

INVESTIGATIVE REPORT

Office of the Child Advocate
March 2021

A MULTI SYSTEM
INVESTIGATION
INTO THE DEATH
OF DAVID
ALMOND

“Safety and security don’t just happen; they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear.”

Nelson Mandela

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A TRIBUTE TO DAVID ALMOND



February 25, 2006 – October 21, 2020

Let it be known by all that David Almond was a capable, caring, and courageous young man.

Always smiling, David's presence was known and felt instantaneously when he entered a room. David had a sense of humor and found joy in making others laugh and joining them in laughter.

David loved and was loved by his brothers. David was a source of comfort and protection for them. The bond between the triplet brothers was extraordinary. The triplets had their own language to communicate, one individual describing it as their "love language."

David loved school. David was described as the "mayor" of his former school. He was a strong reader and was continuing to build confidence and take pride in his developing abilities. A highlight for David and his brothers was when they participated in a school play together.

David loved cartoons, toys, and videogames. Some of David's favorites were Mario, Sonic the Hedgehog, SpongeBob, and Ninja Turtles. David could recite some SpongeBob episodes by memory.

David was eager to please, he was earnest, and he was kind.

David's impact on those who worked with him and loved him was profound and everlasting.

His memory lives on far beyond the circumstances surrounding his death.

INVESTIGATION PURPOSE AND PROCESS

The Office of the Child Advocate's (OCA) enabling statute, [M.G.L. c. 18C § 5](#), requires that state agencies providing services to children or young adults notify the OCA via a "critical incident report" if a child or young adult suffers a fatality, near fatality, serious bodily injury, or emotional injury.¹ On October 23, 2020, the OCA received a critical incident report from the Department of Children and Families (DCF)² about the October 21, 2020 death of David Almond, the serious bodily and emotional injuries of his brother Michael Almond and the emotional injury of their younger paternal half-sibling, Aiden.³ Consistent with OCA practice, the OCA conducted an immediate administrative review to learn more about the circumstances of the event and DCF's involvement with the family. The OCA initiated a full-scale investigation based on the egregious circumstances of David's death, the harm to Michael and Aiden, concerns about DCF's management of the family's case, and the complications that the COVID-19 pandemic may have had on the provision of state services to this family.

The purpose of this investigation, in accordance with [M.G.L. c. 18C § 5](#), is to determine: (1) the factual circumstances surrounding the critical incident; (2) whether an agency's activities or services provided to a child and his family were adequate and appropriate and in accordance with agency policies and state and federal law; and (3) whether agency policies, regulations, training or delivery of services or state law can be improved.⁴

This investigation is based on a review of confidential electronic and physical records, as well as correspondence and interviews with approximately fifty individuals from all the entities that were responsible for providing services to the family for the 18 months prior to the critical incident report. These individuals include direct service and management personnel from the Department of Children and Families, the Department of Public Health, the Department of Elementary and Secondary Education, the Fall River Public School District, the Massachusetts Juvenile Court, the Massachusetts Probation Service, medical personnel, six human service provider organizations, and the former foster parent of Aiden. As required by our statute, the OCA coordinated efforts with the Bristol County District

¹ For the purposes of critical incident reporting to the OCA, a **fatality** occurs when a child or young adult between the age of birth to twenty-two dies. A **serious bodily injury** "involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ, mental faculty or emotional distress" and may be the result of an accident, an underlying medical condition, or abuse and/or neglect (M.G.L. c. 18C § 1). An **emotional injury** occurs when a child or young adult is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.

² During Fiscal Year 2020 (FY20), DCF submitted 295 statutorily required critical incident reports. Of these 295 reports, the OCA identified 464 individual critical incidents (fatality, near fatality, serious bodily injury, emotional injury) involving 449 children and young adults. There are more children/young adults than number of reports as there can be more than one child or young adult involved in a critical incident report. The number of children and young adults identified in DCF critical incident reports (449) submitted to the OCA during FY20 is 0.006% of the total population served by DCF in FY20.

³ Aiden is a pseudonym to protect this child's identity and privacy. David and Michael have a triplet brother, who will have the pseudonym Noah in this report to protect his identity and privacy. Noah was not in the home at the time of the critical incident. The OCA considered providing Michael with a pseudonym in this report out of respect for his privacy. However, Michael's name has been extensively reported in the media surrounding the incidents described in this report and the OCA believes that providing clarity and analysis to the already existing public information is a service to Michael. Therefore, Michael's name is being used to avoid speculation on the facts as they relate to Michael and to reflect a true accounting of Michael's experience.

⁴ The scope of the OCA investigation is different from the criminal investigation, which will address any individual responsibility in the death of David.

Attorney's office during this investigation.⁵ The OCA wishes to acknowledge with gratitude the individuals from all these entities for their cooperation and collaboration on this investigation.

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 the statutory duties. Confidential information may not be shared with the public and for this reason many protected details are not included in this report.

ABOUT THE OFFICE OF THE CHILD ADVOCATE

The [Office of the Child Advocate \(OCA\)](#) is an independent executive branch agency with oversight and ombudsperson responsibilities, established by the legislature in 2008.⁶ Our mission is to provide independent oversight of state services for children to ensure they receive appropriate, timely and quality services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children can thrive. Through collaboration with public and private stakeholders, the OCA identifies gaps in state services and recommends improvements in policy and practice. The OCA also serves as a resource for families who are receiving, or are eligible to receive, services from the Commonwealth.

⁵ M.G.L. c. 18C § 5.

⁶ The Office of the Child Advocate Statute is [M.G.L. c. 18C](#).

INTRODUCTION

Early in the morning of October 21, 2020, the Fall River Police Department received a 911 call concerning an unresponsive child. Fall River police responded to the home of John Almond, Jaclyn Coleman and Ann Shadburn and found David Almond, a 14-year-old with Autism Spectrum Disorder,⁷ emaciated, bruised, and unresponsive.⁸ David was transported to Charlton Memorial Hospital where he was pronounced deceased. David's triplet brother Michael, also diagnosed with Autism Spectrum Disorder, and his three-year-old paternal half-sibling, Aiden, were in the home as well. Michael was responsive but emaciated, and Aiden was well-nourished and appeared physically unharmed. David and Michael's triplet brother Noah was not in the care or custody of this family at the time of David's death. The home was in deplorable condition and substances believed to be heroin and fentanyl were found in the apartment.⁹ On March 17, 2021, the Office of the Chief Medical Examiner ruled David's cause of death *Failure to Thrive and Malnutrition due to Starvation and Neglect in an Adolescent with Autism Spectrum Disorder* and the manner of death *Homicide*.¹⁰ At the time of the release of this report, both Mr. Almond and Ms. Coleman are in jail and facing criminal charges.

As discussed herein, the OCA reviews critical incidents that are reported to our office pursuant to [M.G.L. c. 18C § 5](#). The Department of Children and Families (DCF) critical incident report detailing the harm that came to David, Michael, and Aiden was of such an extreme nature that the OCA determined a full investigation was warranted. Once the OCA became aware of how many state agencies,¹¹ entities, and providers were involved with this family prior to the death of David, the OCA recognized that an investigation into this case was an opportunity to engage in a public discussion of the strength of our state system of service provision to children and families. Additionally, the Secretary of the Executive Office of Health and Human Services requested that the OCA independently investigate the events that led to David's death. The resulting investigation is a multi-system analysis of the safety net of state services provided to children and families and the performance of that safety net when under the pressure of the COVID-19 pandemic.

⁷ According to the American Psychological Association, "Autism spectrum disorder (ASD) refers to a neurodevelopment disorder that is characterized by difficulties with social communication and social interaction and restricted and repetitive patterns in behaviors, interests, and activities. The symptoms are present early on in development and affect daily functioning. ASD occurs in all racial and ethnic groups, and across every socioeconomic status level. Boys are about four times more likely to have ASD than girls." <https://www.apa.org/topics/autism-spectrum-disorder>

⁸ The apartment was leased to Ms. Shadburn, Mr. Almond's biological mother.

⁹ For detailed information, refer to the **Family Background and Child Welfare Involvement** section.

¹⁰ The OCA is sharing these details as death certificates in Massachusetts are public documents: <https://www.mass.gov/death-certificates>

¹¹ A state agency as defined by the OCA's statute is an agency within the Office of the Governor, including the Executive Office of Education, the Executive Office of Public Safety and Security, the Executive Office of Health and Human Services, and their constituent agencies. [M.G.L. c. 18C § 1](#)

FAMILY INVOLVEMENT WITH STATE SERVICES

The Almond family were under the supervision of DCF and had ongoing Juvenile Court involvement at the time of David's death. This family's long history with child protective services is relevant to understanding the gravity of the state systems' missteps and the consequences those missteps had for this family. Many state systems¹² and service providers were in contact with this family at the time David and Michael were being abused and neglected by Mr. Almond and Ms. Coleman. This report, as much as possible, describes the state systems and service provider involvement with this family to explain how such a devastating situation happened when this family was being provided services.

Detailed information about the Almond family and their child welfare history is provided in the *Family Background and Child Welfare Involvement* section of this report.

THE ROLE OF THE CHILDREN'S DISABILITY

David died from child abuse and neglect. Children with disabilities are at least three times as likely to be maltreated than their peers without disabilities, and they are more likely to be seriously injured or harmed by abuse or neglect.¹³ The OCA has determined that David and Michael's disabilities played a critical role in this situation, as their disabilities were intimately tied to their vulnerabilities. Further, the lack of general knowledge about disabilities, and the lack of specific knowledge of how these children's disabilities presented in them as individuals, resulted in state systems overlooking the risk factors and warning signs that precipitated David's death. **Detailed information about the role of the children's disabilities is provided in the *Family Background and Child Welfare Involvement, Findings and Recommendations: Department of Children and Families, and Department of Elementary and Secondary Education (DESE) and Fall River Public School District (FRPS)* sections of this report.**

THE ROLE OF THE COVID-19 PANDEMIC

On March 10, 2020, Governor Charlie Baker declared a State of Emergency in Massachusetts due to the outbreak of the 2019 Coronavirus (COVID-19).¹⁴ This state of emergency continues to be in effect at the time of the release of this report. This pandemic has created an unprecedented strain on the Commonwealth's children and families, and on the public and private entities that provide support to them. Economic stress, social isolation, and uncertainty in times of crisis can affect rates of child abuse and neglect.¹⁵ Child-serving state agencies, especially DCF, are in the unenviable role of trying to protect and care for their own workforce in addition to dealing with the new and challenging landscape of abuse and neglect in the time of a nationwide pandemic. The pandemic has required that state systems continuously shift and alter their operating procedures to continue their work in a manner that is safe.

¹² **State systems** is a term used in this report to refer to state agencies such as DCF as well as state entities such as the Juvenile Court.

