025. https://www.mass.gov/doc/supervision-policy-0/download
[72] Massachusetts Department of Children and Families. (2021). DCF Supervision Policy. Accessed December 2, 2025. https://www.mass.gov/doc/supervision-policy-0/download
[73] For the definition of support and stabilization services, refer to **Appendix A: Glossary of Terms**.

case."[74] This **action plan** lists the actions, tasks, services, and support that family members will participate in to accomplish the goals identified. As a family engages in their action plan, the tasks should support and strengthen parental capacities, including a parent's skills, knowledge, and abilities to ensure child safety.[75]

In January 2021, the DCF case management team completed their **family assessment**, which concluded that there was heightened concern for the impact of Ms. Romero's and Mr. Ortiz's marijuana use on their parenting abilities, that Luna and A'zella remained behind in routine pediatric medical care, and that the children had not received early intervention evaluations.[76] The **action plan** tasked Ms. Romero and Mr. Ortiz with ensuring Luna and A'zella were medically up to date, following through with early intervention evaluations for both children, and meeting with the DCF case management team once a month. Neither parent was tasked with participating in substance use services despite both Luna and A'zella being prenatally exposed to marijuana, the parents' admission of ongoing marijuana use, and the DCF case management team identifying this as an area of concern that impacted Ms. Romero's and Mr. Ortiz's parenting.

During each home visit, conversations between the DCF case management team and Ms. Romero and Mr. Ortiz focused solely on encouraging the parents to comply with the tasks in their action plan. The DCF case management team's focus on encouraging participation resulted in missed opportunities to assess and address Ms. Romero's and Mr. Ortiz's behaviors impacting their ability to meet the children's physical, emotional, and developmental needs. Assessing and addressing parental behaviors are crucial steps in building parental capacities and mitigating risks to children.

Families are not static, and a DCF case management team should have an evolving understanding of a family's functioning, needs, safety, risk, and well-being during their

[74] Massachusetts Department of Children and Families. (2021). DCF Family Assessment and Action Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download

[75] The Children's Bureau. (2020). Child Welfare Information Gateway Protective Factors Approaches in Child Welfare. Accessed December 2, 2025. https://cwig-prod-prod-drupal-s3fs-us-east-1.s3.amazonaws.com/public/documents/protective_factors.pdf?VersionId=IZwL49bdftS7hslDmSFKViT5xyza4StT

[76] **Early Intervention (EI)** is a voluntary program that is free of charge to caregivers for children birth to three who have developmental delays or are at risk of a developmental delay. EI services are meant to help support families and caregivers and to enhance the development and learning of infants and toddlers through individualized, developmentally appropriate activities within the child's and family's everyday life. Any Massachusetts family with a child under three may be eligible for EI services if the child is not reaching age-appropriate milestones, is diagnosed with certain conditions, and/or has a medical or social history which may put the child at risk for a developmental delay. Massachusetts Department of Public Health. (n.d.). About Massachusetts Early Intervention (EI). Accessed December 2, 2025. https://www.mass.gov/info-details/about-massachusetts-early-intervention-ei

involvement. These changes should be reflected through updated assessments and action plans as the DCF case management team and the family continue their work together.[77]

The Romero Oritz family was provided with **six different action plans** while involved with the DCF Area Office, meaning there were six opportunities to identify areas for growth and create targeted interventions that could assist Ms. Romero and Mr. Ortiz in meeting the needs of their children. These were also opportunities for an evolution and transformation in action plan tasks to reflect changes in the family that occurred over several years, or for the DCF case management team to assess the additional risk the lack of progress created for the family by elevating the case to the DCF management team or DCF legal team.

Despite these six opportunities, the goals and tasks identified in the first action plan provided to the Romero Ortiz family in January 2021 remained almost identical in all action plans provided to the family thereafter, until the case closed in October 2023. At times, the DCF case management team included deadlines for the tasks to be completed; however, when Ms. Romero and Mr. Ortiz missed the deadlines, the dates on the action plans were not updated and the tasks remained incomplete. **Although the DCF case management team knew that the family was not making progress in alleviating concerns or improving their caregiving capacity, the DCF case management team did not make any changes in their understanding of the family or their casework approach to the family for the entirety of the time they were involved.**

FINDING #3: The DCF Area Office did not use required monthly home visits as a tool to assess the family's functioning and engage the family in a meaningful way that would promote positive outcomes for the family.

Home visits in cases involving intact families are purposeful interactions between DCF case management teams, children, and their caregivers that set the foundation for achieving outcomes of safety, permanency, and well-being. Home visits require a crucial component of follow-up on tasks or concerns discussed previously, including the need for meaningful conversations if the family is not making progress on addressing those concerns.

Per the DCF Family Assessment and Action Planning Policy, DCF case management teams are required to visit with a child and family at least monthly. **The DCF case management team made diligent attempts to meet with the Romero Ortiz family, resulting in 36 home visits in three years. This is a strength of the DCF case management team's casework, particularly since this case was open during the Covid-19 pandemic.** While the DCF case management team made significant efforts to successfully meet with the family each month, the substance of

[77] Massachusetts Department of Children and Families. (2021). DCF Family Assessment and Action Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download

the home visits, including the questions asked by the DCF case management team, did not change from the time the case opened in September 2020 to the time the case closed in October 2023, reflecting a static and inadequate clinical formulation. Additionally, there was minimal meaningful engagement with the children, beyond noting their activity during the home visit and that they didn't exhibit any visible injuries.

Ms. Romero and Mr. Ortiz knew what questions would be asked during each monthly home visit, as they often gave the same answers month to month. They reported not making any progress on their identified action plan tasks and provided similar descriptions of barriers and excuses that prevented task completion. The DCF case management team accepted Ms. Romero's and Mr. Ortiz's month-to-month reports and did not provide any solution-focused assessment or strategies to either assist the parents or disprove that a barrier truly existed.

The DCF case management team was aware that they were the only link between the children and the world outside the family home. As a result, they identified the primary goal of home visits as maintaining a good relationship with Ms. Romero and Mr. Ortiz so that they would allow the DCF case management team into the home each month, often at the expense of having difficult conversations regarding the DCF case management team's concerns. **This focus, which was not child centered, resulted in the ongoing miscalculation of the numerous escalating risk factors present in the home, and resulted in missed opportunities to support the family and directly address the needs of the children.**

Because of the routine nature of the DCF case management team's home visits, the documentation was nearly identical each month for three years, with evidence of an extensive cut-and-paste approach to case dictation.[78] The case management team also documented confusion as to why Ms. Romero and Mr. Ortiz could not follow through with the requests of the DCF case management team. DCF area office management teams use multiple methods to track compliance with required 30-day home visits, including review of DCF case management teams' documentation. During this three-year time span, the DCF Area Office management team should have identified the repeated patterns in the home visit documentation indicating stagnation in the clinical work with the family as well as reduced casework effort. **The absence of this identification resulted in a missed opportunity to intervene and support the DCF case management team in strengthening their clinical formulation and resulting work with the family.**

[78] The OCA analyzed case dictation and determined that the DCF case management team used identical language and phrasing to describe parents' marijuana use, observations of the children, and parents' description of their relationship over multiple home visits. The DCF case management team reported that this was a result of asking the same questions each month during home visits and cutting and pasting case dictation, as no new information had been learned. The OCA's analysis of case dictation identified that identical passages included repeated typos that support this assessment of the cut-and-paste approach.

FINDING #4: The DCF Case Closing Policy does not provide adequate guidance to DCF area offices when assessing whether to close a case when a family is missing or unresponsive and there is a continued risk of maltreatment to the children involved.

The DCF Case Closing Policy guides a DCF case management team's decision to end DCF involvement with a family, providing a specific set of activities to assist in this decision-making. When a DCF case management team determines an intact family's case is ready to close, this decision typically signifies that the family has met and sustained the safety and well-being of the children in their home. However, there are several other scenarios that would prompt a DCF case management team to close an intact family's case if progress has not been made, such as if the family has moved out of state or if the whereabouts of the family are unknown. For these specific scenarios, there are additional administrative tasks and responsibilities outlined in the DCF Case Closing Policy and the DCF Family Assessment and Action Planning Policy. These tasks and responsibilities are designed to ensure that all possible tools and interventions are used to locate and engage the family prior to case closure.

