



Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump

Making government work better

Official Audit Report – Issued December 7, 2017

Department of Children and Families

For the period January 1, 2014 through December 31, 2015





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December 7, 2017

Ms. Linda S. Spears, Commissioner
Department of Children and Families
600 Washington Street, Sixth Floor
Boston, MA 02111

Dear Commissioner Spears:

I am pleased to provide this performance audit of the Department of Children and Families. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2014 through December 31, 2015. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

I would also like to express my appreciation to the Department of Children and Families for the cooperation and assistance provided to my staff during the audit.

Sincerely,

A handwritten signature in blue ink, appearing to read "SMB", written over a light blue circular stamp.

Suzanne M. Bump
Auditor of the Commonwealth

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services
Maria Z. Mossaides, Child Advocate, Office of the Child Advocate

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LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
DA	district attorney
DCF	Department of Children and Families
MMIS	Medicaid Management Information System
OCA	Office of the Child Advocate
OSA	Office of the State Auditor

EXECUTIVE SUMMARY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of the Department of Children and Families (DCF) for the period January 1, 2014 through December 31, 2015. In this performance audit, we examined DCF's process for reporting critical incidents and fatality investigations.

Below is a summary of our findings and recommendations, with links to each page listed.

Finding 1 Page 13	DCF does not effectively identify and investigate all occurrences of serious bodily injury to children in its care.
Recommendation Page 14	DCF should establish policies and procedures that require its staff to routinely monitor data from the Medicaid Management Information System in order to ensure that it can identify, and investigate as necessary, medical occurrences that appear to be critical incidents involving children in its care.
Finding 2 Page 16	DCF does not report all critical incidents affecting children in its care to the Office of the Child Advocate (OCA).
Recommendations Page 17	<ol style="list-style-type: none">1. DCF should establish a single consistent standard for defining and reporting critical incidents that matches the General Laws.2. Based on this standard, DCF should develop policies, procedures, controls, and monitoring activities that allow for adequate oversight of the reporting of critical incidents.
Finding 3 Page 19	DCF does not report incidents of abuse, neglect, and/or sexual abuse of children in its care to district attorneys' (DAs') offices for investigation whenever it is required to do so.
Recommendations Page 19	<ol style="list-style-type: none">1. DCF should update its policies and procedures to include clear and consistent criteria and reporting standards and should establish monitoring activities over all parties to ensure compliance with these standards.2. DCF should establish monitoring controls to ensure that its staff complies with its policies and procedures for reporting critical incidents to DAs' offices.3. DCF should schedule regular meetings with DAs' offices to ensure that the incidents it reports are applicable and that the DAs do not need additional information to help with their investigations.

Finding 4 Page <u>20</u>	DCF does not complete its fatality investigation reports and submit them to OCA within the established timeframe.
Recommendation Page <u>21</u>	DCF should take the measures necessary to ensure that all fatality review reports are completed and submitted to OCA within the established timeframe. Specifically, DCF should evaluate its current processes, identify opportunities to make them more efficient and less complicated, and update its policies to reflect these changes.

OVERVIEW OF AUDITED ENTITY

The Department of Children and Families (DCF), established by Section 1 of Chapter 18B of the Massachusetts General Laws, provides services to children 0 through 21 years old who are at risk or have been victims of abuse or neglect, as well as their families. According to its website, DCF “is charged with protecting children from abuse and neglect and strengthening families.” DCF’s services include adoption/guardianship, foster care, housing stabilization, family support and stabilization, adolescent services, protective services, and other in-home supports to reduce risks to children (see Appendix A). During our audit period, the department administered its services from a central office in Boston and four regional offices administered by regional directors who oversee 29 local area offices. In fiscal years 2014 and 2015, DCF served an average of 44,919 and 51,822 children under 18 years old each month, respectively. DCF had an annual appropriation of approximately \$827 million for fiscal year 2015 and an annual appropriation of approximately \$908 million for fiscal year 2016.

Children are referred to DCF for services in several ways. Section 51A of Chapter 119 of the General Laws requires professionals whose work brings them into contact with children to notify DCF if they suspect that a child is being abused and/or neglected. This law designates these professionals “mandated reporters,” and they are required to make an immediate oral report and a subsequent written report to DCF when, in their professional capacity, they have reasonable cause to believe that a child under the age of 18 is suffering from abuse and/or neglect. DCF’s guide *Child Abuse and Neglect Reporting: A Guide for Mandated Reporters* states, “When DCF receives a report of abuse and/or neglect, called a 51A report, from either a mandated reporter or another concerned citizen, DCF is required to evaluate the allegations and determine the safety of the children.” DCF does not move forward with an investigation if the issues reported are not considered abuse or neglect or if the abuse was by someone who was not a caregiver of the child. DCF also may not move forward with a new investigation if it is already aware of issues with the family in question. If the report is considered to have merit, DCF conducts what is called a 51B investigation. If DCF determines, as a result of this investigation, that the child is or has been abused or neglected, the 51A report is considered supported, or substantiated. For children who are in immediate danger of harm, DCF can file a care and protection case in the Juvenile Court and request that a judge order the child’s immediate removal from the household. Children/families also come to DCF’s attention from other sources besides 51A reports,

including cases referred by the Juvenile Court, cases referred by the Probate Court, instances of babies surrendered under the Safe Haven Act, and parents' or other relatives' requests for DCF services.

When a child is removed from a household, DCF develops a service plan to provide a long-term stable resolution as soon as possible. According to its *Guide for Foster and Pre-Adoptive Parents*, DCF develops and works with three types of families to provide foster care:

- **Kinship Family:** A licensed family (i.e., one approved to care for children who are in the custody of DCF) that includes those known to the child who may be related by blood, marriage, or adoption or may be no relation to the child, but have family ties based on culture, affection, or family values.
- **Child Specific Family:** A licensed, non-kinship family or person, such as a schoolteacher or a friend's parent.
- **Unrestricted Family:** A person or family, unknown to the child, that has been licensed by DCF to provide foster/pre-adoptive care for a child and that can best meet the child's needs and maintain the child's connection to his/her community and culture.

During fiscal year 2016, on average, approximately 8,981 children under the age of 18 were living in foster care or some type of residential facility each month.