¹³ Center for Disease Control: The Risk and Prevention of Maltreatment of Children with Disabilities. <https://www.childwelfare.gov/pubPDFs/focus.pdf>

¹⁴ <https://www.mass.gov/news/declaration-of-a-state-of-emergency-to-respond-to-covid-19>

¹⁵ See for example, Zagorsky, J., Schlesinger, M., Sege, R. (2010, October). What happens to child maltreatment when unemployment goes up? [Paper presentation]. American Academy of Pediatrics 2010 National Conference and Exhibition, San Francisco, CA. <https://aap.confex.com/aap/2010/webprogram/Paper11475.html>

This shifting has resulted in some confusion regarding policies and procedures, prioritization of some policies and procedures over others, and extensive new and changing guidance for practitioners to internalize in trying to meet the requirements of their roles.

Many families are earnestly struggling during this time to keep themselves and their children safe from harm and the state is working hard to meet those families' needs. This family, and we suspect many others, have seized the opportunity of this pandemic to exploit the confusion and change in operating procedures to conceal the reality of their situations behind closed doors. The OCA is using this investigation as a learning opportunity to see what policies, procedures, and safety net measures can be put in place to cope with any unexpected upheavals to ensure that child protection always remains a top priority.

Since the state of emergency began in March 2020, ensuring the welfare and safety of the most vulnerable children and families has remained the OCA's top priority. The OCA has focused its pandemic response efforts on preventative work that identifies where families can get the help they need.¹⁶ This includes collecting information about gaps and challenges in providing children with needed services, identifying special populations of particularly at-risk children who need focused attention, and working with our public and private partners to identify creative solutions to both in-the-moment crises and emerging and anticipated challenges. This report is the OCA's next step in this work.

OCA STATEMENT ABOUT THE INVESTIGATION

The OCA believes, without reservation, that from the time David and Michael returned to the home of Mr. Almond and Ms. Coleman on March 13, 2020 until David's death on October 21, 2020, Mr. Almond and Ms. Coleman took active and persistent steps to keep David and Michael out of sight from DCF, the service providers assigned to family, and from school officials. All entities working with the family failed to understand that this avoidance and minimal contact with David and Michael was a purposeful effort intending to conceal the severe neglect and abuse that both children suffered. In contrast, Aiden, the child of both Mr. Almond and Ms. Coleman, continued to receive state services throughout the pandemic. Mr. Almond and Ms. Coleman exploited the complexity of the pandemic's impact on state-mandated and authorized services. They blocked virtual contact with David and Michael by lying about their technology access and they successfully manipulated the professionals involved with the family. This report does not underestimate the difficulty of working with a family that actively tries to evade assistance.

The OCA greatly respects and supports the state systems that are discussed in this report. The OCA had the full cooperation of the state systems mentioned herein and is grateful that every single one of them took up this difficult evaluative task in the spirit of improving the Commonwealth's protection of children. The OCA's oversight responsibilities result in the OCA having to say difficult things to individuals and agencies who have dedicated their professional and personal lives to working to improve

¹⁶ See, for example: [We All Need Help Sometimes | Mass.gov](https://www.mass.gov/info-details/we-all-need-help-sometimes)

the lives of others. The OCA recognizes that DCF and the other state systems discussed in this report have some of the most difficult jobs in the Commonwealth. The complexity and risks to personal safety and well-being, but also the responsibility to keep children safe, is unlike any other weight. Mistakes in judgement and case management will haunt these providers.

This report is meant to be read in its entirety, not only to understand what happened to these children, but also to understand the complexities of the interplay of these state systems in providing services to families. Individual state agency and entity sections within this report include themes, findings, and recommendations specific to that state agency or entity. This report explicitly identifies policies, procedures, and practices when the report intends to distinguish the state system from the individual personnel within that state system.

This report is grounded in the understanding that the safety and well-being of a child, particularly a child with disabilities, is the shared responsibility of the family, community, and entities responsible for providing services to children and families. It is the OCA's obligation to critically examine this tragedy and ask how we, as a Commonwealth, can do better. Our answer to this question is detailed below in this report, which is dedicated to David Almond.

FAMILY BACKGROUND AND CHILD WELFARE INVOLVEMENT

David, Michael, and Noah were born in Syracuse, New York in February 2006 to Sarah (Dawes) Almond and John Almond. The children were each diagnosed with **Autism Spectrum Disorder** at approximately age two. All three triplets received early intervention services until age three and then began receiving special education services from their school system. David was eligible for special education services until the date of his death.

Between 2006 and June 2013, the triplets were removed from Mr. Almond and Ms. Almond three times by the New York Office of Children and Family Services (OCFS) because of parental substance use, parental mental health challenges, deplorable living conditions, medical neglect of the children, inadequate supervision, and a general lack of basic care. Mr. Almond moved to Massachusetts near or about April 2013 and had limited contact with the triplets, who remained in the legal custody of New York OCFS. Following the triplets' final removal from Ms. Almond's care in June 2013, she reportedly did not have any contact with them for several years leading up to David's death.¹⁷

Between June 2013 and 2016, the triplets remained in the legal custody of New York OCFS. The triplets reportedly participated in therapeutic services to meet their special needs and were doing well. Legal steps were taken by New York OCFS to initiate the termination of both parents' parental rights, as neither of them were having regular contact with David or his brothers, nor participating in services that would facilitate the family's reunification. Neither parent had their parental rights terminated. **From a review of the New York records, the OCA could not determine the reason that the termination of parental rights was not completed, as a termination appeared to be the appropriate legal action under the circumstances.**

In September 2016, while Mr. Almond was living in Massachusetts, New York Family Court awarded full custody of David, Michael, and Noah to Mr. Almond. Mr. Almond was granted custody of the triplets after years of minimal to no contact with them. There was no evidence available for the OCA to review that indicated Mr. Almond ever completed any service on his extensive New York service plan. There is also no evidence that New York OCFS ever initiated contact with Massachusetts DCF, or any other state entity, to determine if Mr. Almond had the means and ability to parent these children prior to the New York Family Court placing

What is Autism Spectrum Disorder (ASD)?

ASD is a neurodevelopmental disorder that is characterized by difficulties with social communication, social interaction and restricted and repetitive patterns in behavior, interests, and activities. The symptoms are present early in development and affect daily functioning.

ASD is a "spectrum" disorder because there is a wide variety in the type and severity of symptoms individuals experience.

American Psychological Association

¹⁷ Since the family became involved with Massachusetts DCF in 2017, both DCF and the Juvenile Court made reasonable efforts to locate Ms. Almond. She did not respond and her whereabouts were unknown to both entities until shortly after David's death when she initiated contact with the Fall River Police Department.

the children with him in Massachusetts. **This decision remains a mystery to the OCA as returning custody to Mr. Almond appears not to have been the appropriate legal action under the circumstances.**

When awarded custody in 2016, Mr. Almond moved the triplets to Fall River, Massachusetts, where he was living. He and the triplets lived in a small one-bedroom apartment with his non-marital partner Jaclyn Coleman and his mother Ann Shadburn, who was the apartment's lessee. Mr. Almond and Ms. Coleman both have histories with child protective services as children and as parents. **Both Mr. Almond and Ms. Coleman were in DCF custody for parts of their childhoods with histories notable for abuse and neglect, mental health concerns, physical violence, and substance use. Ms. Shadburn's parental rights to Mr. Almond and her other children were terminated.**

In June 2017, approximately nine months after New York Family Court returned the triplets to Mr. Almond's custody, the DCF Fall River Area Office received two reports alleging neglect and physical abuse of the triplets. All three triplets allegedly had poor hygiene, excessive absences from school, and two of them had injuries.¹⁸ The DCF Fall River Area Office investigated but did not support allegations of neglect and physical abuse of all three children.

The current case was opened by the DCF Fall River Area Office¹⁹ in August 2017 due to Ms. Coleman's substance use, and concern for Mr. Almond and Ms. Coleman's ability to meet the needs of their newborn Aiden and the needs of the triplets. In October 2017, all four children were removed from Mr. Almond and Ms.

Coleman's custody because of allegations of neglect and physical abuse of the children, parental substance use, unsanitary conditions of the home, medical neglect of the children, and the triplets' excessive absences from school. **This was the fourth time in the triplets' young lives that they were removed from Mr. Almond for the identical pattern of abuse and neglect.** The DCF case management

What is a DCF Family Assessment and Action Plan?

When a child is removed from their caregiver, DCF is mandated to provide reasonable efforts to help the family resolve the concerns that led to removal and make efforts to reunify that child with his/her family.

DCF utilizes a Family Assessment and Action Plan (FAAP) to outline the path toward reunification. This FAAP lists the services that the family must engage in prior to reunification to mitigate or eliminate the risk to the children.

Although DCF monitors progress on the tasks outlined in the FAAP, there is no formal DCF process in place that analyzes the effect of the FAAP on parental capacity prior to a decision to reunify a child with his/her family.

¹⁸ Aiden was not born yet.

¹⁹The DCF Fall River Area Office is responsible for this family's case since it opened in August 2017. 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 "DCF administration" mean the DCF Central Office which oversees the entire DCF workforce. References to the "DCF Fall River Area Office" mean the social worker, supervisor, area program manager, area clinical manager, and area director. References to the "DCF area office management" mean the area program manager, area clinical manager and/or area director. References to the "DCF case management team" mean the direct social worker and/or supervisor responsible for this case.

team placed Aiden in a foster home and placed the triplets in a temporary congregate care setting²⁰ before moving them to a second congregate care setting that specializes in the care of children with intellectual disabilities and Autism Spectrum Disorder.

After the children’s removal in October 2017, the DCF case management team provided Mr. Almond and Ms. Coleman a **Family Assessment and Action Plan (FAAP or “action plan”)**. The action plan is intended to address the concerns that brought the family to the attention of DCF. This action plan identified that Mr. Almond and Ms. Coleman should engage in and comply with individual therapy to address long-standing substance use and mental health related concerns, submit to random drug tests, participate in family therapy with the triplets, and complete psychological evaluations and parenting classes.

Foster Care Reviews were held in April and October of 2018. It was determined in these reviews that Mr. Almond and Ms. Coleman had made minimal progress toward reunifying with the children based on their lack of consistent participation in the services outlined in the action plan. At the October review, the DCF case management team proposed changing the children’s permanency goal from reunification to adoption. In January 2019, the children’s permanency goal was formally changed to adoption.

Four months later, at the Foster Care Review in April 2019, the DCF case management team reported to the foster care review panel that Mr. Almond and Ms. Coleman’s participation in their action plan services had improved. Although their participation had increased, they were only at the beginning stages of compliance with many of their services. Additionally, there were services, such as Mr. Almond’s individual therapy, that the family were not engaged in and in which the family never engaged. At this meeting, the foster care review panel recommended that if Mr. Almond and Ms. Coleman continued to participate in the services for the next four months, which would have been an eight-month pattern of semi-engagement, the DCF case management team should convene a **Permanency Planning Conference** to consider changing the children’s permanency goal back to return to parent.