In July 2023, Ms. Romero cancelled a scheduled home visit with the DCF case management team, stating the family was in New York but expected to return to Massachusetts within a couple of days. Ms. Romero rescheduled the home visit for the day of their expected return but contacted the DCF case management team to report that the family remained in New York. One day later, the DCF Area Office received a report of neglect from a non-mandated reporter expressing concern that the family had been evicted, Ms. Romero and Mr. Ortiz were using substances, and the children were frequently left unattended and soiled in feces and urine for long periods of time.

Between August 2023 and October 2023 and in compliance with the Case Closing Policy, the DCF case management team took steps to locate and engage the family. However, the DCF case management team's efforts did not reflect an urgency proportionate to the risks to the children in their parents' care in that several days or weeks would pass in between the DCF case management team's efforts to contact the parents and locate the family.

- On **August 7, 2023**, Ms. Romero informed the DCF case management team that the family was staying with the maternal grandmother in New York. Ms. Romero did not respond to the DCF case management team's request for the address.
- **Two weeks later**, the DCF case management team conducted a search for family members and attempted to contact Mr. Ortiz. The DCF case management team also contacted a paternal family member, who reported not knowing the family's whereabouts.

- **Five days later,** the DCF case management team attempted to contact Ms. Romero and Mr. Ortiz separately but they did not respond.
- **One week later**, the DCF case management team contacted Ms. Romero. Ms. Romero confirmed the family remained in New York and agreed to a Facetime call an hour later with the children. When Ms. Romero did not answer the agreed upon call an hour later, the DCF case management team decided to file a report of concern with NY CPS and close the family's DCF case.
- **One week later,** the DCF case management team attempted to call Ms. Romero and texted her, asking for the family's New York address. Ms. Romero did not respond.
- **One week later**, the DCF case management team contacted NY CPS and the New York police. The information provided to NY CPS did not convey the risks to the children in the care of Ms. Romero and Mr. Ortiz, and it did not convey the concerns of the DCF case management team.
- **One month later** on October 20, 2023, the DCF case management team closed the Romero Ortiz case on the belief that the family had moved out of state and their specific whereabouts were unknown.

At the time of case closure, the DCF Area Office had been continuously involved with the family for three years, and during those three years there had been no progress by Ms. Romero or Mr. Ortiz toward meeting the goals set by the DCF case management team. Prior to the decision to close the case, the family was "missing" for three months with minimal contact between Ms. Romero and the DCF case management team. The DCF case management team had not located the family or ensured the children's safety, citing confusion about what steps were appropriate to locate a family in another state and a lack of clarity regarding the strategies and tools available to the DCF case management team. As a result, the DCF case management team had not seen the children for 114 days prior to the case closure.

FINDING #5: There was a steady progression from neglect to chronic neglect of Luna, A'zella, and Mateo in the care of Ms. Romero and Mr. Ortiz. The DCF Area Office did not adequately address neglect, resulting in profound impacts on the children.

Safe, stable environments are essential for young children's development and lifelong well-being. Science has shown that early exposure to maltreatment or neglect can disrupt the development of healthy brain architecture, affecting learning, problem-solving, and relationships.[79] Chronic neglect refers to cases in which there are multiple incidents of neglect

[79] Center on the Developing Child. (n.d.). A Guide to Neglect. Accessed December 2, 2025. https://developingchild.harvard.edu/resource-guides/guide-neglect/

in multiple domains rather than single instances of neglect.[80] Chronic neglect may be identified by its duration and frequency, resulting in families experiencing repeated maltreatment reports or many referrals to services over a long period of time. Chronic neglect happens when a child's healthy developmental needs are not met on a recurring or enduring basis.[81]

According to the Center on the Developing Child at Harvard, "Chronic neglect is particularly damaging, with research showing it leads to more widespread developmental impacts than abuse despite receiving less attention in policy and practice."[82] Science tells us that young children who experience significantly limited caregiver responsiveness may sustain a range of adverse physical and mental health consequences that produce more widespread developmental impairments than overt physical abuse.[83] These can include cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.[84]

Chronic Child Neglect

Chronic child neglect occurs when a caregiver repeatedly fails to meet a child's basic physical, developmental, and/or emotional needs over time, establishing a pattern of harmful conditions that can have long-term negative consequences for health and well-being. This differs from a report of child neglect, which refers to a single incident of failing to meet a child's basic physical, psychological, or safety needs.

The Children's Bureau. (2019). Chronic Child Neglect. Accessed December 2, 2025. https://www.govinfo.gov/content/pkg/GOVPUB-HE-PURL-gpo156923/pdf/GOVPUB-HE-PURL-gpo156923.pdf

The DCF case management team worked with the Romero Ortiz family for three years, during which time the presence of protective factors shifted continuously, but numerous risks to the children remained, compounding and escalating over time. The patterns of inadequate supervision, substance use, missed routine and non-routine pediatric medical care, and isolation of the children did not improve over time, and the effect on the children increased. Most prominently, Luna and A'zella were each deemed non-verbal during the DCF case management teams' engagement with the family, yet neither of them received an evaluation of what caused their speech delays or any services to address those speech delays, missing the opportunity to

[80] The Children's Bureau. (2019). Chronic Child Neglect. Accessed December 2, 2025. https://www.govinfo.gov/content/pkg/GOVPUB-HE-PURL-gpo156923/pdf/GOVPUB-HE-PURL-gpo156923.pdf
[81] The Children's Bureau. (2019). Chronic Child Neglect. Accessed December 2, 2025. https://www.govinfo.gov/content/pkg/GOVPUB-HE-PURL-gpo156923/pdf/GOVPUB-HE-PURL-gpo156923.pdf
[82] Center on the Developing Child. (n.d.). A Guide to Neglect. Accessed December 2, 2025. https://developingchild.harvard.edu/resource-guides/guide-neglect/
[83] Center on the Developing Child. (n.d.). The Science of Neglect. Accessed December 2, 2025. https://developingchild.harvard.edu/wp-content/uploads/2024/10/InBrief-The-Science-of-Neglect-3.pdf
[84] Center on the Developing Child. (n.d.). The Science of Neglect. Accessed December 2, 2025. https://developingchild.harvard.edu/wp-content/uploads/2024/10/InBrief-The-Science-of-Neglect-3.pdf

intervene early and help to potentially mitigate the consequences of developmental delays. When Luna, six years old, and Mateo, two years old, came into care after A'zella's death, they were both non-verbal. Although the DCF case management team had additionally identified a need for the children to receive appropriate dental care, it was not until after A'zella's death that the consequence of extreme dental decay was identified for Luna.

At each intervention point for the DCF case management team, at each birth and each filing of a report of neglect, the family's functioning had declined from the previous intervention point,[85] and the effects of that decline had become more obvious. The DCF case management team did not appear to characterize this trajectory as decline, however. The information available to the OCA indicates that the DCF case management team saw that there was no progress on alleviating the neglect concerns but did not identify the resulting decline in family functioning after this long period of inaction. A lack of progress is qualitatively different than decline. For this reason, the DCF case management team's approach to the family did not change over time, and the situation was viewed as concerning but stable.

As an agency, DCF has no mechanism to identify or address when prolonged neglect becomes a chronic issue and therefore the DCF case management team did not appear to identify prolonged neglect as its own risk to the children's safety and well-being. Other than repeatedly and persistently asking Ms. Romero and Mr. Ortiz to follow up with service referrals made by the DCF case management team or pediatrician, the DCF case management team took no further action to make sure Luna, A'zella, and Mateo received routine pediatric medical care or specialist services. The DCF case management team did not identify that the pattern of parental de-prioritization of the children's needs and welfare over a period of years was its own risk to be assessed and addressed. It is DCF's obligation to effectively engage and mitigate risk, but because the DCF case management team did not recognize the chronic nature of the situation as its own risk, the DCF case management team was unable to address it.