Critical Incidents

Section 5 of Chapter 18C of the General Laws states that agencies, such as DCF, must inform the Office of the Child Advocate (OCA) when a critical incident has occurred. Section 1 of Chapter 18C of the General Laws defines a critical incident as follows:

(a) a fatality, near fatality, or serious bodily injury of a child who is in the custody of or receiving services from the executive office of health and human services or 1 of its constituent agencies; or (b) circumstances which result in a reasonable belief that the executive office of health and human services or 1 of its constituent agencies failed in its duty to protect a child and, as a result, the child was at imminent risk of, or suffered, serious bodily injury.

A "near fatality" can only be designated as such by a hospital staff member and requires that the hospital staff member determine that a child has a life-threatening condition as a result of physical abuse, sexual abuse, or neglect.

Until July 2016, Section 1 of Chapter 18C of the General Laws defined "serious bodily injury" as follows:

Bodily injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

Subsequently, the law was amended to include “serious bodily **or emotional** injury” (emphasis added):

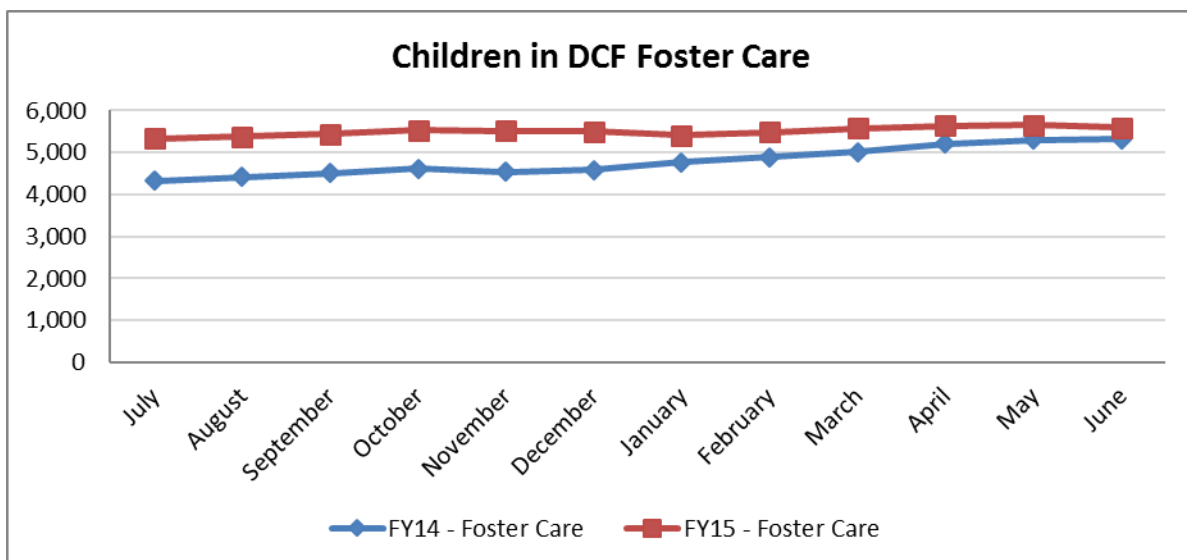
*An injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty **or emotional distress**.* [Emphasis added.]

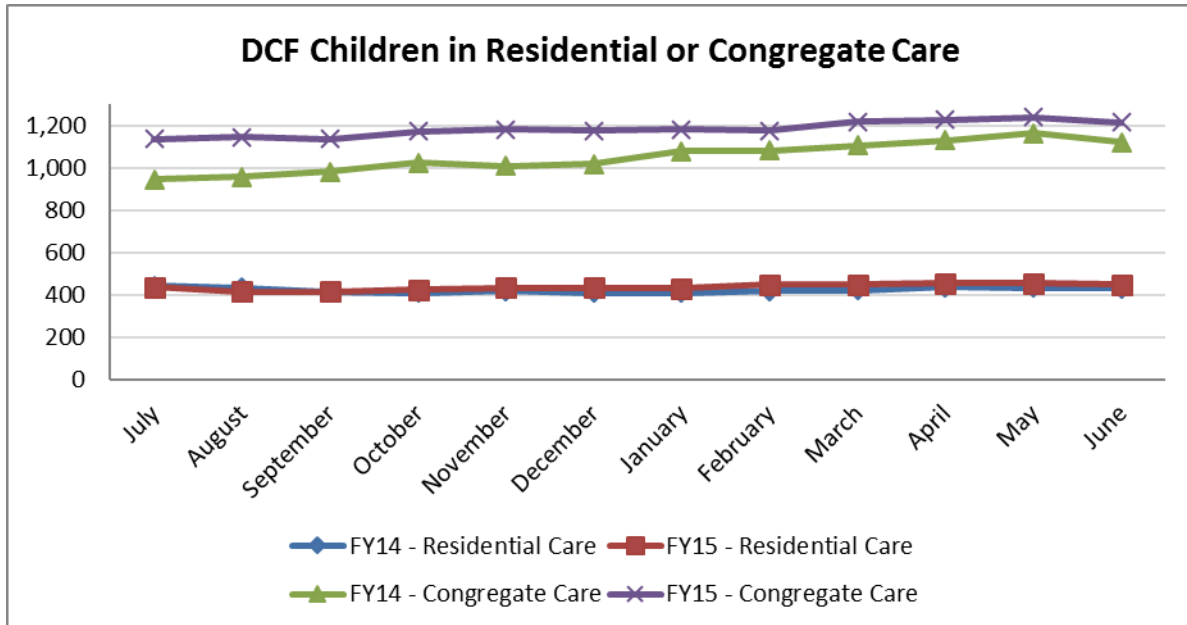
This change was made in order to be more inclusive of children’s mental health.

If DCF determines that “in the best interests of the child, based upon safety, well-being and permanency of the child and the child’s individual needs” the child needs to be placed outside his/her home, the child is placed in one of the following types of DCF-contracted or DCF-operated setting:

1. foster care, which includes kinship families, child-specific families, family foster care homes where a child has previously been placed, and/or family foster care
2. shelter/short-term programs or group care (“congregate care”), which include short-term placements for emergency situations or assessment, called Stabilization and Rapid Reintegration Programs; group homes for children who need specialty care; and long-term residential placements for children who need a higher safety level than a foster or group home can provide
3. community residential care facilities, which are a form of substitute care that provides planned, temporary care in a licensed or approved residential facility 24 hours a day

The graphs below represent the number of children under 18 years old in DCF out-of-home settings each month of the audit period.