What is a Foster Care Review?

DCF is mandated by federal and state law to have an independent Foster Care Review Unit that operates outside of DCF’s daily delivery of casework services and provides quality oversight of case decisions.

The purpose of a Foster Care Review meeting is to determine the progress a family is making to resolve the reasons for DCF involvement and to make recommendations for a child to safely achieve permanency.

Foster Care Reviews are chaired by a three-person panel whose members are not responsible for case management, oversight or service delivery of the case being reviewed. They are held every six months for the duration a child is in out-of-home placement and compliments the oversight role of the juvenile court.

DCF Foster Care Review Policy, 2019

²⁰ Congregate care is a term for placement settings that consists of 24-hour supervision for children in a varying degree of highly structured settings such as group homes, residential childcare communities, childcare institutions, residential treatment facilities, or maternity homes. <https://www.mass.gov/doc/dcf-annual-reportfy2020/download>

Three months later, at a Permanency Planning Conference on July 11, 2019, the DCF Fall River Area Office changed all four children’s permanency goal from adoption back to return to parent. Aiden was reunified with Mr. Almond and Ms. Coleman the following day.²¹ This permanency plan decision was made despite a Juvenile Court hearing on July 10, 2019, one day prior, that deemed Mr. Almond unfit to care for the triplets and found the triplets in need of Care and Protection.²² The decisions to change the children’s permanency goal to return to parent and to immediately reunify Aiden were made despite Mr. Almond and Ms. Coleman’s minimal participation in services and without the DCF Fall River Area Office assessing any change in their parenting abilities. This decision appears to be largely based on a parenting evaluation conducted by a DCF contracted service provider agency.²³

DCF held another Foster Care Review in October 2019. At the time, Aiden remained in the home with Mr. Almond and Ms. Coleman, and the triplets were in the physical and legal custody of DCF and living at their congregate care program. It was reported by the DCF case management team that Mr. Almond and Ms. Coleman were participating in a home-based parenting support service and they continued to have visits with the triplets at their congregate care setting. The foster care review panel recommended that the triplets should begin visiting with Mr. Almond and Ms. Coleman in the family home once the family obtained a larger apartment.

On December 18, 2019, a utilization review²⁴ meeting took place between the DCF Fall River Area Office and the parenting support service provider. The parenting support service provider reported that Mr. Almond and Ms. Coleman were frequently canceling appointments and the provider expressed concern about Mr. Almond and Ms. Coleman’s ability to meet the triplets’ needs if they were sent home. The parenting support service provider was on the verge of recommending the cancellation of the service with Mr. Almond and Ms. Coleman due to inconsistency

What is a Permanency Planning Conference (PPC)?

Permanency planning begins with the goal of safely maintaining a child at home. If placement becomes necessary to ensure safety, the child’s first goal is reunification with his/her family. If the risk posed to the child’s safety by his/her family remains high and prognosis for reunification is poor, an alternative plan for permanency is developed concurrently with the family.

As soon as the Department determines that reunification is not in the child’s best interests, an alternative permanency plan is established. One type of permanency plan, or goal, is adoption.

DCF Permanency Planning Policy

²¹ Aiden remained in the temporary legal custody of DCF when he was physically reunified with Mr. Almond and Ms. Coleman. On October 9, 2019, legal custody of Aiden was returned to Mr. Almond and Ms. Coleman.

²² Previous to the hearing on the merits for the triplets’ Care and Protection case on July 10, 2019, they were in the temporary custody of DCF. That DCF custody continued but ceased to be temporary on July 10, 2019.

²³ Massachusetts Operational Services Division defines Purchase of Service for human or social services as a social, rehabilitative, health, special education, employment and training, and other services provided to help, maintain, or improve the well-being of clients.

²⁴ A **Utilization Review** is a periodic meeting between a DCF contracted provider, DCF, and sometimes, but not always, the family, to discuss the family’s use and progress in the contracted service.

and lack of engagement. Additionally, Aiden was receiving early intervention services and Mr. Almond and Ms. Coleman also frequently cancelled those scheduled appointments.

At the end of December 2019, DCF area office management made the decision to begin the reunification process of the triplets with Mr. Almond and Ms. Coleman. DCF area office management made this decision without any familiarity with the case and without conducting any administrative review of the case record. The decision to begin this process appears to be based, at least in part, on the apparent successful reunification of Aiden in July 2019. There was no consultation with any of the children's or family's current service providers before making the decision to reunify the triplets. At this meeting, the DCF case management team expressed apprehension about the readiness of Mr. Almond and Ms. Coleman to care for the triplets. There is no written documentation of the discussion or of the rationale for the decisions made at this meeting.

DCF area office management set a reunification date for the triplets in late January 2020. **The DCF case management team, congregate care provider and the triplets' collaborative school²⁵ all independently requested a slower transition.** The concerns expressed to DCF area office management centered around the fact that the triplets had been at their congregate care program since December 2017 and in their collaborative school since January 2018. The children were thriving and successful due to the predictable routine, structure, and expectations provided in these settings. Any swift transition home or to a new educational setting would result in a decrease in the children's ability to manage their behaviors and would increase their anxiety. Additional concerns were expressed about the limited engagement Mr. Almond and Ms. Coleman had in their action plan services and the difficulties the physical space of the home presented for the family. If the triplets returned home, the family faced the threat of eviction because the landlord would not allow seven people to live in a one-bedroom apartment. DCF area office management were aware that there was a notice of eviction from the landlord, no therapeutic home-based services in place for the triplets, and the parenting support service provider was on the verge of terminating services with the family for non-participation. However, DCF area office management instructed the DCF case management team to move forward with the reunification in January 2020 despite the requests for a slower transition and despite these complicating factors.

During the first day home visit for the triplets on January 10, 2020, Ms. Coleman expressed to the DCF case management team that reunification was moving too fast. Ms. Coleman also expressed that the family was not ready for overnight visits with the triplets because the apartment was too small. In the following weeks, Mr. Almond and Ms. Coleman cancelled scheduled day-home visits with the triplets, cancelled parenting support service provider appointments, and failed to complete the required tasks to secure larger housing. As a result, the first overnight home visit for the triplets and reunification was delayed one month.

²⁵ Collaborative schools provide intensive educational programs and services for students with disabilities.

During the triplets first overnight home visit on February 7, 2020, Mr. Almond and Ms. Coleman reported that Noah’s behavior quickly escalated to a point where there was a physical altercation. As a result, Noah was returned to his congregate care program late at night. The DCF Fall River Area Office **did not evaluate this overnight home visit in terms of Mr. Almond and Ms. Coleman’s ability to appropriately care for Noah. The reunification process went forward with David and Michael as if nothing concerning had occurred. After this home visit, Noah remained in his congregate care placement and in DCF custody due to his own self-advocacy and his refusal to return to the care of Mr. Almond and Ms. Coleman.**

On February 11, 2020, the triplets’ congregate care provider sent the DCF Fall River Area Office a letter opposing David and Michael’s reunification citing numerous concerns. The concerns included that the physical environment of the home was inadequate to meet the children’s therapeutic needs, that Mr. Almond and Ms. Coleman were facing eviction, and that a slower and more suitable transition plan was needed. This was an extraordinary step on the congregate care provider’s part to reach-out to the DCF Fall River Area Office. After discussion between the DCF Fall River Area Office and the congregate care provider, the reunification date was changed to March 2020 to accommodate a longer transition period and to put home-based services in place. **The reunification extension to March 2020 did not alleviate the concerns of the DCF case management team, nor concerns of the congregate care provider that reunification was moving too fast.**

On March 13, 2020 David and Michael returned home to Mr. Almond and Ms. Coleman while remaining in the legal custody of DCF. In anticipation of this reunification, the DCF case management team arranged for the family to receive **continuum services** and referred David and Michael for outpatient individual therapy. Although the DCF case management team referred the family for Applied Behavior Analysis (ABA) services, an effective treatment model for individuals with autism, the waitlist was several months long. The DCF area office management chose not to postpone the return until ABA services could be in place. The in-home parenting support service provider that had previously considered cancelling services in December 2019 agreed to provide continued support to Mr. Almond and Ms. Coleman in the reunification of David and Michael. David and Michael did not receive any special education services between their return home on March 13, 2020 and David’s death.²⁶

What is the Continuum service?

The Continuum service provides an array of community-based wraparound services that are designed to maintain youth within their homes and support families as the primary caregivers. This includes in-home family treatment, parent support, youth mentoring, youth and family outreach, care coordination, and linkage with both formal and informal community resources and supports. For youth who cannot be maintained safely at home, services available within Continuum include long-term and short-term, out-of-home care (e.g. group home, pre-independence living, intensive foster care, or respite).

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²⁶ For detailed information, refer to the Findings and Recommendations: Department of Elementary and Secondary Education (DESE) and Fall River Public School District (FRPS) section.

The COVID-19 state of emergency effectively coincided with David and Michael's return home. The mandate that all provider and state agencies provide non-emergency services remotely complicated the family's reunification plan, and the impact was immediately apparent. Reunification occurred on March 13, 2020 and the COVID-19 in-person restrictions went into effect on March 17, 2020. On March 20, 2020, the DCF case management team was notified that the continuum service provider was transitioning to virtual service provision only. This was a significant change in the service provision model and should have prompted the DCF case management team to analyze whether virtual services were sufficient to support this family's successful reunification.

Why did DCF send David and Michael home, and so quickly?

This question is one of the central questions in this case and at the core of the OCA investigation. David and Michael had been living at their congregate care program and attending their collaborative school for over two years and were thriving. Noah refused to return home. Mr. Almond and Ms. Coleman were minimally participating in services and hesitant to have David and Michael returned to their care.

Despite extensive record reviews and interviews with all levels of personnel at the DCF Central Office and the DCF Fall River Area Office, the OCA could not deduce, and no DCF personnel were able to articulate, any clear reason why David and Michael were reunified with Mr. Almond and Ms. Coleman. DCF Fall River Area Office management made the decision to send David and Michael home despite ongoing concerns expressed by the DCF case management team, legal counsel for David and Michael, the congregate care provider, the collaborative school, and Mr. Almond and Ms. Coleman. This family and reunification concerns were not brought to the attention of the DCF Regional or Central Office.

The DCF administration confirmed during this investigation that there were adequate funds in the Fall River Area Office's budget to continue the triplet's congregate care placement.