THEME: DCF lacks a structured quality assurance framework to effectively guide their work with intact families, particularly those families who come to the attention of DCF due to neglect.

Massachusetts DCF has a highly structured quality assurance framework for overseeing children placed in state custody, with clear policies, resources, standardized monitoring practices, and consistent reporting requirements to ensure a child's safety and permanency. These include a

[85] See for example **page 32** discussing the results of the structured decision-making tools.

mandatory six-week placement review,[86] foster care review,[87] and permanency planning conferences.[88] Overlaying the internal DCF framework is a legal framework in the Juvenile Court with laws, rules, and timeframes that need to be followed.[89] This level of guidance and independent oversight is intended to ensure that children receive permanent nurturing homes in a timeframe that supports their safety and well-being.

No framework exists to govern DCF's involvement with intact families, but intact families made up 78% of families receiving DCF services at the end of FY25.[90] When DCF provides services to an intact family with no Juvenile Court involvement, it signifies that DCF has found that abuse or neglect has occurred and there is concern for the safety of the child at home with their caregiver, but the result of the DCF investigation found that the child is not currently at imminent risk of harm. This is not a one-time assessment that occurs at the beginning of the family's involvement with the agency but rather an ongoing assessment throughout the life of a case. **A DCF case management team's ongoing assessment of a child's safety at home and of the caregivers' ability to resolve the risk to the child is one of the most important tasks for a DCF case management team and needs to be supported through a structured quality assurance framework.**

DCF uses their Family Assessment and Action Planning Policy as a tool to assess and support a family's progress toward achieving safety in the home. The first step in this process, the family assessment, is completed within 60 days after a family's case opens following supported allegations of abuse and/or neglect and happens again at six-month intervals until case closure.[91] **This policy is the extent of the mandatory DCF structured decision-making timeframes and requirements for work with intact families. It does not provide the breadth or**

[86] A **6-week placement review** occurs when a child enters placement from home or hospital or returns to placement after a significant stay at home of six months or longer. Massachusetts Department for Children and Families. (2021). DCF Permanency Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/permanency-planning-policy-1/download

[87] Federal and state laws require that DCF operate a system of **foster care review** dedicated to engaging key participants in a timely and periodic review of all cases involving children, youth, and young adults in out-of-home care. The purpose of a foster care review is to assess the progress being made to address the reason(s) for DCF's involvement with the family and to examine and make recommendations regarding efforts to safely achieve permanence for the child, youth, or young adult. Massachusetts Department of Children and Families. (n.d). DCF Foster Care Review Policy. Accessed December 2, 2025. https://www.mass.gov/doc/foster-care-review-policy-0/download

[88] The **permanency planning conference** (PPC) is DCF's primary internal planning vehicle for reviewing the clinical and legal issues related to permanence and decision-making. Massachusetts Department for Children and Families. (2021). DCF Permanency Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/permanency-planning-policy-1/download

[89] Massachusetts Juvenile Court. (n.d). Care and Protection Proceedings in Juvenile Court. Accessed December 2, 2025. https://www.mass.gov/guides/care-and-protection-proceedings-in-juvenile-court

[90] At the end of FY25, DCF was serving 60,609 families and young adults involved in 17,853 cases that included 28,975 children ages 0-17. Of those 28,975 children, 78% (22,656) were maintained at home (intact family) with services as needed.

[91] The FAAP can be updated prior to the six-month mark if a family's circumstances change significantly. This can include but is not limited to the birth/death of a child including when a youth or young adult in the case gives birth to a child, a new household member/caregiver, loss of a caregiver to death, divorce or incarceration, and/or the family becomes homeless. Massachusetts Department of Children and Families. (2021). DCF Family Assessment and Action Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download

depth of the guidance necessary for DCF case management teams to effectively monitor progress in increasing caregiving capacity and reassessing child safety in a manner responsive to the evolving needs and experiences of the family.

The absence of a framework to support and hold DCF case management teams accountable for their work creates opportunities for complacency or siloed clinical formulations about a family. This can lead to miscalculations of safety and risk, a lack of a shared understanding between the DCF case management team and family about expectations and accountability, and a lack of clear tasks and goals to improve family functioning and safety in a timely manner. The following findings articulate how the absence of a structured quality assurance framework manifested itself throughout the DCF Area Office's work with the Romero Ortiz family.

FINDING #1: The DCF case management team was not held accountable to provide effective support and services to the family.

A structured quality assurance framework for casework with intact families is needed to support the majority of DCF's caseload. Such a framework, including policy and practice guidance, would ground DCF case management teams in the purpose, goals, and limitations of their work with intact families. DCF case management teams can be influenced by their own assessments and decisions, defaulting to an established clinical formulation that may no longer accurately represent a family, and as a result they can miss when the risk to a child is changing and when a different approach to a family is warranted because the current one is not working. A quality assurance framework would mitigate some of the challenges DCF case management teams face in effectively working with intact families.

With the Romero Ortiz family, the DCF case management team appropriately focused on encouraging the family to participate in services and comply with their action plan. **However, when the family continuously refused to engage with services over the course of months and years, the DCF case management team did not try a different or stronger approach. This means they did not consistently seek to better understand the reasons for non-engagement, nor did they proactively work with the family to overcome barriers.** They also did not follow through with some repeated directives and recommendations resulting from multiple DCF management case reviews, such as contacting the paternal grandmother or other family members, which could have provided deeper insights into the family's natural support and functioning. Additionally, the DCF case management team did not elevate the case, for example, by seeking a legal consultation, despite clear indications that the children were at increased risk at home with their parents.

The goal of child protection must always be to strengthen families whenever safely possible – not to separate them. To ensure that children who come to DCF's attention and who are

experiencing maltreatment can stay safely at home, DCF's intervention with intact families should be purposeful, time limited, and serve to stabilize a family unit and ensure the appropriate care of children. Without a framework designed specifically to guide DCF's work with intact families – which would include periodic and mandatory internal case reviews of a DCF case management team's clinical formulation and resulting approach – DCF case management teams' risk siloed decision-making, decision bias, and possible ineffective intervention strategies without constructive feedback and accountability.

FINDING #2: The current framework of consultations with DCF clinical specialists lacks crucial guidance and accountability measures.

DCF serves families with complex, co-occurring factors, such as substance use, domestic violence, mental health needs, medical needs, disabilities, and housing instability. DCF employs subject matter experts, called clinical specialists, in these areas to ensure that DCF case management teams have the support to provide quality services and make informed decisions. These DCF clinical specialists provide case consultations either at the request of a DCF case management team or after triggering events as required by policy.[92] The consultations include a review of the family's DCF history and current concerns. The DCF clinical specialists use their expertise to generate recommendations to support DCF case management teams in their work with families. These recommendations are always non-mandatory and can include guidance for DCF case management teams to assist in their ongoing assessment of risk and safety in the home, as well as specific services beneficial for a family.

A DCF substance use specialist was consulted on the Romero Ortiz case twice during the family's involvement with the DCF Area Office. In both consultations, the DCF substance use specialist assisted the DCF case management team in identifying red flag behavior that indicated parents' use of substances was impacting their parental capacity and needed to be more fully assessed. Each consultation also identified additional services that could be beneficial for the family and recommended that extended family members be engaged by the DCF case management team. While the DCF case management team offered Ms. Romero and Mr. Ortiz the recommended services, the parents refused those services. The DCF case management team did not contact extended family members or fully assess the parents' substance use as was recommended in both consultations. As a result, both consultations had little to no impact on the DCF case management team's involvement with the Romero Ortiz family.

Case consultations are intended to encourage a deeper level of thinking and assessment, an important task for DCF case management teams working with intact families. Despite this

[92] DCF Supervision Policy: Supervisors or social workers must seek consultation from clinical specialists when a case is determined to be high risk through discussions in supervision, the use of a structured decision-making tool, and presents with multiple risk factors.

potential benefit, the effectiveness of case consultations is hindered by their design. DCF clinical specialists are located at the regional level of the DCF infrastructure and have no direct case management responsibilities. DCF clinical specialists are not assigned to a case once they are consulted, so they may have very limited engagement with the record and the DCF case management team. There is no framework to ensure that guidance and recommendations provided by DCF clinical specialists are followed, nor is there a requirement or expectation that a DCF clinical specialist will follow up on their own recommendations to learn whether their advice was helpful to the DCF case management team or to the family.