When an incident occurs at one of these out-of-home locations, DCF’s Special Investigation Unit is responsible for reviewing the details of the incident and determining whether to screen it in (if it meets DCF’s criteria for suspected neglect or abuse) or out (if it does not meet these criteria). Specifically, when an incident meets DCF’s internal definition of a critical incident,¹ the DCF area director in the area where it occurred completes an internal Critical Incident Form and forwards the form to the regional and/or central office for further review and potential OCA notification. The central office reviews all the area’s Critical Incident Forms, makes a final determination of whether each incident meets the statutory definition of a critical incident and should be screened in, and notifies OCA if an incident does meet that definition.

DCF’s FamilyNet System

DCF’s website describes its FamilyNet system as follows:

[FamilyNet] is a statewide automated child welfare information system that was implemented in February, 1998. This management information system is used for virtually all DCF activities, including intake, investigation, assessment, clinical/case management, adoption, financial, legal and provider services.

1. According to DCF’s *Guidelines for Reporting Critical Incidents to Central Office*, a critical incident is one of three categories of incident that can happen to a child receiving DCF services: a fatality; a near fatality; or a central office alert, which is an incident that might generate media attention.

i-FamilyNet is the Web-based version of FamilyNet. i-FamilyNet files include information about the nature and extent of a child’s abuse and neglect and the child’s foster-care family history, but does not contain a dedicated critical incident report field. Therefore, the audit team did not rely on i-FamilyNet data for analysis purposes; this system was used only as corroborative evidence for researching critical incidents. For example, i-FamilyNet retains a history of addresses for both children and adults involved with the agency and maintains a placement history for all children in out-of-home placement. The aggregate and case-specific data available from this database can be accessed by DCF personnel through reports, through extracts, and directly online. Others, such as employees of residential facilities, can enter incident reports in i-FamilyNet, and OCA employees can review cases but not enter data.

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is the claim-processing and data warehouse system used by the Commonwealth’s Medicaid program (MassHealth) and its Children’s Health Insurance Program. MMIS contains various types of information, such as healthcare information on services provided to MassHealth members and billing submission data, and is used for processing data, verifying eligibility, and running reports that identify medical treatment. During our audit period, DCF was able to access MMIS data for children in its care.

Referrals to District Attorneys

When DCF determines that a 51A report meets the conditions that require a district attorney (DA) referral,² it is required to report this to the DA’s office that covers the geographic area where the incident took place and the DA’s office for the area where the victim resides (if different), according to Section 51B of Chapter 119 of the General Laws.³ According to DCF’s District Attorney Referrals Policy, DCF’s notification to the DA “may be by telephone and must be followed by a written referral.” Additionally, within 30 working days, DCF meets with a social worker, a representative of the DA, and at least one other person outside DCF and the DA’s office to discuss what actions have been and should be taken.

2. According to the version of Section 51B(k)(1–4) of Chapter 119 of the General Laws that was in effect during our audit period, DCF must notify the DA’s office when “early evidence indicates there is reasonable cause to believe that . . . a child has died or has suffered brain damage, loss or substantial impairment of a bodily function or organ, substantial disfigurement, or serious physical injury . . . a child has been sexually assaulted . . . a child has been sexually exploited . . . or there is evidence of physical abuse as a result of a child’s disclosure of sexual assault or the presence of physical evidence of sexual assault.”

3. See Appendix B for DCF policy regarding conditions that warrant a mandatory DA referral.

Fatality Review Reporting Process

According to Section 13.01 of Title 110 of the Code of Massachusetts Regulations (CMR),

[DCF] shall have a Case Investigation Unit (C.I.U.) within the Central Office of the Department. The C.I.U. must conduct internal reviews of all Department and contracted casework provider agency cases involving the death of any child who was:

- (a) a member of a family with an open case; or*
- (b) a member of a family being investigated as a result of a M.G.L. c. 119, § 51A report received prior to the child's death; or*
- (c) a member of a family who had an open case within the six months preceding the child's death; or*
- (d) a member of a family who had a supported 51A report, but a case was not open for services, within the six months proceeding [sic] the child's death.*

According to 110 CMR 13.02(4), at the conclusion of the investigation, the Case Investigation Unit is required to submit a final written report to the DCF commissioner for a review for accuracy and approval within 30 calendar days, unless the death was determined to be of natural causes, in which case the report must be reviewed by the DCF commissioner and submitted to OCA within 60 calendar days.

Additionally, according to 110 CMR 13.02(4),

The report may contain or address recommendations and/or comments covering a range of issues including: commendable or deficient casework practices demonstrated in the case, compliance with existing regulations and procedures, the need for new or revised policies or procedures, operational and administrative issues, etc. . . . The report shall include a narrative of the facts of the case based upon the information gathered by the C.I.U.

OCA

OCA was established by Section 2 of Chapter 18C of the General Laws, which states,

There shall be an office of the child advocate which shall be independent of any supervision or control by any executive agency. The office shall:

- (a) ensure that children involved with an executive agency, in particular, children served by the child welfare or juvenile justice systems, receive timely, safe and effective services;*
- (b) ensure that children placed in the care of the commonwealth or receiving services under the supervision of an executive agency in any public or private facility shall receive humane and dignified treatment at all times, with full respect for the child's personal*

dignity, right to privacy, and right to a free and appropriate education in accordance with state and federal law.

In accordance with Section 3 of Chapter 18C of the General Laws, the Child Advocate, who oversees OCA, is selected and appointed by the Governor from three nominees recommended and submitted by a nominating committee. This committee has 14 members from various public and private organizations whose purposes are directly in line with OCA's. OCA's mission, according to its website, is "to ensure that every child involved with state agencies in Massachusetts is protected from harm and receives quality services." The Child Advocate is appointed by the Governor to serve a four-year term but stays in office until a new Child Advocate is appointed.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of the Department of Children and Families (DCF) for the period January 1, 2014 through December 31, 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer, the conclusion we reached regarding each objective, and where each objective is discussed in the audit findings.