Within days of David's return home and up until his death, Mr. Almond and Ms. Coleman deliberately avoided contact with the DCF case management team, the Fall River Public Schools, the continuum service provider, and the parenting support service provider. When reached on their cell phones, they often claimed to have phone or internet access issues that prevented them from responding or being on video. Ms. Coleman reported to the DCF case management team and service providers that she could only use the WhatsApp application for video conferencing and for short periods of time due to internet connectivity issues. The DCF case management team, the Fall River Public Schools and the continuum service provider all offered to help the family access technology. Mr. Almond and Ms. Coleman refused, stating they could use Ms. Shadburn's laptop or provided conflicting information about their access to technology and ability to engage in video conferencing.

Despite Ms. Coleman's report to the DCF case management team about technology access barriers, Ms. Coleman was significantly more consistent with video communication with Aiden's early intervention provider and with his former foster parent. In fact, she used different applications, including Facebook Messenger, to video conference and communicate with them. In addition to frequency, early intervention's virtual contacts were at times an hour or longer. **Because the DCF case management team did not elicit information from the early intervention provider about how the family participated virtually, the DCF case management team lacked this critical assessment information. Additionally, the DCF case management team did not re-examine the immediate post-reunification risks based on the family's avoidance of contact, the DCF case management team's inability to visit the home, and the immediate lack of in-person service provision.**

Between March and September 2020, the DCF case management team conducted monthly virtual home visits with the family and saw David, Michael, and Aiden. Ms. Coleman reported to the continuum service provider in March that David was exhibiting challenging behaviors and that the family did not have access to a laptop. When the DCF case management team conducted a virtual home visit with the family in the beginning of April²⁷, Ms. Coleman reported that there were no concerns regarding the children's behaviors and the children had access to a laptop for the purposes of schooling. **The DCF case management team did not recognize that Ms. Coleman provided contradictory information to the DCF case management team and the continuum service provider.**

In mid-May, Ms. Coleman rescheduled a DCF virtual home visit supposedly due to technology access issues. During this phone call, Ms. Coleman reported to the DCF case management team that David was vomiting from having too many snacks and lying in his own vomit. The DCF case management team did not follow up with Ms. Coleman about how David was feeling or the possibility that David could be sick from something other than eating snacks. When the virtual home visit was accomplished ten days later, Ms. Coleman took a strong and controlling role in the communication between the DCF case management team and the children. Ms. Coleman prompted the children to provide specific answers to the DCF case management team questions. In the same month, the parenting support service provider cancelled the service with Mr. Almond and Ms. Coleman due to their lack of engagement with the service.

In June 2020, the continuum service provider updated the DCF case management team twice on how the family was doing. The first service update included information reported by Ms. Coleman that Mr. Almond physically restrained David due to David's aggression and that David was completing his chores, which included scrubbing the floor with a toothbrush. In the second service update, the continuum service provider informed the DCF case management team that Ms. Coleman reported being fearful that David and Michael would both attack her at the same time and that David refused to take his medication. The DCF case management team was aware through these reports that the continuum

²⁷ If Mr. Almond was present for virtual visits between DCF and the family, he minimally participated. DCF and service providers described Mr. Almond as passive, often deferring to Ms. Coleman as the spokesperson for the family.

service provider stressed the importance of seeing the family in-person and offered to hold outside visits at the family's residence which Ms. Coleman refused citing fears of COVID-19. Additionally, the DCF case management team was made aware that the family was not utilizing the 24/7 emergency crisis line that the continuum service provider believed was an important tool for this family. **Each time that Ms. Coleman expressed concerns about the children or her safety in relation to the children's behaviors, she was offered support by the continuum service provider. Each time she declined any professional support.**

At the June 2020 DCF case management team virtual home visit, Ms. Coleman reported that David had oppositional behaviors and described some of them. These behaviors were different than the ones that the continuum service provider informed the DCF case management team about. Despite Ms. Coleman's description of David's behaviors, she denied feeling overwhelmed. The DCF case management team attempted to speak with David and Michael about the fact that they had not had any contact with their brother Noah since they returned home in March. Ms. Coleman continuously interrupted and interjected, preventing the children from answering the DCF case management team questions. The DCF case management team addressed Ms. Coleman's obstruction directly and reiterated the question to the children. David and Michael both stated that they wanted to visit with Noah. **It is the OCA's belief that Ms. Coleman intentionally prevented David and Michael from virtually visiting with Noah to isolate them from Noah and isolate them from the congregate care program staff that knew them well and might have identified concerns.**

Another Foster Care Review was held on June 17, 2020. The foster care review panel found that Mr. Almond and Ms. Coleman were meeting the needs of the children and participating in the continuum services. It is unclear if the foster care review panel was aware that the parenting support service provider closed the case in May due to a lack of responsiveness from Mr. Almond and Ms. Coleman, and it was unclear also if the panel knew of the continuum service provider's description of the challenges facing the family.

In June and July, Mr. Almond and Ms. Coleman's participation in the continuum service did not increase and David and Michael's behavior challenges continued. Despite no improvements, upon the DCF Fall River Area Office's recommendation, the Juvenile Court returned legal custody of David and Michael to Mr. Almond on July 17, 2020. Mr. Almond was not present at this court hearing. Additionally, Ms. Coleman refused an outside home visit with the DCF case management team on this same date due to a reported COVID-19 exposure of Mr. Almond. Ms. Coleman also refused a virtual home visit stating that the video conferencing applications were not working on her phone. **The DCF case management team did not observe the children, the home, or Mr. Almond or Ms. Coleman between June 19, 2020 and July 17, 2020 when David and Michael were legally returned to Mr. Almond's care.**

The DCF Fall River Area Office supervision of the family continued when legal custody of David and Michael was returned to Mr. Almond. During a virtual home visit with the family on July 22, 2020, Ms. Coleman berated David in front of the DCF case management team for behavior she claimed he was purposefully and defiantly exhibiting. David told the DCF case management team he was embarrassed and upset and then he stopped talking. When Michael provided information that was contrary to Ms.

Coleman's narrative in front of the DCF case management team, Ms. Coleman stated that Michael was making her look like a liar. **The DCF case management team did not at any time seek to interview David or Michael outside of the presence of Ms. Coleman.**

In August 2020, the continuum service provider informed the DCF case management team via their weekly update that Ms. Coleman had reported David scratched his collar bone until it had become raw. The DCF case management team did not follow-up with Mr. Almond or Ms. Coleman about this injury. The continuum service provider also expressed that the family was not fully engaging with the service and that the children needed Applied Behavioral Analysis (ABA) services.

On August 21, 2020, the DCF Fall River Area Office intake unit received an anonymous neglect report with concerns for the conditions of the family's home and substance use by Mr. Almond and Ms. Coleman. The reporter noted that Ms. Shadburn lived in the home and had a significant criminal history. This report was screened-out by the DCF Fall River Area Office intake unit which indicates that the allegations were not accepted for a DCF investigation response. Instead of assigning this report for investigation by a DCF Fall River Area Office response worker, DCF area office management required the DCF case management team to have another virtual home visit with the family.

The DCF case management team conducted a virtual home visit with the family on August 24, 2020. The DCF case management team discussed with Ms. Coleman the allegation in the neglect report, and she attributed it to issues with a neighbor and denied the concerns expressed in the report. The DCF case management team did not engage in further assessment of the reported substance abuse concerns nor did they request Mr. Almond and Ms. Coleman submit to a random drug test. The DCF case management team accepted the family's self-report of sobriety as fact.

During this virtual home visit, the DCF case management team noticed a bandage covering David's nose. Ms. Coleman attributed the injury to self-injurious behavior. When the DCF case management team questioned David about the injury, Ms. Coleman instructed David how to respond and David complied with Ms. Coleman's direction. The DCF case management team did not ask to see the injury or speak with David further, and did not recognize that his self-injurious behavior was a sign of distress which was a cause for serious concern regarding his safety and welfare. Given the history of Mr. Almond and Ms. Coleman's use of physical discipline with the children, this warranted further questioning.

On September 14, 2020, Michael was brought by his caregivers to an out-of-state hospital emergency department for an injury that Ms. Coleman reported was self-inflicted. Michael was admitted for overnight observation and discharged home the next day. The OCA is concerned that, given Michael's physical presentation when he was taken into custody five weeks later, there was no documentation of possible concern for his physical well-being by hospital personnel at this visit in September. A report of child abuse or neglect was not filed with Massachusetts DCF.

The DCF case management team's last virtual home visit with the family was on September 25, 2020. David was on video and refused to speak. Ms. Coleman described David as having behavioral issues and expressed concern for the behaviors. Between September 20, 2020 and October 3, 2020, the family canceled or did not attend all their scheduled appointments with the continuum service provider.

On October 1, 2020, an attendance officer from the Fall River Public School District went to the family's home to drop off Chromebooks to facilitate David and Michael's school participation. The attendance officer did not attempt to see David or Michael and met Ms. Coleman outside the family's apartment building. Although the Fall River Public School District staff had contact with Ms. Coleman, **school staff never saw or spoke with David or Michael from March 16, 2020, when they were scheduled to begin school, to the time of David's death.**

The DCF case management team was made aware in October that David's individual therapist had only been successful in contacting the family one time since August. Ms. Coleman provided the DCF case management team with an excuse for why that therapist was not appropriate for David. **It is the OCA's belief that this lack of contact with David's therapist was an intentional effort on Ms. Coleman's part to isolate David and prevent professionals from identifying concerns.**

On October 5, 2020 and again on October 14, 2020, a teacher from Fall River Public Schools contacted the DCF case management team and reported that David and Michael were not logging into school virtually. The DCF case management team contacted Ms. Coleman, who disputed this claim and reported both David and Michael were attending school virtually.

On October 7, 2020, the DCF case management team learned that David missed his physical in July and the family had missed two subsequently scheduled appointments for him.

Another Foster Care Review was held on October 14, 2020. Mr. Almond and Ms. Coleman did not attend the review. The foster care review panel inexplicably found that Mr. Almond and Ms. Coleman were meeting all the children's needs in the home. This determination was made despite concerns regarding the family's lack of consistent engagement and utilization of services, that David and Michael had not attended school or received any special education services since their reunification in March, and despite Ms. Coleman's reports of David engaging in serious self-injurious behaviors.

On the morning of October 21, 2020, emergency medical personnel attended to David in the home pursuant to a 911 call; he was bruised, emaciated, and not breathing. He was transported to Charlton Memorial Hospital and pronounced deceased. Michael was found emaciated but responsive, and Aiden was well nourished and appeared physically unharmed. Michael and Aiden were immediately removed from the care and custody of Mr. Almond and Ms. Coleman by the DCF Fall River Area Office.

What happened to David?

Between his return home on March 13, 2020 and his death on October 21, 2020, David experienced abuse, starvation, and was deprived of a safe and nurturing home environment. Mr. Almond and Ms. Coleman made ongoing and deliberate efforts to keep him from receiving any therapeutic or education services, and his presentation during monthly DCF virtual home visits was orchestrated.