FINDING #3: The DCF case management team did not follow through with recommendations resulting from multiple DCF investigations, internal case reviews, or specialist consultations, and there is no framework to ensure such actions occur.

During a DCF case management team's ongoing work with an intact family, opportunities exist for outside DCF case management teams to review a family's case and offer guidance and recommendations. Although these opportunities are not mandatory or as structured or robust as reviews conducted on cases where children are in DCF custody, they are valuable and should be seen as an integral part of case management because fresh perspectives add critical context and offer constructive opportunities for improved casework.

During the DCF case management team's involvement with the Romero Ortiz family, there were a minimum of six occasions where recommendations were made to the DCF case management team either following supported investigations, an internal case review, specialist consultations, or supervision.[93] These recommendations directly related to ensuring the safety and stability of Luna, A'zella, and Mateo at home with their parents. They contained guidance for tools and strategies that, if utilized, could have enhanced the DCF case management team's assessment of risk in the home. Despite this, the DCF case management team did not follow most recommendations provided and continued to use ineffective methods to engage the family.

The DCF case management team was not held accountable to implement these recommendations, as there is not a quality assurance framework in place to support this crucial aspect of case management. This highlights the need for a system of structured responsibility when recommendations are issued on DCF cases, one where recommendations are embedded in structured data for which an audit can be conducted. Given that DCF case management teams have many duties and often juggle competing priorities and deadlines, a system of accountability that includes timelines like the required six-month foster care review system for

[93] For more detailed information, refer to the **Background** section of this report.

children in state custody, would provide support and shared responsibility while improving effective casework with intact families.

FINDING #4: Without a framework for casework with intact families, the requirement that DCF make "reasonable efforts" to prevent a child's removal is open to misinterpretation by DCF case management teams.

Federal and state laws[94] require that DCF make "reasonable efforts" to preserve intact families and to prevent the removal of children by providing timely and appropriate services that are designed to improve the capacity of caregivers to provide safe and stable homes for their children.[95] These efforts must be made prior to DCF's decision to petition for custody of a child, except in circumstances where the abuse and neglect is particularly egregious.[96] Reasonable efforts made by the agency should be tailored to a family's unique situation and should incorporate an ongoing assessment of the impact and specific vulnerabilities of the children within the home.

Without a strong framework for casework with intact families, the requirement to make reasonable efforts can be misinterpreted and seen as a barrier to taking additional action or intervention to safeguard a child. This is particularly true in situations of chronic neglect, where the impact of the culmination of neglect over a long period of time is not identified in the totality of the circumstances. The DCF case management team had a flawed understanding of reasonable efforts in this case, evidenced by their approach in working with the Romero Ortiz family. Throughout all three years of involvement, Ms. Romero and Mr. Ortiz made no progress in addressing and mitigating the risk to their children due to their unwillingness and inability to complete their action plan tasks. From month to month, Ms. Romero and Mr. Ortiz provided the same set of barriers and excuses as to why they couldn't complete them, all of which were accepted and unchallenged by the DCF case management team.

The OCA believes the DCF case management team would have greatly benefited from a legal consultation in this case when their engagement with the family did not mitigate the risks to the

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[94] For related federal authority, see 42 USC § 671(a)(15)(B); 45 CFR § 1356.21(b). Accessed December 9, 2025. https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section671&num=0&edition=prelim; https://www.ecfr.gov/current/title-45/subtitle-B/chapter-XIII/subchapter-G/part-1356/section-1356.21. For Massachusetts authority, see MGL c. 119 § 1; MGL c. 119 § 29C; 110 CMR 1.01, 1.02, 1.06, 1.08, and 1.09; and the following DCF policies: DCF Family Assessment and Action Planning Policy, DCF Permanency Planning Policy, and DCF Protective Intake Policy. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section1; https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section29C; https://www.mass.gov/regulations/110-CMR-100-principles-and-responsibilities-of-the-department-of-social-services; https://www.mass.gov/lists/review-dcf-policies.

[95] The Children's Bureau. (2019). Reasonable Efforts to Preserve or Reunify Families and Achieve Permanency for Children. Accessed December 2, 2025. https://cwig-prod-prod-drupal-s3fs-us-east-1.s3.amazonaws.com/public/documents/resonable-efforts-preserve-reunify-families-achieve-permanency-children.pdf?VersionId=xvcO5mQb.wW23ily4tDX8jxDPTsq2UPA

[96] Specific circumstances that do not require DCF to make reasonable efforts prior to removal can be found here.

children. DCF employs attorneys who represent the agency in child protection cases in the Juvenile Court. These attorneys are staffed at the DCF regional level and consult and collaborate with DCF case management teams on an ongoing basis. DCF legal staff are an invaluable resource for DCF case management teams, especially when there is concern regarding reasonable efforts and a lack of progress with an intact family. DCF legal staff can partner with DCF case management teams to assess what efforts have been made and how those efforts specifically relate to the safety and well-being of the children involved. **Legal consultation does not necessarily have to focus on whether custody should be sought by DCF; consultation can provide structured thinking from a perspective outside of the DCF case management team to help inform the case and any potential next steps.**

Recommendations

The tragic death of A'zella and the serious harm to Luna and Mateo highlight critical gaps in DCF policy and casework and underscore the need for systemic improvements. The OCA's recommendations presented herein are consistent with many of the recommendations for improvements the OCA has made in previously released reports and investigations[97] as well as the continuous feedback presented to DCF as part of the OCA's core function of reviewing critical incident reports from child-serving agencies in Massachusetts.[98]

The OCA acknowledges the DCF administration's ongoing and diligent efforts to implement improvements to DCF policy and continuously improve casework. Historically, the DCF administration has engaged earnestly in the OCA's concerns and is in the challenging position of translating recommendations into action. These findings and recommendations are intended to assist DCF in making further improvements to support child safety and well-being.

RECOMMENDATION #1: The DCF administration should revise and update the DCF Case Closing Policy. The revised policy should include additional requirements, guidance, and structured decision-making tools for assessing a case for closure, with a particular focus on scenarios where a family has prolonged DCF involvement and/or their whereabouts are unknown.

The decision of a DCF area office to close their involvement with a family is the "formal recognition that Department involvement is no longer needed. The necessary changes to sustain child safety, permanency and well-being have been achieved, and the child is safely able to live in a permanent setting."[99] While these are optimal reasons for case closure, sometimes DCF case management teams close a family's case because they are unable to meet DCF's goals with an intact family, either because the family does not achieve meaningful progress for an extended period and/or the family's whereabouts are unknown.[100]

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[97] Office of the Child Advocate. (2021). A Multi-System Investigation into the Death of David Almond. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocateinvestigative-reportmarch-2021/download; Office of the Child Advocate. (2022). A Multi-System Investigation Regarding Harmony Montgomery. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocate-investigative-reportharmony-montgomerymay-2022/download

[98] The Office of the Child Advocate. (2024). Office of the Child Advocate Annual Report FY2024. Accessed December 2, 2025. https://www.mass.gov/doc/oca-annual-report-fiscal-year-2024/download; MGL c. 18C § 5. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C/Section5

[99] Massachusetts Department of Children and Families. (2017). DCF Case Closing Policy. Accessed December 2, 2025. https://www.mass.gov/doc/case-closing-policy/download

[100] Other reasons a DCF area office may close a family's case include that the family moved out of state or the family declines DCF involvement. Neither scenario was present in this case.

In the Romero Ortiz case, the DCF case management team closed the family's case in October 2023 because the family's whereabouts became unknown. At the time of closure, the DCF Area Office had been continuously involved with the family for three years, and during those three years there had been no progress toward meeting the goals set by the DCF case management team. Prior to the decision to close the case, the family was "missing" for three months with minimal contact between Ms. Romero and the DCF case management team. When the DCF Area Office closed the case, the DCF case management team had not located the family or ensured the children's safety, citing confusion about what steps were appropriate to locate a family in another state and a lack of clarity regarding the tools available to the DCF case management team to do so. The DCF case management team had not seen the children for 114 days prior to the case closure.