Objective	Conclusion
1. Does DCF properly report critical incidents to the Office of the Child Advocate (OCA) when required?	No; see Findings <u>1</u> , <u>2</u> , and <u>3</u>
2. Is the fatality review report completed, approved, and disseminated on request as required by Section 13.02(4) of Title 110 of the Code of Massachusetts Regulations (CMR)?	No; see Finding <u>4</u>

To achieve our audit objectives, we gained an understanding of the internal controls we determined to be relevant to our audit objectives and tested the controls' operating effectiveness over fatality review reports.

In a previous project, OSA assessed the reliability of the MassHealth data in the Medicaid Management Information System (MMIS), which is maintained by the Executive Office of Health and Human Services. As part of that assessment, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, and (3) looking for dates outside specific time periods. Based on the analysis conducted, we determined that the data obtained were sufficiently reliable for the purposes of this report.

We performed data validity and integrity tests on data received from DCF in various spreadsheets, including testing for missing data and scanning for duplicate records and hidden rows, columns, and formulas. We also ensured that data from MMIS were recorded in i-FamilyNet before including the data in our populations. Based on the analyses conducted, we determined that the data obtained were sufficiently reliable for the purposes of this audit. We relied on the hardcopy source documents for other data needs.

Unreported Incidents

During our audit, we extracted from MMIS information about 617 unique medical incidents. The information included medical billing and procedure codes involving children receiving DCF care. The incidents included physical assaults, injuries that resulted from the use of weapons, drug overdoses or poisonings, suicide attempts, fire-related injuries, and severe burns or bone fractures. We then matched the entire population of 617 incident details from MMIS to each child's case file in i-FamilyNet. The purpose of this testing was to determine whether DCF was aware of these incidents and, if necessary, performed an investigation to determine the child's current health and welfare.

We obtained a population of 781⁴ incidents that involved DCF children in residential facilities and homes from January 1, 2014 through December 31, 2015 and that in OSA's opinion, based on information including medical billing and procedure codes, represented a serious bodily injury as outlined in the definition of a critical incident. These incidents included fatalities, near fatalities, suicide attempts, and gunshot wounds. From this population, we selected a nonstatistical judgmental sample of 40 incidents to determine whether DCF properly notified OCA of critical incidents as required by Sections 1 and 5 of Chapter 18C of the General Laws.

Additionally, we ran a query from MMIS that identified a population of 75 incidents involving children in DCF care during the audit period that might have required district attorney (DA) referrals according to DCF officials. Two of the 75 incidents occurred outside Massachusetts, but OSA sent the remaining 73 incidents to the appropriate DAs' offices to obtain evidence of whether DCF had referred them as required by Section 51B of Chapter 119 of the General Laws.

4. This population of 781 incidents was obtained from DCF via i-FamilyNet and from MassHealth via the MMIS database.

Fatalities

We requested the complete list of children who died in DCF care during our audit period and should have had corresponding fatality review reports.⁵ Because we determined that controls over the fatality review reports were not designed effectively, we tested the full population of 73 fatalities that occurred during the audit period. We requested the fatality review reports to determine whether each report was completed on time,⁶ contained the required elements, and evidenced the DCF commissioner's approval as required by 110 CMR 13. We also determined whether each completed fatality review report was made available to OCA on request in accordance with Section 6 of Chapter 18C of the General Laws.

Whenever sampling was used, we applied a nonstatistical approach, and as a result, we were not able to project our results to the entire populations.

-
5. To be considered reportable under DCF's policy during the audit period, a fatality had to involve a child under the age of 18 who had, or whose family had, an open case or a case that had closed within six months before the date of the fatality.
 6. According to 110 CMR 13.02(4), a fatality review report must be sent to the commissioner within 30 calendar days unless the death was determined to be of natural causes, in which case the report must be sent within 60 calendar days.
-

DETAILED AUDIT FINDINGS WITH AUDITEE’S RESPONSE

1. The Department of Children and Families does not effectively identify and investigate all occurrences of serious bodily injury to children in its care.

The Department of Children and Families (DCF) does not ensure that it is aware of all incidents of abuse, neglect, and injury involving children that it serves. If DCF does not effectively monitor the medical services provided to children in its care, unreported critical incidents may go undetected. This can put children at risk of further abuse, neglect, and bodily injury.

Using the information in the Medicaid Management Information System (MMIS), we analyzed the medical information related to a sample of 566 children in DCF care and found 617 occurrences that appeared to involve serious bodily injury to a child, based on the description of the medical treatment provided. For 260 of these occurrences, DCF had no record of their ever being reported to the department or of DCF identifying them as incidents that should be followed up to determine whether they were critical incidents that should have been reported and possibly investigated. Examples of these occurrences include a 15-year-old with brain damage from a firearm injury, a 1-year-old with first- and second-degree burns on multiple body parts, and a 12-year-old with multiple head contusions that the treating physician determined were a result of an assault.

Serious Medical Incidents Involving Children in DCF Care

	Assault	Weapon	Drug Overdose or Poisoning	Suicide Attempt with Injury	Fire-Related Injury or Severe Burn	Bone Fracture	Total*
Not Reported to DCF	147	26	96	101	30	150	547
Vendor Major Incident Report[†]	10	2	2	25	0	12	44
51A or Institutional Abuse Report	8	0	2	14	0	4	26
	<u>165</u>	<u>28</u>	<u>100</u>	<u>140</u>	<u>30</u>	<u>166</u>	<u>617</u>

* The sum of the individual columns will not equal the Total column because there are incidents classified in multiple categories (e.g., assault with a weapon would be classified under both Assault and Weapon). The Total column represents unique incidents, which means that the same incident can only be counted once no matter how many categories it is found in.

† A vendor major incident report is a written report filed by a licensed individual (i.e., someone who has been approved by DCF to care for children in its custody) detailing an incident that occurred. Some examples of major incidents are incidents that require emergency room visits; suicide ideation or attempts that require medical attention; and injuries resulting from use of weapons.

Authoritative Guidance

Section 1.02 of Title 110 of the Code of Massachusetts Regulations (CMR) states, "In delivering services to children and families the Department shall . . . seek to ensure the safety of children." To meet this responsibility effectively, DCF should use all the information and resources available to it to monitor all incidents involving the health and safety of children in its care, even those that are not reported by mandated reporters, to determine whether any actions are necessary.