David never received any community-based therapeutic services. David also did not attend Fall River Public Schools, in-person or virtually, and did not receive any special education services. Although Fall River Public School staff had contact with Ms. Coleman, school staff never saw or spoke with David from March 16, 2020, when he was scheduled to begin school, to the time of his death.

DCF was the only agency to physically see and speak with David during once-a-month virtual home visits. All DCF visits were done virtually due, in part, to Mr. Almond and Ms. Coleman's claims of continuous exposure to, or fear of COVID-19, though these claims were dubious based on the family's behavior including an alleged vacation they took outside of the home. During these virtual home visits, David was always observed in the presence of Ms. Coleman, was always seated, was always quiet and Ms. Coleman always directed him on what to say to the DCF case management team.

Persons who should have been in contact with David missed several opportunities to pursue contact with him more aggressively and missed opportunities to file a report of alleged child abuse or neglect. Many of these persons, as described in this report, acted as if DCF involvement relieved them of any obligation to take further steps to investigate the safety of the children. DCF, the agency explicitly charged with protecting these children, failed to put all the clues provided by the family's history, service providers, school officials, the children's own presentation, the screened-out allegations of abuse and neglect, and Mr. Almond and Ms. Coleman's own actions, into a clear picture of the reality of the life that David, Michael, and Aiden were living.

The last DCF virtual home visit was on September 25, 2020. David died three and a half weeks later.

FINDINGS AND RECOMMENDATIONS

The findings presented herein are representative of missed opportunities for prevention and intervention with the Almond family. The recommendations are intended to assist the Department of Children and Families (DCF), the Department of Elementary and Secondary Education (DESE), the Fall River Public School District, the Juvenile Court, and the Massachusetts Probation Service in improving their policies and practices to collectively promote and support child safety and well-being. Many of these findings are inextricably linked to the effect the unprecedented strain the COVID-19 pandemic has had on the Commonwealth's children and families and on the public and private entities that provide support to them.

The OCA interviewed approximately 25 staff members from six different human service agencies responsible for providing services to the family during the 18 months prior to David's death. The OCA does not doubt the commitment of these staff members to their obligations and responsibilities and believes, with very few exceptions, that these staff members were dedicated and competent. There were some overarching themes that emerged from these interviews with human service providers, educators, and state agency personnel:

- 1. Interagency Collaboration and Information Sharing** - In some instances of cross collaboration between DCF and other state systems, information sharing is limited by DCF to protect a family's confidentiality. As a result, these other professionals, who are likely to be mandated reporters, have no knowledge of the protective concerns that underlie a family's current DCF involvement. This lack of knowledge or context may result in the provider missing signs of child abuse and/or neglect. **This report provides several recommendations related to increasing information sharing between DCF other state agencies/entities.**
- 2. Mandated Reporting** - At times, mandated reporters are hesitant to report concerns of abuse or neglect about a DCF involved family because (a) they already informed the ongoing social worker of their concerns, or (b) because they believe DCF must already be aware of the concern, or (c) they believe their report will be viewed as unimportant or duplicative by DCF and will be screened-out. **Mandated reporters have an obligation to file a report of child abuse and/or neglect if they have reasonable cause to believe a child is being harmed. Mandated reporting responsibilities are not absolved if there is current DCF involvement with a family at the time of the suspected abuse or neglect.**
- 3. Raising Concerns within DCF** - When a professional is concerned about DCF's decision making about an involved child or family and they do not believe the DCF area office management is adequately responding to their concerns, they do not know whether they should, or how to report

these concerns above the DCF area office director. **In these situations, professionals should contact their DCF Regional Office, the DCF Ombudsman Office²⁸ or the OCA Complaint Line.**

ABOUT THE OCA COMPLAINT LINE

Anyone with concerns about a child or youth who is receiving state services can contact the OCA Complaint Line. State services are services that are provided directly by a state agency or services that are funded by a state agency. The OCA staff will listen to a person's concerns and provide resources, information, and other options to assist in addressing the problems that are brought to our attention. We also track and analyze the information we receive from persons who contact us to inform our inter-agency work and make recommendations to improve services for children in the Commonwealth. For more information about our Complaint Line, please see: <https://www.mass.gov/oca-complaint-line>

²⁸ DCF Office of the Ombudsman's role is to respond to consumers, foster and adoptive parents, advocates, legislators and concerned citizens regarding agency programs, policies, and services. They can assist in helping understand policy and case practice and try to help address concerns. The staff provides information regarding the appropriate steps to take to address a problem an individual may be experiencing with DCF or direct an individual to additional sources of help or information. For more information: <https://www.mass.gov/service-details/dcf-office-of-the-ombudsman>

DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families (DCF) is the designated child protective service agency for Massachusetts. DCF is the state agency responsible for receiving and responding to allegations of abuse and neglect, for providing services to children and their families that enable caregivers to safely care for their children, and when that is not possible, to assume custodial care as authorized by the courts. DCF provides services to more children and families than any other Executive Office of Health and Human Services child-serving agency. In Fiscal Year 2020, DCF served 75,463 children and families.

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

The Office of the Child Advocate's (OCA) enabling statute requires that state agencies providing services to children or young adults notify the OCA via a "**critical incident report**" if a child or young adult suffers a fatality, near fatality, serious bodily injury, or emotional injury, [M.G.L. c. 18C § 5](#). On October 23, 2020, the OCA received a critical incident report from the Department of Children and Families (DCF) about the October 21, 2020 death of David Almond, the serious bodily and emotional injuries of his brother Michael and the emotional injury of their younger paternal half-sibling, Aiden.

Consistent with OCA practice, the OCA conducted an immediate administrative review to learn more about the circumstances of the event and DCF's involvement with the family. The OCA initiated a full-scale investigation based on the egregious circumstances of David's death, the harm to Michael and Aiden, concerns about DCF's management of the family's case, and the complications that the COVID-19 pandemic may have had on the provision of state agency³⁰ services to this family. Additionally, the Secretary of the Executive Office of Health and Human Services reached out to the OCA to request that the OCA investigate the events that led to David's death.

Critical Incident Reports

During Fiscal Year 2020 (FY20), DCF submitted 295 statutorily required critical incident reports to the OCA. Of these 295 reports, the OCA identified 464 individual critical incidents (fatality, near fatality, serious bodily injury, emotional injury) involving 449 children and young adults. There are more children/young adults than number of reports as there can be more than one child or young adult involved in a critical incident report.

The number of children and young adults identified in DCF critical incident reports (449) submitted to the OCA during FY20 is 0.006% of the total population served by DCF in FY20.

²⁹ In intake and investigation, the "response worker" is responsible for investigating allegations of abuse or neglect. When a family is determined in need of services from DCF, the "ongoing social worker" is responsible for the case management and interacting with the family. Both intake response and ongoing social workers are supported by supervisors and managers.

³⁰ A state agency within the Office of the Governor, including the Executive Office of Education, the Executive Office of Public Safety and Security, the Executive Office of Health and Human Services, and their constituent agencies. [M.G.L. c. 18C § 1](#)

Immediately following the death of David, the DCF Southeast Regional Office conducted an administrative review of their handling of this family’s case, as well as other ongoing cases in the same unit of the DCF personnel responsible for this family’s case management. There were four overall case practice challenges found by this internal review: failure to develop a clinical formulation about the family and other DCF involved families, failure to use a risk assessment tool, a lack of a thorough understanding of substance use, and challenges with family engagement.

The OCA’s findings and recommendations presented here are independent of DCF’s own internal review findings though the OCA concludes that DCF’s internal review findings are accurate and appropriate. Some of the OCA findings in this case are consistent with findings of investigations the OCA has previously released publicly, and are consistent with 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.³¹

The DCF Fall River Area Office is responsible for this family’s case since it opened in August 2017. 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 “DCF administration” means the DCF Central Office which oversees the entire DCF workforce. References to the “DCF Fall River Area Office” mean the social worker, supervisor, area program manager, area clinical manager, and area director. References to the “DCF area office management” mean the area program manager, area clinical manager and/or area director. References to the “DCF case management team” mean the direct social worker and/or supervisor responsible for this case.

For detailed information about the Almond family and their child welfare history, refer to *Family Background and Child Welfare Involvement* section.

THEMES AND FINDINGS

THEME #1: There was an overall lack of a “clinical formulation” that resulted in the failure of the DCF Fall River Area Office to recognize that Mr. Almond and Ms. Coleman had done nothing to mitigate the risk that they posed to the children.

Due to the complexity of the daily demands of their work, DCF social workers must have a task-oriented approach to their case planning and management. DCF social workers, under the support of a supervisor and other area office managers, must also use a “holistic approach for developing the most effective interventions, services and supports to meet the child and family’s needs.”³² This process is often referred to as a “**clinical formulation**” and is the ability to synthesize information about a family to

³¹ This includes investigations into the deaths of Jeremiah Oliver and Bella Bond.

³² Department of Children and Families Family Assessment and Action Planning Policy: <https://www.mass.gov/doc/family-assessment-action-planning-policy/download>

inform case planning and decision-making, and to create an achievable Family Assessment and Action Plan (FAAP)³³ that is intended to promote the safety, permanency, and well-being of a child and family.

The needs of the Almond family are long-standing and complex. Mr. Almond and Ms. Coleman suffered from child abuse and neglect when they were children. They were challenged by housing instability, mental health concerns, and substance use while being responsible for caring for four children, three of whom had special needs. The challenges of this family were not adequately assessed or evaluated by the DCF Fall River Area Office. Additionally, the reunification of David and Michael coincided with the beginning of the COVID-19 pandemic, but the DCF Fall River Area Office did not adequately understand how the pandemic would exacerbate the family's challenges.

While there was a high level of task-oriented competence in the DCF case management of the Almond family, the DCF Fall River Area Office did not formulate or utilize a clinical formulation in this case. DCF social workers are responsible for developing the clinical formulation about a family, and DCF supervisors and managers are responsible for recognizing when social workers need support to form an accurate clinical formulation. The DCF social worker did not get the management support needed to develop the clinical formulation essential to the constant and accurate assessment of safety and risk to these children. The following findings illustrate how the absence of a clinical formulation about the family at the DCF Fall River Area Office impacted the safety and well-being of David and his siblings:

FINDING #1: The DCF Fall River Area Office gathered insufficient information from family service providers prior to reunification. The DCF Fall River Area Office measured Mr. Almond and Ms. Coleman's progress in services based on attendance or completion of a service, and not on meaningful improvement of parental abilities.

DCF case management teams are required to have regular contact with caregivers, service providers, educators, other professionals, and the family's natural supports. Information gathered from professionals delivering support and services to a family provides an important perspective about a caregiver's ability to address their own needs and meet the needs of their children.