The DCF Case Closing Policy details steps to support and guide the DCF area offices in their decision-making when assessing a case for closure. While helpful, these steps do not robustly outline or differentiate between when a case involving an intact family is ready to close due to a family successfully sustaining safety and well-being for the child involved versus when a case is closing because of a family's lack of progress or because their whereabouts are unknown, and risk of child maltreatment remains.

The OCA recommends DCF review and revise the agency's Case Closing Policy to provide the DCF case management teams with clear criteria, guidance, and structured decision-making tools necessary to balance child safety with the practical limits of DCF involvement. The revised Case Closing Policy should ensure that before case closure, efforts to engage the family in services and/or locate the family and assess the child's safety have been exhausted and documented and that **multiple strategies to engage the family** have been used. The Case Closing Policy may benefit from explicitly identifying when a legal consultation would be expected or required prior to case closure, as legal consultations can provide helpful analysis of efforts and expectations. By setting standards for diligence, accountability, and documentation, a revised Case Closing Policy will support DCF case management teams, protect children, and demonstrate DCF's commitment to child safety even when work with a family is not successful or the family is unreachable.

RECOMMENDATION #2: The DCF administration should strengthen the role and use of the DCF clinical specialists by developing and implementing a stand-alone policy addressing their use.

In the Romero Ortiz case, one of the most persistent concerns raised by the DCF Area Office was Ms. Romero's and Mr. Ortiz's marijuana use and the effect it had on their ability to care for the children. The DCF case management team was directed by the DCF Area Office management to gain an understanding of the extent of Ms. Romero's and Mr. Ortiz's marijuana use, the reasons

for suspected extensive usage (e.g. stress), and how such usage directly or indirectly impacted their ability to care for Luna, A'zella, and Mateo. As part of that effort, the DCF case management team sought consultations with a DCF substance use specialist on two occasions. On both occasions, the DCF substance use specialist made case-specific recommendations detailing their advice to the DCF case management team to further assess the impact and extent of Ms. Romero's and Mr. Ortiz's marijuana use on their children.

The DCF case management team did not follow through on most of the recommendations made by the DCF substance use specialist, nor did they gain any insight into the role substance use had in Ms. Romero's and Mr. Ortiz's ability to care for their children. Further, the DCF Area Office management team did not take any action to hold the DCF case management team accountable for not following the recommendations or seek an explanation as to why the recommendations were not followed. The lack of follow-through and accountability with the DCF substance use specialist recommendations in this case is representative of a concern the OCA routinely identifies in DCF casework and communicates to the agency through the OCA's regular case reviews.

The DCF clinical specialists are a valuable resource to DCF case management teams, providing expertise and case consultation in their specialty areas with the goal of informing and supporting decision-making and service delivery. They provide an important targeted perspective on complex issues, often recommending strategies and interventions aimed at promoting a deeper understanding of the impact of the identified area of concern on the child and family to mitigate risks.

Despite the clear benefit of DCF clinical specialists, there is no existing DCF policy to guide the DCF area offices on the role or responsibilities of DCF clinical specialists, the benefit of DCF clinical specialist case consultations, or mechanisms to hold the DCF case management teams accountable to follow through on recommendations. The DCF Supervision Policy provides information about DCF clinical specialists and the criteria for discretionary case consultation, but it is outdated in that it does not include all the DCF specialty areas available. It also provides DCF case management teams with wide discretion in determining whether to seek consultation.

DCF has already created this cadre of subject matter specialists for use in their cases, but the value of this resource is undercut by sporadic use and non-adherence to the recommendations the clinical specialists make. The DCF administration should consider how to utilize this resource to its highest value, including setting expectations for how DCF clinical specialists should engage with case consultations and creating feedback loops that ensure that both DCF case management teams and DCF clinical specialists discuss whether the recommendations were helpful, successful, and/or provided clarity. Strengthening this system through a stand-alone

policy will provide for shared expectations that will improve clinical formulation as well as DCF casework.

RECOMMENDATION #3: The DCF administration should strengthen their definition of clinical formulation to ensure that it is child centered, guides casework and decision-making, and promotes a comprehensive and holistic understanding of the dynamics, strengths, and challenges within a family.

Clinical formulation is an essential part of child protection work because it allows child protective workers to move beyond surface-level observations or isolated events to deeply examine the variety of factors that impact family functioning and risks. These factors include the child's experiences and development, caregiver histories and capacities, intergenerational patterns, trauma, stress, and family dynamics. **A well-developed clinical formulation identifies not only the sources of harm, but also the family's capacity for change and resilience, and therefore serves to inform a balanced and effective intervention plan.** By integrating multiple viewpoints and sources of information, clinical formulation supports professional judgement and ensures that decisions prioritize both child safety and well-being and the potential for sustainable family support and growth.

In the example of A'zella and her family, the DCF case management team did not develop an adequate clinical formulation throughout their case management. The DCF case management team also did not receive the management support required to develop the clinical formulation essential to the constant and accurate assessment of safety and risk to Luna, A'zella, or Mateo. This lack of adequate clinical formulation drove the trajectory of DCF involvement with this family.

In March 2021 the OCA released the Multi-System Investigation into the Death of David Almond. In this investigation, the OCA also identified that the DCF social worker did not receive the supervisor or management support required to form an accurate clinical formulation. Recognizing the critical role DCF supervisors and managers have in supporting DCF social workers and one another in assessing the risks and strengths of a family, the OCA recommended the DCF administration revise the DCF Supervision Policy to "ensure the DCF workforce receive structured supervision that supports the development of task-oriented case management skills, but also the essential clinical formulation skills needed to accurately assess the safety and risks to a family."[101]

[101] Office of the Child Advocate. (2021). A Multi-System Investigation into the Death of David Almond. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocateinvestigative-reportmarch-2021/download

In response, the DCF administration swiftly revised the DCF Supervision Policy to incorporate the OCA's recommendations.[102] While the revised DCF Supervision Policy is improved in that it provides DCF case management teams stronger clarity and guidance to support their assessment and resulting work with families, it does not clearly define clinical formulation, nor does it require DCF case management teams to articulate how they arrived at their clinical formulation or demonstrate its use in their work with a family. Currently, the DCF Family Assessment and Action Planning Policy is the only DCF policy that defines clinical formulation,[103] and while it directs DCF case management teams on the documentation expectations resulting from a clinical formulation, it does not support them in how to develop or use one.

Despite the DCF improvements since the OCA release of the investigation into the death of David Almond, through the course of the OCA's core function oversight work[104] the OCA continues to identify clinical formulation as a persistent area of high concern in DCF casework.[105] Developing an accurate clinical formulation is the most challenging aspect of the DCF role and the most critical to ensure intervention is effective. Routinely, the OCA identifies through our quality assurance DCF case review processes that a lack of a proper assessment (clinical formulation) results in a miscalculation of the needs of the child and family, resulting in missed opportunities to support the child and family in addressing the concerns that led to DCF involvement. While the OCA communicates identified individual casework concerns to a designated liaison at DCF on an immediate and ongoing basis, the OCA believes the lack of clinical formulation extends beyond individual DCF case management teams or a specific DCF area office. This is a systemic issue that requires focused attention by the DCF administration to examine and strengthen policies[106] and training, with a particular focus on the DCF case management teams responsible for the direct support and services to children and families.

DCF casework would greatly improve if clarity around clinical formulation was recorded in policy, embedded in training, and secured through a continuous quality improvement process, ultimately resulting in better outcomes for children and for their families.

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[102] Office of the Child Advocate. (2021). A Multi-System Investigation into the Death of David Almond. Accessed December 2, 2025. https://www.mass.gov/doc/office-of-the-child-advocateinvestigative-reportmarch-2021/download

[103] For the DCF definition of clinical formulation, refer to **Appendix A: Glossary of Terms**.