Reasons for Noncompliance

DCF has not implemented policies, procedures, or processes for routinely monitoring MMIS to identify types of medical services provided to children in DCF's care and to investigate cases that might indicate abuse or neglect. Further, DCF relies on mandated reporters to notify it of critical incidents involving children in its care. However, there are certain types of serious bodily injury that mandated reporters are not required to report to DCF, including ones that occur in homes, institutions, and other settings such as schools, but were not caused by the child's caretaker/s.

Recommendation

DCF should establish policies and procedures that require its staff to routinely monitor MMIS data to ensure that it can identify, and investigate as necessary, medical occurrences that appear to be critical incidents involving children in its care.

Auditee's Response

DCF provided overall comments on this report as well as comments specific to each finding. DCF's overall comments are as follows.

Since September 2015, DCF has been engaged in significant system-wide reforms that are fundamentally changing the way we do our work. Among these reforms are the development and implementation of seven new policies, including a new Protective Intake Policy and the Department's first-ever Supervision Policy. The new Intake Policy provides a comprehensive set of procedures that guide DCF's review and investigation of reports of abuse or neglect. The Supervision Policy strengthens supervisory support of social workers and improves decision-making by bringing special attention to practice areas including parental history, the parent's ability to care safely for the child and factors such as substance use, mental health challenges or domestic violence that may impact child safety.

More than \$100m in new resources has been added to increase the number of social workers on the front lines, to add specialty social workers in the fields of mental health, domestic violence,

medical and addictions, to hire the first medical director and create a medical services unit, and to strengthen management and supervisory processes. A strengthened field structure provides consistent management and supervisory oversight while the Department's completely new Continuous Quality Improvement program provides a means of routinely reviewing and improving clinical practice and decision making so that children served by DCF achieve the best outcomes. While the progress continues, the social work caseloads are the lowest in many years and almost 97% of social workers are licensed.

Recognizing the importance of collaborating closely with our community partners as child welfare is not the work of one person or one agency, the Department remains committed to engaging in learning opportunities in order to improve upon our work.

DCF's comments specific to this audit finding are as follows.

M.G.L. ch. 119, sec. 51A requires certain individuals, such as doctors, to file reports with DCF when they have reasonable cause to believe that a child is being abused or neglected. These mandated reporters are subject to financial penalties should they fail to file a report. Additionally the law requires all licensed mandated reporters to take training to "recognize and report suspected child abuse and neglect." The Department regularly conducts trainings for mandated reporters across the state as well on-line trainings developed by local District Attorneys are available on the Internet. While the responsibility to report remains with mandated reporters, DCF will determine the feasibility of accessing MassHealth claims data in its MMIS system to identify medical treatment that may indicate a child was abused or neglected and should have been reported to DCF (either by our providers or by mandated reporters such as doctors and hospital staff). Given the fact that this data is claims data and likely several months old by the time it might be available to DCF, any process will serve as an "after-the-fact" quality indicator.

Auditor's Reply

Although there is a statutory requirement for mandated reporters to provide DCF with information regarding children who have been abused or neglected, based on the data we reviewed, for a variety of reasons this does not always appear to happen, in which case some children may be at a continued risk of abuse and/or neglect. Therefore, the Office of the State Auditor (OSA) believes that DCF, as the state agency charged with overseeing the protection of children, is responsible for taking whatever measures it has available, including reviewing the MassHealth data regularly to ensure that it is aware of all potential instances of neglect or abuse of a child and can act on these situations appropriately. In its response, DCF asserts that "given the fact that this data is claims data and likely several months old by the time it might be available to DCF, any process will serve as an 'after-the-fact' quality indicator." We do not agree with this assertion. In fact, based on OSA's use of MassHealth data in this and other audits, claim information is typically available to be viewed in MMIS within 2 to 14 calendar days from the date the medical procedure was provided. Moreover, although there may be some lag time between the date

of a potential critical incident and the time this information would be available to DCF, we believe it is better to receive this information late and act on it than not to receive it at all.

Based on its response, DCF is taking measures to address our concerns in this area.

2. DCF does not report all critical incidents affecting children in its care to the Office of the Child Advocate.

DCF does not always report critical incidents to the Office of the Child Advocate (OCA). We gave OCA detailed i-FamilyNet case notes on 40 incidents that appeared to us to meet OCA's definition of "critical incident." OCA officials determined that although 13 of these cases were not reportable critical incidents, at least 16 of them met its definition of "critical incident" and should have been reported to it by DCF. These 16 cases included incidents of stabbing, rape, assault with a baseball bat, gunshot wound, and suicide attempt by fire. OCA officials told us that based on the available records and case notes, it could not definitely determine whether the remaining 11 cases met its definition of "critical incident." However, according to the descriptions of the medical services these children received, these 11 incidents appeared to involve serious bodily injury such as sexual abuse, suicide attempts, and physical assaults, and therefore we believe they met OCA's definition of "critical incident."

Without proper reporting by DCF, OCA cannot perform its oversight function to ensure that children receiving DCF services are appropriately cared for.

Authoritative Guidance

OCA's definition of "critical incident" is drawn from Section 1 of Chapter 18C of the Massachusetts General Laws. Section 5 of Chapter 18C requires DCF to inform OCA when a critical incident has occurred.

Reasons for Noncompliance

DCF's internal reporting requirements for critical incidents do not mirror OCA's requirements. Specifically, DCF's *Guidelines for Reporting Critical Incidents to Central Office* require DCF employees to complete a Critical Incident Form for three categories of occurrence that must be escalated internally: fatalities, near fatalities, and central office alerts.⁷ This form does not include "serious bodily injury" and

7. According to DCF's *Guidelines for Reporting Critical Incidents to Central Office*, "A Central Office Alert is any situation, which is NOT a child fatality or near fatality, that may draw the attention of the media and/or requires that the Deputy Commissioner and the Director of Public Relations be informed of the situation."

thus is not aligned with the OCA reporting requirements or the law noted above. DCF's process of reporting to OCA has two steps, and if the first step of internally reporting a critical incident is not completed, DCF's central office cannot review the incident and, if appropriate, report it to OCA.

There is also lack of centralized written policies, procedures, controls, and monitoring activities that provide the area offices with the necessary oversight over the process of reporting critical incidents.

Recommendations

1. DCF should establish a single consistent standard for defining and reporting critical incidents that matches the General Laws.
2. Based on this standard, DCF should develop policies, procedures, controls, and monitoring activities that allow for adequate oversight of the reporting of critical incidents.