The DCF case management team responsible for the Almond family had frequent and consistent communication with providers but did not elicit information during this communication that would help assess child safety or parental capacity. In this way, the DCF case management team met the task-oriented goal of talking with providers but did not meet the goal of analyzing the information received from those providers in context of the family history or evaluating the safety of the children. No information was gathered prior to reunification of Aiden or David and Michael that showed Mr. Almond and Ms. Coleman were benefitting from the services they participated in, or that showed their behaviors had changed because of their engagement with services. Rather, the DCF case management team

³³ For more information about the DCF Family Assessment and Action Plan (FAAP) visit: <https://www.mass.gov/doc/family-assessment-action-planning-policy/download>

obtained information regarding their irregular attendance or compliance with services but missed opportunities to gather pertinent information from professionals providing services to the family.

DCF area office management had full access to information obtained from collateral contacts via the DCF case management team and the DCF record. DCF area office management did not request, probe, or require that more information be obtained to inform the clinical formulation. DCF area office management should have recognized the need for more information from collaterals during management-led meetings which include Permanency Planning Conferences, placement meetings, and the screening team meeting in August 2020.

The DCF Fall River Area Office did not adequately assess the minimal information they did receive when making their determination of current risk to Aiden prior to his reunification in July 2019 and risks prior to the reunification of David and Michael in March 2020. The DCF Fall River Area Office did not recognize that Mr. Almond and Ms. Coleman's pattern of inconsistent and minimal participation was predictive of their continued inability to parent the children. If Mr. Almond and Ms. Coleman could not participate in services to address their own needs for any meaningful length of time, they were not going to be able to meet the needs of Aiden, or the more intensive needs of the triplets.

FINDING #2: In July 2019, the DCF Fall River Area Office did not have cause to change the children's permanency goal from adoption back to return to parent or to reunify Aiden. Mr. Almond and Ms. Coleman had minimal engagement and participation in services and there was no observable change in their parental capacities.

At the Permanency Planning Conference³⁴ in January 2019, the children's permanency goal was formally changed from return to parent to adoption due to Mr. Almond and Ms. Coleman's lack of participation in services between October 2017 and January 2019. Four months later, at the Foster Care Review³⁵ in April 2019, the DCF case management team reported that Mr. Almond and Ms. Coleman were participating in family therapy with the triplets at their congregate care placement and supervised visits were going well. The DCF case management team reported that Mr. Almond and Ms. Coleman had participated in drug tests and the results were negative. Mr. Almond had participated in an intimate partner violence evaluation, which did not recommend treatment. Reportedly, Mr. Almond had not been able to consistently engage in therapy due to insurance issues. Ms. Coleman had participated in therapy to address her childhood trauma, mental health, and substance use issues.

Despite the DCF case management team report in the Foster Care Review, there is no information in the DCF record that shows whether the drug tests leading up to this review were frequent, random, or supervised. Mr. Almond's intimate partner violence evaluation relied solely on Mr. Almond's self-report and lacked information about his history which included domestic violence concerns. The determination

³⁴ For information about the DCF Permanency Planning Conferences visit: <https://www.mass.gov/doc/permanency-planning-policy/download>

³⁵ For information about DCF Foster Care Review visit: <https://www.mass.gov/doc/foster-care-review-policy-0/download>

that Mr. Almond did not need a batterers intervention program is questionable as it is solely based on his self-report.

The foster care review panel recommended that the DCF Fall River Area Office convene a Permanency Planning Conference to change the goal to return to parent if Mr. Almond and Ms. Coleman continued to participate in services for the next four months. If successful, this would have been an eight-month pattern of semi-engagement prior to reunification. Mr. Almond and Ms. Coleman had minimal engagement in services and there was no information presented at this review to support any observable change in their ability to care for the children. The OCA presumes the foster care review panel's decision was based on the way the DCF case management team presented the information at the review, which did not account for the continued risk posed to the children.

The children's permanency goal was changed from adoption back to return to parent in July 2019 despite Mr. Almond's failure to engage with therapy, despite Ms. Coleman's limited engagement with therapy, and despite the lack of any documentation of any change in Mr. Almond and Ms. Coleman's ability to parent, specifically their ability to parent children with special needs. The decision was largely based on a parenting assessment by a contracted agency as discussed in the finding below.

FINDING #3: The DCF Fall River Area Office relied heavily on a parenting evaluation completed by a DCF contracted service provider agency as the basis for the analysis of Mr. Almond and Ms. Coleman's capacity to provide Aiden and the triplets with a safe and nurturing home environment. That parenting evaluation did not adequately assess the caregivers' ability to care for the children.

A provider agency was contracted by the DCF Fall River Area Office to complete two parenting evaluations, one concerning Mr. Almond and Ms. Coleman's ability to care for Aiden and one concerning their ability to care for the triplets. The evaluations began in March 2019 and included six supervised visits between the parents and Aiden at the DCF Fall River Area Office. The evaluator found Ms. Coleman and Mr. Almond to be committed to Aiden and found that Ms. Coleman demonstrated natural parenting skills and strengths that could be built upon.

The parenting evaluation for the triplets consisted of four supervised visits between Mr. Almond, Ms. Coleman, and the triplets at the congregate care program where the triplets lived. Clinical staff from the congregate care program were present during these visits providing Mr. Almond and Ms. Coleman with direction, coaching, and feedback regarding their interactions with the triplets.

These separate parenting evaluations measured Mr. Almond and Ms. Coleman's parental capacity by their ability to follow the direction and coaching from the professionals supervising the visits. From a review of the records and this parenting evaluation, there was minimal indication that Mr. Almond or Ms. Coleman were able to interact with the triplets in a way that met the triplets' needs without encouragement or direction by trained staff members. Additionally, these visits took place in a familiar and supportive environment for the triplets which affected their ability to maintain control over their emotions and use their learned coping skills. None of these visits occurred in the family home in Fall

River. The parenting evaluation was not structured in a way that provided the evaluator an opportunity to determine how Mr. Almond and Ms. Coleman would respond to, or care for, the triplets in a less structured, more chaotic, or more stressful environment where the children might be overwhelmed, and where the caregivers would be challenged by conflicting demands on their attention.

In both parenting evaluations, the parenting evaluator recommended that Mr. Almond and Ms. Coleman participate in individual counseling, improve their communication to minimize bickering in front of the children, and obtain in-home parenting support should the children return home. The parenting evaluator also recommended that to support a successful reunification of all the children, Mr. Almond and Ms. Coleman would benefit from “ongoing education about age-appropriate expectations and non-physical forms of discipline, as well as how their decisions affect the children’s wellbeing.” Neither Mr. Almond nor Ms. Coleman was provided this education, and they did not successfully engage in the recommended services prior to or after the reunification of Aiden in July 2019 or the reunification of David and Michael in March 2020.

To adequately inform a clinical formulation, a parenting evaluation must determine whether a caregiver can meet the specific needs of the children involved. The DCF Fall River Area Office did not ask the parenting evaluator to assess parental capacity in the context of the triplets’ specific special needs or with the competing needs of their younger sibling Aiden. The DCF case management team also never observed this family for any length of time as a full unit prior to the decision to reunify the children. This was a key aspect of parental capacity that should have been assessed before determining whether, and how, to reunify all the children with Mr. Almond and Ms. Coleman.

The DCF Fall River Area Office is the only entity with the full picture of the Almond family history, challenges, and needs and should therefore not have relied solely on a contracted or other agency to evaluate parental capacities. In the OCA’s interviews with the DCF Fall River Area Office, heavy weight was placed on this parenting evaluation in the decision to reunify David and Michael with Mr. Almond and Ms. Coleman, yet little to none of the recommendations in the parenting evaluation were followed by DCF. Though this parenting evaluation is one valuable piece in determining parental capacity, it was treated as the sole source of information about Mr. Almond’s and Ms. Coleman’s parenting abilities.

FINDING #4: The DCF Fall River Area Office underestimated the impact of Mr. Almond and Ms. Coleman’s substance use and did not identify it as a priority area of focus and monitoring.

The family’s current DCF involvement began in August 2017 because of Ms. Coleman’s substance use. It is well documented in the DCF record that Mr. Almond and Ms. Coleman have independent, long-standing issues with substance use.

To monitor Mr. Almond and Ms. Coleman’s substance use, the DCF case management team appeared to rely primarily, if not solely, on Mr. Almond and Ms. Coleman’s self-reporting despite there being no indication in their histories that they were reliable reporters regarding their sobriety. While the DCF case management team did request Mr. Almond and Ms. Coleman submit to drug tests prior to

reunification of Aiden, there is minimal information in the DCF record to determine whether the drug tests were random or supervised. Ms. Coleman tested positive for cocaine in June 2018, which is the only drug test that the OCA could confirm was random. There is no indication in the record that the DCF case management team took any action, or altered Ms. Coleman's service plan, in response to this positive test. Between Aiden's reunification in July 2019 and David and Michael's reunification in March 2020, Mr. Almond and Ms. Coleman submitted to one drug test in January 2020. Mr. Almond and Ms. Coleman were not referred to any random drug tests from March 2020, when David and Michael were reunified, to the date of David's death, even though allegations of suspected drug use were reported to DCF in August 2020.

There is also no indication that the DCF case management team discussed recovery or relapse prevention plans with Mr. Almond or Ms. Coleman or that their individual current use was evaluated prior to, or continuously after, the children returned home in July 2019 and March 2020. Mr. Almond and Ms. Coleman's risk of reverting to substance use as a coping mechanism for parental stress, and what this relapse could mean for their ability to provide care for the children, was not adequately assessed. **A relapse and recovery plan should have been actively discussed and developed with both Mr. Almond and Ms. Coleman prior to any reunification of the children and during post-reunification monitoring of the family.**

The DCF Southeast Regional Office internal review of cases following the death of David found that all the staff at the DCF Fall River Area Office would benefit from education and capacity building about substance use and its implications on the safety and well-being of a child and family. As a result, the DCF Director of Substance Use conducted trainings with the DCF Fall River Area Office on the brain science of addiction, recovery and relapse, and addiction as a family disease. For the DCF Fall River Area Office personnel who required more one-on-one education, the DCF Fall River Area Office substance use consultant provided them with individual coaching on how to talk with caregivers about their substance use history, recovery, and relapse prevention planning.

FINDING #5: The DCF Fall River Area Office did not evaluate Mr. Almond's capacity to be the educational decision-maker for David and Michael before returning that responsibility to him.

David and Michael³⁶ qualified for special education services under their diagnoses of Autism Spectrum Disorder and were entitled to educational programming that would meet their unique needs.³⁷ Special education services are provided via an individualized education program (IEP). David's IEP, at the time of his reunification and subsequent return of custody to his father required "substantially separate programming" meaning that David would receive special education services outside of a general education classroom for more than 60% of his school day.

³⁶ Aiden was too young to be enrolled in school.

³⁷ To protect Michael's privacy the education portion of this report will focus primarily on David.