[104] The OCA's core oversight functions are operating a Complaint Line, reviewing critical incident reports received from Massachusetts child-serving agencies and conducting non-public and public investigations.

[105] The Office of the Child Advocate. (2024). Office of the Child Advocate Annual Report FY2024. Accessed December 2, 2025. https://www.mass.gov/doc/oca-annual-report-fiscal-year-2024/download

[106] Massachusetts Department of Children and Families. (2021). DCF Protective Intake Policy. Accessed December 2, 2025. https://www.mass.gov/doc/dcf-protective-intake-policy/download; Massachusetts Department of Children and Families. (2021). DCF Family Assessment and Action Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download; Massachusetts Department of Children and Families. (2008). DCF Ongoing Casework and Documentation Policy. Accessed December 2, 2025. https://www.mass.gov/doc/ongoing-casework-policy/download

RECOMMENDATION #4: The DCF Child Welfare Institute (CWI) should conduct a training needs assessment of the 29 DCF area offices to systematically identify the knowledge, skills, and capacity gaps, with a particular focus on clinical formulation, child development and growth, parental engagement, substance use, and neglect. Building upon CWI's existing multifaceted approach to training, the results of the assessment should inform the development and implementation of a strategic training plan that prioritizes continuous learning and capacity building in these key areas.

The DCF Child Welfare Institute is responsible for providing training and professional development opportunities to the entire DCF workforce. The primary goal of CWI is to promote effective child welfare practices through training and professional development programs aimed at enhancing social workers' knowledge and skills, improving supervision quality, and fostering an agency environment that supports creativity and professional growth.[107] CWI has developed a DCF Child Welfare Institute Training Plan 2025-2029[108] that outlines the planned training activities for DCF to achieve excellence in staff development and child welfare practices.

CWI serves as a vital complement to DCF policies by bridging the gap between written guidance and practice. While DCF policies establish standards, procedures, and accountability frameworks, CWI ensures that DCF area offices have the knowledge and skills to consistently and effectively apply these policies to their work. CWI also provides immense value by serving as the central hub where the DCF area offices have access to consistent and high-quality education that has the potential to strengthen assessment, intervention, and decision-making. CWI equips the DCF area offices with casework skills to respond effectively to complex family dynamics and robustly safeguard children.

The presenting concerns that brought the Romero Ortiz family to the attention of the DCF Area Office in September 2020 were never addressed or mitigated through years of DCF involvement with the family. The many missed opportunities for assessment and intervention in this case are not unique to the DCF case management team assigned to the Romero Ortiz family. Rather, they represent a systemic DCF casework knowledge and skill gap identified by the OCA through the

[107] Massachusetts Department of Children and Families. (2025). DCF Child Welfare Institute Training Plan 2025-2029. Accessed December 2, 2025. https://www.mass.gov/doc/title-iv-e-training-plan-2025-2029/download

[108] In compliance with intersecting federal laws, regulations, and program instructions (Administration for Children and Families Program Instruction ACYF-CB-PI-24-02; 45 CFR 1356.60(b); 45 CFR 1357.15(t)(1); and 45 CFR 235.60- 235.66) Accessed December 9, 2025. https://acf.gov/cb/policy-guidance/pi-24-02; https://www.ecfr.gov/current/title-45/subtitle-B/chapter-XIII/subchapter-G/part-1356; https://www.ecfr.gov/current/title-45/subtitle-B/chapter-XIII/subchapter-G/part-1357; https://www.ecfr.gov/current/title-45/subtitle-B/chapter-II/part-235.

course of the OCA's core function oversight work. The OCA recommends that CWI prioritize the following training areas to improve skills and knowledge.

Child Development and Growth

Providing focused training to the DCF case management teams in child development and growth will strengthen their knowledge and skills to recognize when a child's physical, emotional, cognitive, and social needs are not met. Understanding typical developmental milestones will allow DCF case management teams to better identify early indicators of harm, neglect, or trauma that may otherwise be unnoticed. It will also assist in identifying whether there are potential disabilities for some children, which will inform the services and capacity needed to care for those children. This knowledge will provide the DCF case management teams with the ability to interpret a child's behavior within a developmental context, which strengthens case assessment by grounding DCF case management teams in evidence of how adverse experiences can disrupt healthy development, informing accurate risk assessments and intervention planning. **This will also enhance the DCF case management teams' ability to safeguard children by ensuring decisions are made not only considering present concerns but also in relation to the long-term impact on children's growth and future well-being.**

Parental Engagement

Effective parental engagement is critical to the success of DCF's work because it fosters collaboration, trust, and a shared responsibility for a child's safety and well-being. When parents are meaningfully engaged, DCF case management teams can better understand a family's strengths, challenges, and cultural contexts, allowing for tailored interventions that are more likely to succeed and support families in building capacity for long-term sustainable change. By training the DCF case management teams on parental engagement strategies that promote active parental participation and identify the need for concrete improvement in protective factors, DCF case management teams can strengthen family resilience, reduce the recurrence of harm, and create safer environments for children to thrive.

Substance Use

DCF is required to identify if substance use is a barrier to adequate caregiving and to assist the family in addressing this barrier when it is present. The prevalence of substance use in the population of families served by DCF is high, with it being a factor in 65% (11,520 of 17,853) of open DCF cases at the end of FY25.[109] While DCF employs specialists that focus on substance use and can consult on cases to provide recommendations to improve casework, the DCF workforce would benefit from additional CWI training on identifying the link between substance

[109] Data provided by the Department of Children and Families on October 15, 2025.

use and the ability to provide adequate care to a child given the frequency with which substance use is identified as a factor in DCF-involved families.

RECOMMENDATION #5: The DCF administration should evaluate the agency's policies and practices to determine how to address chronic neglect as a subset of neglect with its own unique characteristics and risks. The DCF administration should determine what training and support is necessary to ensure that chronic neglect is recognized and the tools to address it are effectively utilized.

The OCA's evaluation of Luna, A'zella, and Mateo's case is that it is one of chronic neglect. The fact pattern over three years of consistent DCF involvement with this family shows that the children did not receive adequate supervision, did not get adequate routine pediatric medical care including specialist care for identified developmental delays and emerging medical problems, and were isolated in that they rarely left the family home. Ms. Romero's and Mr. Ortiz's patterns of parental engagement throughout the case never improved, and as the children grew and their needs emerged, the consequences of failing to adequately care for the children compounded. The DCF case management team's approach to the family did not change even though there was no improvement in the family's functioning or the children's care.

DCF does not recognize chronic neglect as a distinct subset of neglect and does not provide DCF case management teams with any specific lens, insight, or tools to address chronic neglect. Without a specific focus on chronic neglect built into DCF policy and practice, DCF case management teams risk focusing solely on incident-based neglect and may miss detrimental patterns that require intervention.

Neglect including chronic neglect is categorically different than poverty: Poverty is not neglect.[110] Understanding the complex relationship between poverty and neglect [111] is critical, particularly when assessing chronic neglect. Poverty, as well as a caregiver's inability to provide due to disability, does not mean that a child is neglected, though it could mean that a child or family needs support and services so that the child's basic needs can be met. Poverty can contribute to toxic stress and patterns of decision-making that present risks to children, and it

[110] DCF's regulatory definition of neglect means failure by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition. This definition is not dependent upon location (i.e., neglect can occur while the child is in an out-of-home or in-home setting).

[111] A 2022 study that examined post-2016 research on this topic observed that, at a "high level," the evidence showed "poverty to be consistently and strongly associated with maltreatment." *See* Skinner, Guy & Bywaters, Paul & Kennedy, Eilis. (2022). A review of the relationship between poverty and child abuse and neglect: Insights from scoping reviews, systematic reviews and meta-analyses. Child Abuse Review. 10.1002/car.2795.

can co-occur with mental health and substance use challenges – all of which can reduce a caregiver's capacity to meet a child's basic needs.[112] Poverty and neglect are often co-occurring, but it is critical to ensure that poverty alone is not the cause of child protective services involvement.