Auditee's Response

DCF responded as follows:

The Department's primary responsibility and mission is to ensure the safety of children. DCF respects the role the Office of the Child Advocate has to accomplish within the Commonwealth. DCF takes its reporting obligation to the Office of Child Advocate earnestly and agrees with the OSA's recommendations that our critical incident reporting process needs to be simplified and streamlined. The Department would like to note however that the "reporting up" of incidents to regional, central office or even to the OFFICE OF THE CHILD ADVOCATE does not change the intensity or ferocity by which we ensure children are safe from harm and families receive the needed supports. The "reporting up" provides additional opportunity for review of the case and helps identify practice improvement activities. To that point, DCF is developing a revised streamlined "Central Office Incident Notification" (COIN) form and process for area offices to report to central office all incidents of concern (critical or otherwise). We are also developing guidance for the area offices on when and how to complete and submit the form. This new process will allow DCF Central Office to more easily identify the subset of incidents that meet the criteria of a "critical incident" that need to be reported to the Office of the Child Advocate. DCF is actively working with the Office of the Child Advocate to develop the specific criteria on which incidents are to be reported as critical incidents in accordance with the requirements of the current law as amended by the Legislature after the period under review.

The Department was aware of each of the incidents cited by the OSA and took action to ensure the safety and well-being of the child(ren) involved. As discussed with the OSA, every incident needs to be examined on a case-by-case basis to determine which rise to the level of a "critical incident." Without reviewing the specific details of the case, it is impossible to determine whether an incident is a critical incident or not. DCF Central Office reviewed the details and case documentation for each of the 40 incidents cited and believes it reported appropriately the required critical incidents to the Office of the Child Advocate. DCF reviewed our findings with the OSA for each of the incidents in question. As a further step, DCF will review each incident with

the Office of the Child Advocate to ensure our interpretation of critical incidents was appropriate based upon the details of each incident.

In addition, OCA gave us a written response regarding critical incidents:

The issue of Critical Incident reporting is one that [OCA] is continuing to work on with the child serving agencies, including the Department of Children and Families. As your report highlights, it is complicated and insuring consistency in reporting is a goal of this office.

In the explanation of Critical Incidents, the draft audit states that a "near fatality" can only be designated as such by a hospital staff member and the life threatening condition is a result of physical abuse, sexual abuse or neglect. The Department of Children and Families has adopted the [Child Abuse Prevention and Treatment Act] definition as its guide in determining a "near fatality." The Office of the Child Advocate has the statutory authority to define "critical incidents," and we will continue to refine the circumstances where we would expect to be notified if a child receiving services from any state agency were to suffer a near fatality, regardless of the cause of the injury or medical determination.

We will continue to work with the Commonwealth's child serving agencies to ensure that the expectations of the OCA are clear and that the agencies are complying with those expectations.

Auditor's Reply

We acknowledge that the investigations conducted by DCF are a critical component of the Commonwealth's system of ensuring child safety. However, we cannot minimize the importance of DCF making sure that it reports all critical incidents to OCA. It is OCA's responsibility to monitor the actions DCF takes to address all cases of child abuse and/or neglect to ensure that DCF effectively meets its own responsibilities in this area. Without complete critical incident information, OCA cannot effectively meet its mission of ensuring that every child involved with state agencies in Massachusetts is protected from harm and receives quality services.

Further, contrary to DCF's assertion, it did not appropriately report critical incidents to OCA in all cases in which it was required. As stated in our report, we shared information about the 40 cited incidents with OCA, which has the statutory authority to define "critical incident," and OCA stated that it believed at least 16 of the 40 incidents were serious enough to be considered critical incidents. Although we do not dispute that DCF may have taken the actions it deemed necessary to ensure the safety of the children in question, informing OCA of all critical incidents is a key component to this child safety process.

Based on its response, DCF is taking measures to address our concerns in this area.

3. DCF does not report incidents of abuse, neglect, and/or sexual abuse of children in its care to district attorneys' offices for investigation whenever it is required to do so.

During our audit period, 19 incidents of sexual abuse, physical abuse, and/or neglect that DCF determined had happened to children in its care were not formally reported to and received by district attorneys (DAs). A number of DAs told us that they would have performed detailed investigations of many of the unreported cases if DCF had properly reported them to the DAs' offices. These 19 incidents affected 22 children and included forcible rape, sexual abuse by a DCF-contracted employee at a residential facility, multiple sexual abuses of children by family members, and various assaults on children. By not ensuring that all substantiated cases of sexual abuse are reported to the appropriate DA's office, DCF may be preventing alleged abusers from being prosecuted.

Authoritative Guidance

Section 51B of Chapter 119 of the General Laws requires DCF to notify the appropriate DA's office immediately when early evidence indicates that there is reasonable cause to believe that, as a result of abuse or neglect, a child has been physically and/or sexually abused or sexually exploited.

Reasons for Noncompliance

DCF has no internal controls, such as monitoring procedures including formalized meetings with DAs' offices, to ensure that all incidents are reported as required. These meetings could help clarify areas of ambiguity regarding what is reportable and any other information that DAs' offices need.

Recommendations

1. DCF should update its policies and procedures to include clear and consistent criteria and reporting standards and should establish monitoring activities over all parties to ensure compliance with these standards.
2. DCF should establish monitoring controls to ensure that its staff complies with its policies and procedures for reporting critical incidents to DAs' offices.
3. DCF should schedule regular meetings with DAs' offices to ensure that the incidents it reports are applicable and that the DAs do not need additional information to help with their investigations.

Auditee's Response

DCF agrees with the OSA's recommendations and prior to the audit, the new administration had initiated the process of updating procedures for conducting District Attorney (DA) referrals and

establishing monitoring controls. In February 2017 DCF implemented a revision to policy #85-012 "Policy for Referrals to the District Attorney and Local Law Enforcement Authority." DCF area offices already conduct regular meetings and/or have regular conversations with the DAs that represent their catchment areas. DCF reviewed each incident cited by the OSA during the audit period (January 1, 2014 to December 31, 2015) with the local DCF area office. For each incident, we determined that the local District Attorney, local police, and area office were working collaboratively on the case even if a formal DA referral had not been completed.