One of the reasons the triplets were removed from Mr. Almond and Ms. Coleman’s care in October 2017 was due to excessive absences from school. Between their removal in October 2017 and February 2020 when they were in DCF custody, an educational surrogate had primary responsibility for the educational decision-making³⁸ for each of the triplets. The DCF Fall River Area Office returned educational decision-making to Mr. Almond in February 2020 in anticipation of David and Michael’s reunification, despite DCF retaining legal custody of David and Michael until July 2020. **As a state agency, it is DCF practice to routinely return educational decision-making rights to caregivers prior to reunification or return of custody without any evaluation of that caregiver’s capacity to make educational decisions.**

Mr. Almond was offered the opportunity to meet with the educational surrogate to discuss the education and special needs of his children. Mr. Almond declined the offer. Mr. Almond also declined the offer for the educational surrogate to attend the first IEP meeting to provide the history of educational decisions as a means of assisting Mr. Almond to begin making the educational decisions.

Once educational decision-making was returned to Mr. Almond, he did attend the first and only IEP meeting by phone. He minimally participated in the meeting, and subsequently he failed to complete the necessary IEP paperwork in a timely fashion which resulted in out-of-date IEP goals. **The immediate failure of Mr. Almond to consent to the new IEP reportedly did not raise any concerns for the DCF case management team.**

Mr. Almond’s history with child protective services included the conclusion that Mr. Almond did not have a good understanding of the nature of his children’s disabilities and the impact on their lives. As noted, excessive school absences were one of the underlying reasons for DCF involvement in 2017. **There was no service provided to Mr. Almond, no coaching or guidance provided to Mr. Almond, and absolutely no indication that Mr. Almond’s capacity to understand, advocate for, or comply with, educational services for his children had improved at the time the DCF Fall River Area Office returned his children’s educational decision-making rights to him in 2020. Additionally, there was no subsequent re-evaluation of this decision when Mr. Almond chose the “fully remote” option for David and Michael during COVID-19, or when Mr. Almond was unresponsive to school outreach, or when the children’s school raised concerns about the lack of any educational engagement by the family.**

As discussed extensively in the *Department of Elementary and Secondary Education (DESE)/Fall River Public School District (FRPS)* section below, the DCF case management team was informed of the family’s failure to engage in school including any academics, any special education services, and in any social-emotional learning supports once David and Michael were returned home. **The DCF case management team not only took no action to remedy this situation but warned and advised Ms. Coleman to call the school to avoid having a report of abuse or neglect filed against her.** The DCF case management team did not appear to recognize the extraordinary toll that complete lack of engagement

³⁸ Educational decision-making is a responsibility that can be transferred among adults. DCF automatically receives the educational decision-making rights when a child is taken into custody, but those rights can be transferred back to a caregiver prior to, or simultaneously with, reunification or return of custody.

from special education for children with significant special needs has on their well-being. Despite David and Michael remaining in DCF's legal custody until July 2020 and under DCF's supervision until David's death, the DCF Fall River Area Office took no responsibility over the lack of engagement in school, nor did the DCF case management team engage Mr. Almond, the educational decision-maker, in any substantive conversation about education or special education services.

FINDING #6: The DCF Fall River Area Office did not recognize that Mr. Almond and Ms. Coleman raised access to technology as a barrier and avoidance tactic to their and the children's participation in services.

From the beginning of DCF's involvement, Mr. Almond and Ms. Coleman reported that one of the barriers to their participation in services was their lack access to technology. Between March and October 2020, Ms. Coleman reported to the DCF case management team and service providers that she could only use the WhatsApp phone application for video conferencing. Ms. Coleman also reported that it was only possible to conference for short periods of time due to internet connectivity issues. Despite Ms. Coleman's report to the DCF case management team, Ms. Coleman was significantly more consistent with video communication with Aiden's early intervention provider and his former foster parent. In fact, she used different applications, including the video capability of Facebook Messenger, to communicate with them. In addition to frequency, early intervention contacts were at times an hour or longer. Because the DCF case management team did not elicit information from the early intervention provider about how the family participated virtually, the DCF case management team did not realize that the family's technology access problem was not accurately presented by Ms. Coleman.

The DCF case management team appears to have made no strong effort to resolve issues related to the family's access to technology, despite the children remaining in the custody of DCF until July 2020 and under DCF supervision through to the time of David's death. Particularly as it relates to David and Michael's schooling, the DCF case management team indicated that they believed that technology access for school was the sole responsibility of the school district. The DCF case management team did not connect solving this problem to the need to facilitate the required monthly virtual visits.

When children are in the legal custody of DCF, even if they are placed in their familial home, DCF should ensure that the child is adequately attending school, that barriers to school attendance are resolved, and that the child is receiving their necessary services. When children are in the legal custody of their caregivers and DCF has supervision and planning responsibilities for the family, DCF can and should take an active role in alleviating legitimate barriers to engagement in school and services. In this case the DCF case management team could have sought greater technology access for the family to facilitate virtual visitation with the family and the children during the pandemic, to connect the family with services, and to facilitate virtual schooling.³⁹

³⁹ Some resources were available to assist in this effort. For example, in May 2020 the OCA worked with the Court Improvement Project to secure 200 Chromebooks for DCF involved families to allow participation in court hearings, to improve case management, and to provide access to services.

FINDING #7: The DCF Fall River Area Office received a report of neglect on August 21, 2020 alleging substance use by Mr. Almond and Ms. Coleman, poor home conditions and neglect of the children. The DCF Fall River Area Office decision to screen-out⁴⁰ this report was a misjudgment of the information provided in the report and a violation of the DCF *Protective Intake Policy*.⁴¹

On August 21, 2020, the DCF Fall River Area Office intake unit received an anonymous neglect report with concerns for the conditions of the family's home and substance use by Mr. Almond and Ms. Coleman. The reporter noted that Ms. Shadburn lived in the home and had a significant criminal history. This report was screened-out by the DCF Fall River Area Office intake unit which means that the allegations were not accepted for a DCF investigation response. The screen-out decision was a violation of the DCF *Protective Intake Policy* because the concerns expressed constituted a "reportable condition" of neglect. A report that accurately described and fit into the narrative of the long-standing pattern of substance use, poor home conditions, neglect of the children, and minimal participation in services should have been screened-in for an investigation by the DCF Fall River Area Office response unit.

The screening-out of this report meant that instead of assigning this report for investigation by a DCF Fall River Area Office response worker, DCF area office management required the already assigned DCF case management team to have a virtual home visit with the family. The DCF case management team conducted a virtual home visit with the family on August 24, 2020. The DCF case management team discussed with Ms. Coleman the allegation in the neglect report, and she attributed it to issues with a neighbor and denied the concerns expressed in the report. There was no further assessment of the reported substance abuse concerns nor did the case management team request Mr. Almond and Ms. Coleman submit to a random drug test. The DCF case management team accepted the family's self-report of sobriety as fact.

During this virtual home visit, the DCF case management team noticed a bandage covering David's nose. Ms. Coleman attributed the injury to self-injurious behavior. When David was questioned about the injury, Ms. Coleman instructed David how to respond and David complied with Ms. Coleman's direction. The DCF case management team did not ask to see the injury, did not speak with David further, and did not recognize that his self-injurious behavior was a sign of distress and that this was a cause for serious concern regarding his safety and welfare. Given the history of Mr. Almond and Ms. Coleman's use of physical discipline with the children, this warranted further questioning.

The implication of a report of child abuse and/or neglect during an open DCF case is that DCF is either missing information about the safety of the children, or that DCF has incorrectly weighed the information they do have regarding the safety of the children. The virtual home visit conducted in

⁴⁰ DCF's **Protective Intake Policy** (#86 015, 2020) states "the purpose of a screening is to gather sufficient information to determine whether a Department response is necessary to ensure a child's safety and well-being. Screening is the first step in determining the Department's subsequent actions and interventions with the child and family." <https://www.mass.gov/doc/protective-intake-policy-2-28-16/download>

⁴¹ DCF's **Protective Intake Policy** (#86 015, 2020) defines "reportable condition" as "information indicating that a child may have been abused and/or neglected or may be at risk of being abused and/or neglected by a caregiver." <https://www.mass.gov/doc/protective-intake-policy-2-28-16/download>

response to the screened-out neglect report was conducted as if it were routine; no specific steps were taken to analyze the conditions of the home or Mr. Almond or Ms. Coleman's substance use in any new or different way. Rather, the DCF Fall River Area Office assumed that the reporter had incorrect information instead of investigating whether they had incorrectly interpreted their own information. The failure to conduct an investigation in response to the screened-out August 2020 report was a missed opportunity to see David and his brothers in person which the OCA believes would have identified the mistreatment and starvation of the other brothers.

FINDING #8: The DCF Fall River Area Office did not address safety risks and protective concerns regarding the paternal grandmother, Ms. Shadburn.

Mr. Almond, Ms. Coleman, and the children lived with Ann Shadburn, Mr. Almond's biological mother. The DCF Fall River Area Office had knowledge that Ms. Shadburn lived in the home and that when Mr. Almond was a child he was removed from her care and her parental rights to him were terminated. The primary safety concern for Ms. Shadburn was the risk that she would engage in substance use within the home.

The DCF Fall River Area Office response to Ms. Shadburn's child protective history was to create an informal verbal safety plan with the family indicating that Ms. Shadburn would not be the primary caregiver for the children if they returned home. There is no written documentation of this plan in the record and no documentation indicating whether this plan was discussed with or agreed to by Ms. Shadburn. There is also no indication this plan was ever monitored or evaluated by the DCF case management team for effectiveness. This was a violation of DCF's *Permanency Planning Policy* which states "should any information obtained from any background record check raise concerns for child's health and/or safety she/he is NOT returned home until action is taken to alleviate the concerns."

The informal verbal safety plan was not realistic and did not increase safety for the children. Even if Ms. Shadburn were not directly caring for the children, the children would still be at risk for exposure to substance use if it were taking place in the home. Further, the informal verbal safety plan did not take into consideration the family dynamics among the adults, or with the children in the home, and did not appear to analyze Ms. Shadburn as part of the family unit.

THEME #2: The DCF Fall River Area Office lacked a basic knowledge and understanding of Autism Spectrum Disorder and the individual needs of David, Michael, and Noah. This significantly impacted DCF's ability to make decisions in their best interest.

While there are core characteristics of autism such as difficulties with social interaction and communication, sensory sensitivities, and inflexible behavior – these characteristics will present differently in every individual on the autism spectrum. The DCF Fall River Area Office lacked an understanding of the core characteristics of autism and did not recognize that they needed to consult with the internal DCF and provider experts. As a result, they did not seek or receive any support or guidance about working with a family that includes children with disabilities.