The DCF administration should address chronic neglect as a distinct subset of neglect in their work so that they can adequately assist families. Additionally, the DCF administration should

- Evaluate their policies and practices to determine how to address chronic neglect as a subset of neglect with its own unique characteristics and risks.
- Determine what tools they already have in place to identify chronic neglect, including evaluation of the length of the child's experience, the repetitive experiences, and the need for a changed approach or support that can be identified and addressed to stop the pattern of neglect.
- Identify what tools they may need to put in place, what definitional clarity is needed, what triggers may exist or require internal review, and how to identify when interventions aren't successful for intact families experiencing neglect.
- Consider whether a regulatory definition of chronic neglect could be a useful tool in adequately addressing chronic neglect.

The goal of adequately addressing chronic neglect is to ensure that DCF's interventions with families are time limited and successful. Without such clarity, DCF risks intervention that fails to take a long view of parental capacity growth, fails to recognize when barriers to change are purposeful rather than situational, and risks DCF intervention that amounts solely to monitoring the neglect that is occurring.

Any such definition and delineated approach, as well as associated DCF implementation of that approach, must carefully distinguish chronic neglect from poverty. DCF is well suited, through their engagement with intact families, to explore and detail the distinguishing factors of chronic neglect and poverty.

[112] See U.S. Center for Disease Control and Prevention. (2024). Risk and Protective Factors. Accessed December 2, 2025. https://www.cdc.gov/child-abuse-neglect/risk-factors/index.html; National Conference of State Legislatures. (2023). Poverty and Child Neglect: How Did We Get It Wrong? Accessed December 2, 2025. https://www.ncsl.org/state-legislatures-news/details/poverty-and-child-neglect-how-did-we-get-it-wrong; Francis L, DePriest K, Wilson M, Gross D. Child Poverty, Toxic Stress, and Social Determinants of Health: Screening and Care Coordination. Online J Issues Nurs. 2018 Sep;23(3):2.

RECOMMENDATION #6: The DCF administration should commit significant resources to establish a structured quality assurance framework that is well researched and multifaceted to guide their work with intact families.

The issues presented by the Romero Ortiz case reflect a need for greater clarity of mission, shared expectations, and effective timeframes for working with intact families while continuously evaluating risks to children not in DCF custody. These issues are mirrored in the cases of other families involved with DCF that have been brought to the attention of the OCA through our statutory core functions.

It cannot be overstated how important it is to a child and family that removal of a child from the home is the absolute last resort for protecting the child. Preventing the removal of children from their caregivers through improved parental capacity and supportive services is a top priority for 78% or more of the DCF caseload.[113] When children must be removed from their home, DCF has a strong multifaceted framework for overseeing children placed in state custody. Since DCF has become the legal parent of children in their custody, it is nonnegotiable that the children entrusted to their care have a framework of policies and practices that support child safety and well-being. **It is equally important that DCF has a structured quality assurance framework to guide their work with intact families; but no such framework currently exists.**

To inform the development of such a framework, the DCF administration should analyze the wealth of information available in data, qualitative experience (including information gathered from families with DCF involvement), and in the experience of community partners to identify how to structure intervention with intact families so that it is successful and appropriately time limited. Any developed framework should also include the following key components:

A System of Family Assessment and Action Plan Reviews

The DCF Family Assessment and Action Plan (FAAP) is a tool to support a family's progress toward achieving safety in the home environment. DCF case management teams are required to update the FAAP at six-month intervals until the case is closed. As seen in this case, there is no requirement that the FAAP be changed or reassessed when there is little to no progress on achieving the goals. Sometimes, no progress will mean that a case escalates into a petition by a DCF case management team for custody of a child, but in many cases, it should result in a reassessment of the viability and appropriateness of the FAAP itself.

It is natural that a DCF case management team working to support a family may have difficulty constructively reviewing their own clinical formulation or the adequacy of a FAAP, particularly when such an evaluation may feel like a criticism of their work. DCF could greatly improve their

[113] Data provided by the Department of Children and Families on October 15, 2025.

work with intact families by structuring assessment points for review of FAAPs by DCF clinical staff external to the DCF case management team. This assessment by staff external to the case should include an evaluation of the clinical formulation, updated information from service providers, updated information from collateral contacts, and any other relevant assessment tools all with the aim of moving a case quickly toward safe permanence of the children involved.

A Dedicated DCF Casework Policy

Perhaps the most critical element of this recommendation is the creation of a policy that specifically addresses DCF's work with intact families. Most DCF policies are designed to address DCF's work with children who are in the state's custody. Some elements of those policies are applicable to DCF's work with intact families, and the DCF workforce employs them as such. However, no policy exists solely to support DCF's work with intact families.

The current policy most relevant to DCF's work with intact families is the DCF Family Assessment and Action Planning Policy. The Family Assessment and Action Planning Policy relates to the assessment, creation, and monitoring of the FAAP, which is described as "a family-focused, collaborative process of engaging families, collaterals, and family supports in providing information about the family's history, functioning, strengths and needs and about how well the safety, permanency and well-being needs are being met for the child."[114] This is a robust policy that was updated in 2021 in consultation with the OCA and is discussed in *Recommendation #3* of this report as requiring an increased focus on clinical formulation.

The DCF administration should develop a stand-alone policy that directly guides the agency's work with intact families in addition to the Family Assessment and Action Planning Policy. This policy should clearly identify the goals of such work, and the overarching principles of how the work should be accomplished. The DCF policy should particularly address the delicate balance of supporting a family's success and carefully monitoring the risks to the child.

A child's safety, short term and long term, must be the center of all DCF's work with any family or caregiver. The creation of a policy provides clarity to the DCF case management teams, the Juvenile Court, and most importantly the families and children themselves about what they should expect and can anticipate from DCF involvement. In this case, as with other cases the OCA has reviewed, DCF case management teams are not always clear with families about what successful strengthening of a family and what alleviation of risk to a child looks like. The creation of a policy specifically addressing the agency's work with intact families would not only provide this clarity but may also be a tool to guide challenging discussions on what children require to be safe at home.

[114] Massachusetts Department of Children and Families. (2021). DCF Family Assessment and Action Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download

Multidisciplinary Case Review Team Requirements

DCF currently has multidisciplinary case review teams within both the DCF regional offices and DCF area offices, but there is no framework for when such case reviews are required during DCF involvement with an intact family. Working with intact families presents unique challenges for DCF case management teams because they must balance safety with family preservation. A timeline-oriented, multidisciplinary approach to casework would help to ensure that DCF case management teams' assessments of risks to children and protective factors are calibrated clearly and that resulting interventions are measurable and goal oriented.

To further ensure accuracy and objectivity, DCF multidisciplinary team members must include DCF case management team personnel from outside of the DCF case management team's unit and include DCF clinical specialists and DCF legal staff. DCF legal staff should be consulted when DCF case management teams identify the possibility of a child's removal from their parents' care, and they can also be engaged as partners in helping to structure thinking about the risks to a child even when removal of the child from the family is not anticipated.

Triggers for Heightened Case Review

The DCF administration should consider which factors in the trajectory of a DCF case with an intact family require that the case receive a heightened review. "Heightened review" is any elevation of a case and can include but is not limited to identifying when

- A DCF area office is considering seeking custody of a child.
- A case should be closed when concerns have not been alleviated.
- Lack of service availability is preventing the necessary changes from moving forward.
- New strategies or new approaches are necessary to support improved outcomes.
- The clinical formulation of a case does not accurately describe the child or family's experience.

Conversely, establishing when a heightened review is necessary will create a shared understanding of when a case is progressing in an expected and positive manner.

DCF has numerous data reports that are available to DCF area offices for intact families and for children who are in DCF custody. These data reports offer opportunities to identify cases that require a heightened and/or multidisciplinary review. Undoubtedly, some DCF regional offices and DCF area offices are already using these reports in this fashion. A supportive framework for working with intact families would not only standardize the use of these reports in this manner but also provide guidance on how to interpret and engage with these reports and reporting functions so they can be utilized as effectively as possible.