Going forward, we will reinforce compliance with our updated policy to ensure that DA referrals are appropriately made. To accomplish this the DCF [Continuous Quality Improvement] Unit will use its structured case review instruments which include sections that identify intakes/responses requiring a Mandatory (or Discretionary) DA Referral, and whether that referral was made. Administered on a periodic basis, these instruments are scored and DA Referral findings are factored into the overall quality improvement feedback to DCF field offices.

Auditor's Reply

DCF does not dispute that we found 19 incidents, affecting 22 children, of sexual abuse, physical abuse, and/or neglect that DCF determined had happened to children in its care but that were not formally reported to and received by DAs. However, DCF does state, "For each incident, we determined that the local District Attorney, local police, and area office were working collaboratively on the case even if a formal DA referral had not been completed." This assertion is not supported by our audit work: the DAs' offices themselves reported to us that they were never contacted either formally or informally by DCF and were unaware of each incident. In fact, once we presented case information to the DAs, some indicated that based on the information provided, they would have conducted investigations.

Based on its response, DCF is taking measures to address our concerns in this area.

4. DCF does not complete its fatality review reports and submit them to OCA within the established timeframe.

Of the 73 fatality investigations performed by DCF during our audit period, none was completed and submitted to OCA within the established 30- or 60-day timeframe. Specifically, the reports for 68 of these 73 investigations had not been completed and submitted to OCA; 31 (46%) of the 68 were instances where DCF had been aware of a child's death for more than 365 days. Two of the remaining five reports were completed an average of 316 days late.⁸ These five reports were ultimately submitted to OCA for review.

8. Three of the five reports were not dated, so we could not determine their report completion dates or calculate their average number of days late.

OCA evaluates the effectiveness of DCF's work on cases; assesses implications for DCF policies, regulations, training, and contracted services; and determines whether case management and other services provided are adequate, appropriate, and compliant with DCF's own policies and regulations. Without timely fatality review reports from DCF, OCA cannot properly perform this function.

Authoritative Guidance

According to 110 CMR 13.02(4), DCF is required to finalize its fatality review report within 30 days after receiving notification of an unnatural death or 60 days after receiving notification of a natural one. The regulation also states that the report must be approved by the DCF commissioner. Internal DCF policies state that a fatality review report is considered "complete" and available for dissemination when it is signed and approved by the commissioner.

Reasons for Noncompliance

Management told us that the process that DCF has established to approve and submit these completed review reports is too complex; it includes internal and external investigations and no fewer than six departments and/or personnel within DCF to discuss, review, and update the report.

Recommendation

DCF should take the measures necessary to ensure that all fatality review reports are completed and submitted to OCA within the established timeframe. Specifically, DCF should evaluate its current processes, identify opportunities to make them more efficient and less complicated, and update its policies to reflect these changes.

Auditee's Response

Given the complexity of the issues that may be involved in a child death and the time needed to gather the relevant materials, the current regulations may need to be amended to allow for a more reasonable timeframe. In any event, DCF agrees with the OSA's recommendations regarding streamlining our fatality investigation report process to ensure more timely completion and submission to the Office of the Child Advocate. DCF is working with the Office of the Child Advocate to develop a process that best meets this need and will take appropriate actions which may include reviewing and/or revising our regulations, updating the format of the report, and updating our policy. DCF is committed to modifying our process to ensure these reports will be completed and submitted in a timely manner and so that the Department can utilize them as a continuous quality improvement (CQI) tool. All of the fatality investigation reports for the period under audit and requested by the current Office of the Child Advocate have been submitted.

OTHER MATTERS

1. The Department of Children and Families could more effectively address child-on-child incidents of abuse.

When a child in the care of the Department of Children and Families (DCF) is involved in an incident with another child in DCF care, DCF typically only documents the incident in the victim's i-FamilyNet case file, not the perpetrator's, although it does take steps to address the perpetrator's behavior. Our review of case file records indicated that these incidents often involve physical altercations, some serious, including stabbings and other physical injuries. DCF officials with whom we spoke did not explain why the incidents were not documented in the perpetrators' case files, but we determined that the department does not have a policy that requires such incidents to be documented in both parties' files. Thus DCF is not maintaining a complete and accurate record of each perpetrator's behavior. That may limit its ability to effectively assess the risk associated with placing children in the same residence as a perpetrator, whether within DCF or in programs run by other agencies. An inadequate risk assessment could expose other children to violence. Therefore, we believe DCF should consider adopting a policy of documenting this kind of incident in both victims' and perpetrators' case files.

Auditee's Response

DCF agrees with the OSA's recommendation that child-on-child incidents should be recorded in both the victim's and perpetrator's i-FamilyNet case file.

2. DCF should categorize sexual abuse as a critical incident.

DCF does not consider sexual abuse to rise to the level of a critical incident and therefore did not report to the Office of the Child Advocate (OCA) any of the 118 validated⁹ cases of sexual abuse that affected children in DCF care during the audit period. These instances included two male employees at different DCF-contracted residential facilities who sexually abused three girls each; a 10-year-old who was raped by his father; a 4-year-old who was sexually abused by her mother; and a 17-year-old who was gang-raped by five assailants. In one case, a male who had sexually abused one child abused the child's sibling less than one year later. The Office of the State Auditor (OSA) believes that the lack of notification to OCA significantly inhibits OCA's ability to advocate effectively for children in DCF care.

9. "Validated" means that the case was investigated and supported by DCF.

During the audit period, Section 1 of Chapter 18C of the Massachusetts General Laws defined a critical incident, in part, as follows:

A fatality, near fatality, or serious bodily injury of a child who is in the custody of or receiving services from the executive office of health and human services or 1 of its constituent agencies.

It further defined “serious bodily injury” as follows:

An injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty.

However, effective July 1, 2016, Section 21 of Chapter 133 of the Acts of 2016 replaced “serious bodily injury” with “serious bodily or emotional injury,” defined as follows:

An injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress.

DCF officials told us that they believe that sexual abuse does not necessarily include “extreme physical pain” or “protracted loss of impairment of mental faculty” and therefore is not a serious bodily injury. They stated that consequently, although the documented instances of sexual abuse that occurred during our audit period were serious, they did not warrant reporting to OCA.

However, during our audit, we spoke with a number of professionals in this area, including professors and doctors from Boston University School of Social Work, the Massachusetts Children’s Alliance, Boston Children’s Hospital, Massachusetts General Hospital, and the Baystate Family Advocacy Center (see Appendix C), who all said they strongly believed that sexual abuse should be considered a critical incident that DCF should report to OCA because of the severe and prolonged distress and trauma it inflicts on victims.

Based on this—and the fact that “serious bodily injury” has been replaced with “serious bodily or emotional injury,” which includes “mental faculty or emotional distress”—OSA believes that DCF should collaborate with OCA and report these cases of sexual abuse to OCA.

Auditee’s Response

The Department takes reports of sexual abuse very seriously and recognizes the emotional impact that all forms of sexual abuse have on a child. DCF’s 51B investigation process includes

collaboration with the local District Attorney and law enforcement who may also conduct a separate criminal investigation. The Department utilizes the investigation process as its principal intervention to ensure the child's safety. The primary focus of DCF throughout the investigation process is to determine whether a child is at imminent risk of harm and whether removal is necessary to protect the child. As recommended by the OSA, DCF is already collaborating with the Office of the Child Advocate to determine under what circumstances the sexual abuse allegation should be reported to the Office of the Child Advocate.

APPENDIX A

Section 2 of Chapter 18B of the Massachusetts General Laws establishes the duties and responsibilities of the Department of Children and Families as follows:

The department shall provide and administer a comprehensive child welfare program for children and families, including the following services:--

- 1. casework or counseling, including services to families, foster families or individuals;*
- 2. protective services for children;*
- 3. legal services for families, children or individuals who are clients of the department;*
- 4. adoption services;*
- 5. information and referral services;*
- 6. foster family care for children and specialized foster family care for children with special needs;*
- 7. residential care for children with special needs who are not suited for foster family care or specialized foster family care;*
- 8. informal education and group activities;*
- 9. training in parenthood and home management for parents, foster parents and prospective parents;*
- 10. family services intended to prevent the need for foster care and services to children in foster care;*
- 11. temporary residential programs providing counseling and supportive assistance for families in transition and their children who, because of domestic violence, homelessness, or other situations, require temporary shelter and assistance;*
- 12. camping services;*
- 13. information and referral services;*
- 14. services for families and individuals in emergency and transitional housing;*
- 15. comprehensive youth development services;*
- 16. access to and coordination of medical, dental and mental health services for children in foster care whose families are receiving services from other state agencies; and*

17. child care placements for children whose families have an open case with the department.

APPENDIX B

The Department of Children and Families' District Attorney Referrals Policy dated July 8, 2008, which was in effect during our audit period, states, in part,

Pursuant to MGL c. 119, § 51B(4), the Department is mandated to notify and provide information to the appropriate District Attorney and local law enforcement authority if certain specific conditions have resulted from abuse or neglect. The Department is also permitted to notify and provide information about other possible criminal conduct to the appropriate District Attorney and local law enforcement authority.

In addition, the Department is required to establish a Multi-Disciplinary Service Team for each referral to the District Attorney. The purpose of this team is to review the provision of services to children and their families who are the subjects of the referral.

POLICY: MANDATORY REFERRALS

Mandatory referrals are made to the District Attorney for the county and the local law enforcement authority of the city(ies)/town(s) in which the referred child resides and in which the alleged crime occurred. . . .

Conditions that warrant Mandatory Referrals:

- (a) a child has died.*
- (b) a child has been sexually assaulted. This category includes the crimes of:*
 - indecent assault and battery on a child under 14 (MGL. c. 265, § 13B);*
 - indecent assault and battery on a child over 14 (MGL c. 265, § 13H);*
 - rape by force or threat of bodily injury, if the act results in or is committed with acts resulting in serious bodily injury (MGL c. 265, § 22);*
 - rape of a child under 16 by force (MGL c. 265, § 22A);*
 - rape and abuse of a child under 16 (MGL c. 265, § 23);*
 - assault with intent to commit rape (MGL c. 265, § 24);*
 - assault of a child with intent to commit rape (MGL c. 265, § 24B); and*
 - unnatural and lascivious acts with a child under 16 (MGL c. 272, § 35A).*
- (c) a child has suffered brain damage, loss or substantial impairment of a bodily function or organ, or substantial disfigurement.*
- (d) a child has been sexually exploited. This category includes the acts of:*
 - encouraging a child to engage in prostitution (MGL c. 272, §§ 4A and 4B); and*

- *obscene or pornographic photographing, filming, or depicting of a child (MGL c. 272, § 29).*

The definition of the category of sexual exploitation is not dependent on money being paid for prostitution or pictures.

(e) a child has suffered serious physical or sexual abuse [as described in MGL c. 119, § 51B(4)(e) and 110 CMR 4.51(1)(e)] including, but not limited to:

- *fracture of any bone, severe burn, impairment of any organ, or any other serious injury;*
- *injury requiring the child to be placed on life-support systems;*
- *disclosure of physical abuse involving physical evidence that may be destroyed;*
- *current disclosure of sexual abuse; and/or*
- *the presence of physical evidence of sexual assault.*

APPENDIX C

- Massachusetts General Hospital: Dr. Alice Newton, who is the medical director of the hospital's Child Protection Team and an assistant professor at Harvard Medical School. Dr. Newton serves on the Massachusetts Sexual Assault Nurse Examiner Board and the board of the Massachusetts Children's Alliance. She is a member of the Suffolk County Child Fatality Review Team and the Massachusetts Shaken Baby Prevention Coalition.
- Boston Children's Hospital: Dr. Hiu-Fai Fong, who is a staff physician on the hospital's Child Protection Team in the Division of General Pediatrics and an instructor in pediatrics at Harvard Medical School.
- Baystate Medical Center: Dr. Stephen Boos, who is the medical director of the Baystate Family Advocacy Center, an associate professor at the University of Massachusetts Medical School, and an adjunct associate professor at Tufts University School of Medicine.
- Boston University School of Social Work: Professor Mary Elizabeth Collins, the chair of the Social Welfare Policy Department.
- Boston University School of Social Work: Professor Ellen DeVoe, who is the director of the Doctoral Program in Social Work and Sociology and the founding director of the university's Trauma Certificate Program.
- National Children's Alliance: Will Laird, the state government affairs officer.
- Massachusetts Children's Alliance: Tom King, the executive director.