Continuous Quality Improvement

A highly structured and well-researched framework of support requires the creation of quantitative and qualitative monitoring systems to guide DCF work with intact families and the establishment of feedback loops to promote a culture of continuous learning and improvement. The stressors and pressures on families that can result in abuse and neglect are complex and evolving, so it is critical that continuous quality improvement mechanisms are built into systems that need to address such complexity.

Conclusion

The weight of the untimely death of A'zella and the significant harm to Luna and Mateo are heavy for DCF and the OCA to carry, even recognizing that the children's parents are the perpetrators of the harm inflicted on these precious children. This case example looks deeply at what we, as a society, should expect from state intervention in the lives of a family. Although it is difficult to use case examples to assess the functioning of an entire system, this case was chosen because it is not a singular instance of something having gone horribly wrong but instead a routine fact pattern that mirrors the everyday work of DCF seen through the regular oversight of the OCA. Although the escalation of the situation was rare and may not have been foreseeable, DCF's intervention with the family over the course of three years provided no measurable improvement to the safety of the children is obvious.

The facts prior to A'zella's death may be ordinary, but the children, as with all children that come to the OCA's attention, are extraordinary. The OCA regrets that we know very little about A'zella, as details of her as a person are not available to the OCA. It is unfortunate that we see her through the lens of the neglect and abuse she experienced. The OCA has access to more information about Luna and Mateo, who are bright stars, each thriving after receiving medical attention and sustained specialist support for their developmental needs. They are tightly bonded to one another and have the energy and enthusiasm fit for their ages. The OCA grieves the sibling bond broken with A'zella's death and recognizes that such pain is lifelong.

The OCA recognizes the unique position we are in, as we are gifted with superior access to information and the benefit of hindsight that can illuminate truths. We are mindful that this access can also result in unfair analysis of previous behavior. In this report, we are asking that the DCF administration step back and consider the big picture of how the Commonwealth engages with intact families, how the agency measures risk with only limited knowledge, and how to evaluate the cumulative effects of chronic neglect. Although the goal is lofty, the recommendations herein are actionable and achievable and do not deviate from the work that is at the core of DCF's mission. DCF is given the task of interrupting harm to children, knowing that it is impossible to prevent harm in all circumstances and thus the work is never done. The OCA is deeply grateful for the shared investment in that work.

The mission of the Office of the Child Advocate 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. One way we accomplish this is through tireless advocacy for policy, practice, and legislative change that we believe will improve the state systems on behalf of all the Commonwealth's children. This report asks that we, as a Commonwealth, consider seriously the investment needed to support and stabilize families so that children can truly thrive and safely enter adulthood. DCF deserves and requires

the support of the Commonwealth in this effort so that we can truly honor and serve our children.

Appendix A: Glossary of Terms

Clinical formulation: DCF defines clinical formulation as succinctly summarizing the family profile and functioning, parental capacities, and the safety, permanency and well-being of each child. In the clinical formulation, the social worker states whether continued Department involvement is being recommended or not and the reason(s) for this recommendation; and identifies the priority areas of focus for the action plan to enable the family to provide for the safety, permanency, and well-being of each child.[115]

Emotional injury: A critical incident 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.

Family preservation: This approach emphasizes supporting families to stay together, recognizing the importance of the parent-child bond, and using all possible means to prevent a child from being removed from their home.

Fatality: A critical incident fatality occurs when a child or young adult between the ages of birth and 22 dies.

Intact family: For this report, an intact family is a family unit where children remain in the home with their parent(s), as opposed to being removed into foster care.

Kin: DCF defines kin as an adult who is not the child's parent and who acts now, or may act in the future, in a caregiving role. This individual may reside in or outside of the home.[116]

Near fatality: A critical incident near fatality can be accidental, the result of a medical condition, or the result of abuse and/or neglect. A verbal certification by a physician that the child or young adult's condition is considered life-threatening is needed for an incident to meet the critical incident definition of a near fatality.

Neglect: In Massachusetts, neglect means failure by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition. This definition is not

[115] Massachusetts Department of Children and Families. (2021). DCF Family Assessment and Action Planning Policy. Accessed December 2, 2025. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download

[116] Massachusetts Department of Children and Families. (2021). DCF Protective Intake Policy. Accessed December 2, 2025. https://www.mass.gov/doc/dcf-protective-intake-policy/download

dependent upon location (i.e., neglect can occur while the child is in an out-of-home or in-home setting).[117]

Open case: DCF defines open case as a child/family in the process of a family assessment or with an active action plan.[118]

Permanency: DCF defines permanency as ensuring a nurturing family – preferably one that is legally permanent – for every child within a timeframe supportive of their needs.[119]

Response worker: DCF defines response worker as a social worker employed by DCF who conducts a response to allegations of abuse and/or neglect under MGL c. 119, § 51B and who has completed DCF's training for response workers.[120]

Serious bodily injury: A critical incident 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.[121]

Screen out: DCF defines a screen-out report as a report that does NOT meet DCF's criteria for suspected abuse and/or neglect. This is a determination that

- The report does not involve a child, or the allegations are not within DCF's mandate concerning child abuse and neglect.
- There was no indication that a child(ren) has been or may have been abused or neglected or may be at risk of being abused and/or neglected by a caregiver.
- The alleged perpetrator has been identified and was not a caregiver or the child's caregiver is safely protecting the child(ren) from the alleged perpetrator unless the allegations involve sexual exploitation or human trafficking.
- The specific injury or specific situation being reported is so old that it has no bearing on the current risk to the reported or other child(ren).
- There are NO other protective concerns, and the only issue is maternal use of appropriately prescribed medication resulting in a substance exposed newborn, the only substance affecting the newborn(s) was appropriately prescribed medication, and the

[117] MGL. c. 18B. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18B; 110 C.M.R. 2.00. Accessed December 2, 2025. https://www.mass.gov/regulations/110-CMR-200-glossary.
[118] Massachusetts Department of Children and Families. (2023). DCF Annual Report Fiscal Year 2023. Accessed December 2, 2025. https://www.mass.gov/doc/fy2023-dcf-annual-report/download
[119] Massachusetts Department of Children and Families. (2023). DCF Annual Report Fiscal Year 2023. Accessed December 2, 2025. https://www.mass.gov/doc/fy2023-dcf-annual-report/download
[120] Massachusetts Department of Children and Families. (2021). DCF Protective Intake Policy. Accessed December 2, 2025. https://www.mass.gov/doc/dcf-protective-intake-policy/download
[121] MGL c. 18C. Accessed December 9, 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C

mother was using the medication(s) as prescribed, which can be verified by a qualified medical or other provider.[122]

Substance exposed newborn (SEN): DCF defines a substance exposed newborn as a newborn who was exposed to alcohol or other drugs in utero ingested by the mother, whether this exposure is detected at birth through a drug screen or withdrawal symptoms. A SEN may also be experiencing neonatal abstinence syndrome (NAS), which are symptoms and signs exhibited by a newborn due to drug withdrawal. NAS is a subset of SEN. Fetal alcohol syndrome (FAS), as diagnosed by a qualified licensed medical professional, is also a subset of SEN.[123]

Supported allegations: DCF defines a supported allegation as reasonable cause to believe that a child(ren) was or is at substantial risk of being abused and/or neglected and the actions or inactions by the parent(s)/caregiver(s) place child(ren) in danger or present substantial risk to the child(ren)'s safety or well-being.[124]

Support and stabilization services: Intensive in-home programs designed to prevent out-of-home placement and promote family preservation and reunification.

[122] Massachusetts Department of Children and Families. (2023). DCF Annual Report Fiscal Year 2023. Accessed December 2, 2025. https://www.mass.gov/doc/fy2023-dcf-annual-report/download
[123] Massachusetts Department of Children and Families. (2021). DCF Protective Intake Policy. Accessed December 2, 2025. https://www.mass.gov/doc/dcf-protective-intake-policy/download
[124] Massachusetts Department of Children and Families. (2021). DCF Protective Intake Policy. Accessed December 2, 2025. https://www.mass.gov/doc/dcf-protective-intake-policy/download

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