Because the DCF Fall River Area Office did not appear to know or be able to evaluate the triplets as individuals with autism with different needs and different presentations, the DCF Fall River Area Office greatly underestimated these children’s capacity to communicate effectively. As a result, the DCF Fall River Area Office was unable to accurately evaluate the risks to the children in the home because they did not have a basic understanding of how these children express stress and distress. This lack of understanding negatively impacted the DCF Fall River Area Office reunification decision making, the ability to plan a successful transition home, and the post-reunification safety and stability of David and Michael in the following ways:

FINDING #1: The DCF Fall River Area Office misinterpreted Aiden’s “successful” reunification as a predictor of the likelihood of a successful reunification of the triplets.⁴²

It was clear in December 2019 when the DCF area office management decided to begin the reunification process of David, Michael, and Noah⁴³ with Mr. Almond and Ms. Coleman,⁴⁴ that neither caregiver had an intention to adequately engage in random drug testing, therapy, or with the parenting support service provider. Aiden was reunified with his parents several months prior to the reunification of David and Michael and Mr. Almond and Ms. Coleman appeared to be adequately caring for Aiden, despite not following their action plan. This apparent success at parenting Aiden made it more likely that David and Michael would be reunified with the family without DCF Fall River Area Office insisting that Mr. Almond and Ms. Coleman re-engage with services on their action plan.

There is no evidence available that the sporadic engagement Mr. Almond and Ms. Coleman did have with services resulted in any change to their parenting skills, insight, judgment, or temperament, particularly considering the specific needs of the triplets who require a very calm and structured environment to remain safe. Parenting is a tough job under the best circumstances. The demands of raising a child with a disability can cause increased financial, physical, and emotional stress to any caregiver – which can, in turn, lessen the caregiver’s overall well-being and ability to provide safe and appropriate care for the child. The additional stress on a caregiver struggling with mental health concerns, substance use, trauma, and economic stress increases the risk for abuse or neglect.

Although the DCF Fall River Area Office recognized that David and Michael had higher needs than Aiden, there was no focus on the different standard of parental capability that was necessary to successfully care for the older children with disabilities. Additionally, there did not appear to be any calculation of what type of stress reunifying two more children in the home would cause the family and the subsequent effect on the parenting abilities of Mr. Almond and Ms. Coleman.

⁴² The OCA notes that Aiden’s reunification was only “successful” until his subsequent removal from Mr. Almond and Ms. Coleman’s care in 2020.

⁴³ The December 2019 decision to begin reunification included David, Michael, and Noah. Ultimately, Noah remained in his placement and in the legal custody of DCF throughout the life of this case due to his own self-advocacy and refusal to return to the care of Mr. Almond and Ms. Coleman.

⁴⁴ Ms. Coleman’s action plan was related to her case with Aiden as she was not a legal guardian for David, Michael, or Noah. However, it is undisputed that Mr. Almond and Ms. Coleman were a caregiving unit, and that Ms. Coleman would be the primary caregiver for all the children in the home. Thus, her engagement with services or lack thereof had safety implications for all the children.

FINDING #2: The December 2019 decision by the DCF Fall River Area Office management to reunify the triplets and their transition plan home was inappropriate. This decision-making and planning did not take into consideration the parental capacities of Mr. Almond or Ms. Coleman, the therapeutic needs of the children, or the concerns expressed by Mr. Almond, Ms. Coleman, the legal counsel for David and Michael, the DCF case management team, the congregate care provider, the collaborative school, and several provider agencies.

At the end of December 2019, DCF area office management made the decision to begin the reunification process of the triplets with Mr. Almond and Ms. Coleman. DCF area office management made this decision without having any familiarity with the Almond family case or conducting any administrative review of the case record. The decision to begin this process appears to be based, at least in part, on the apparent successful reunification of Aiden in July 2019. There was no consultation with any of the children’s or family’s current service providers before making this decision. At this meeting, the DCF case management team expressed apprehension about the readiness of Mr. Almond and Ms. Coleman to care for the triplets. There is no written documentation of the discussion or rationale for the decisions made at this meeting.

DCF area office management set a reunification date for late January 2020. The DCF case management team, the congregate care provider, and the triplets’ collaborative school⁴⁵ each independently requested a slower transition. The triplets were thriving and successful due to the predictable routine, structure, and expectations provided in their congregate care placement and collaborative school. Concern was expressed to DCF area office management that the triplets had lived at their congregate care program since December 2017 and attended their collaborative school since January 2018. Any swift transition home or to a new educational setting would result in a decrease in the children’s ability to manage their behaviors and would increase their anxiety.

Children with autism do best with natural transitions. The children’s congregate care provider and the collaborative school recommended that reunification be scheduled for the end of the school year in June. This would be a natural transition to summer so the triplets would be expecting and prepared for a change in their routine. This timeline would have supported a more planful return to a new school setting as the triplets would be moving on to high school in the next school year. Instead, the triplets were to be transitioned mid-year into a middle school program and then transitioned again to a high school program a few months later when school resumed in September.

Additional concerns were expressed about Mr. Almond and Ms. Coleman’s minimal participation in their action plan services, as well as the difficulties the physical space of the home presented for the family. If the triplets’ returned home, the family faced the threat of eviction because the landlord would not allow seven people to live in a one-bedroom apartment. Despite the request for a slower transition, a notice of eviction from the landlord, no therapeutic home-based services in place for the triplets, and the parenting support service provider on the verge of terminating services with the family, DCF area office

⁴⁵ Collaborative schools provide intensive educational programs and services for students with disabilities.

management instructed the DCF case management team to move forward with the reunification in January 2020.

During the first day home visit for the triplets on January 10, 2020, Ms. Coleman expressed to the DCF case management team that reunification was moving too fast. Ms. Coleman also expressed the family was not ready for overnight visits with the triplets because the apartment was too small. In the following weeks, Mr. Almond and Ms. Coleman canceled scheduled day home visits with the triplets, canceled parenting support service provider appointments, and failed to complete the required tasks to secure larger housing. As a result, the first overnight home visit for the triplets and reunification was delayed until February.

During the triplets' first overnight home visit on February 7, 2020, Mr. Almond and Ms. Coleman reported that Noah's behavior quickly escalated to a point where there was a physical altercation. As a result, Noah was returned to his congregate care program late at night. **The DCF Fall River Area Office did not evaluate this overnight home visit in terms of Mr. Almond and Ms. Coleman's ability to appropriately care for Noah. The reunification process went forward with David and Michael as if nothing concerning had occurred. After this home visit, Noah remained in his congregate care placement and in DCF custody due to his own self-advocacy and refusal to return to the care of Mr. Almond and Ms. Coleman.**

The milieu of both the congregate care program and the collaborative school settings afforded each of the triplets with opportunities to learn social, communicative, adaptive, and coping skills. The triplets could not, however, generalize these skills to unfamiliar settings quickly and without practice. They needed time, at their own individual paces, to learn the skills required for stability and success in their home environment prior to reunification and post-reunification. Transition into a new home environment for these individual children, taking into consideration their autism, would have required a several month visitation schedule that included extended overnight visits for several days both during the week and on the weekends. It also would require an evaluation by the DCF case management team of Mr. Almond and Ms. Coleman's ability to manage the children's behaviors over a long period of time and an evaluation of the children's ability to transition their learned skills to their home environment.

On February 11, 2020, the triplets' congregate care provider sent the DCF Fall River Area Office a letter opposing David and Michael's reunification citing numerous concerns. The concerns were that the physical environment of the home was inadequate to meet the children's therapeutic needs, that Mr. Almond and Ms. Coleman were facing eviction, and that a slower and more suitable transition plan was needed. **This was an extraordinary step on the congregate care provider's part to reach-out to the DCF Fall River Area Office senior managers.** After discussion between the DCF office management and the congregate care provider, the reunification date was changed to March 2020 to accommodate a longer transition period and to put home-based services in place. This delay did not adequately address the numerous concerns expressed by the DCF case management team, multiple service providers, and the collaborative school. **DCF area office management appeared willing to accommodate slight delays in the reunification plan but unwilling to fundamentally rethink the plan despite the serious concerns**

brought to their attention. The OCA was unable to determine any reason for the unwillingness to reconsider the appropriateness of the reunification plan, particularly as there was no pressure from the Juvenile Court, nor Mr. Almond or Ms. Coleman or their attorneys, nor the children's attorney to rush a transition home. DCF administration also confirmed during this investigation that there were adequate funds in the Fall River Area Office's budget to continue the triplet's congregate care placement.

Multiple individuals interviewed for this investigation expressed that this reunification was an unprecedentedly fast transition home for children with autism and was not planned in a child-centered manner. **As a result of the DCF area office management decision-making in this case, David and Michael were not provided the opportunity they needed to generalize their adaptive or coping skills. Within days of their return home, they began to regress in their social, communication, and daily living skills.** According to Ms. Coleman, they also became aggressive, which was uncharacteristic of their behavior while at their congregate care program and at their collaborative school. As reported by Ms. Coleman, these regressions and aggression continued and escalated as the months passed.

FINDING #3: The DCF Fall River Area Office did not secure the recommended essential services for David and Michael to be stable and successful at home. As a result, and due to Mr. Almond and Ms. Coleman's deliberate efforts to prevent David from receiving any offered services, David did not receive any individual services during his transition home or in the seven months he was in the home prior to his death.

The therapeutic setting of the congregate care program and the collaborative school David and Michael attended is grounded in **Applied Behavior Analysis (ABA)**. Prior to any reunification, the congregate care provider and the parenting support evaluator recommended that the DCF Fall River Area Office secure in-home ABA services for David and Michael. **ABA was the critical service needed to support use of David and Michael's adaptive and coping skills when David and Michael returned home. This service would also provide Mr. Almond and Ms. Coleman concrete parenting tools and support to meet David and Michael's autism needs - which they needed to support a successful reunification.**

In the weeks leading up to the planned March 13, 2020 reunification, the DCF case management team made two referrals for ABA services but was informed there were waitlists of six months or more. **Instead of slowing down the reunification process to wait for a service that was deemed essential by treatment providers for both David and Michael to return home, DCF area office management made the decision to proceed with reunification and secure continuum services⁴⁶ for the family while they waited for ABA services.** Continuum services are not a substitute for ABA services. The continuum service is family-directed, includes case management and in-home therapy, and centers around one identified child in the home. The DCF case management team chose Michael as the child to receive the service. Though the continuum service was an appropriate service for the family, it was an

⁴⁶ Continuum services are provided to children and their families involved with DCF or the Department of Mental Health. The average length of the service is 6-9 months.

inappropriate and unsuccessful substitute for the disability-specific ABA services both brothers and the family required.

The continuum service provider consistently reported to the DCF case management team that while Ms. Coleman participated in scheduled phone calls, she refused to allow the continuum service provider to speak with Michael. They also consistently reported that Mr. Almond and Ms. Coleman were resistant to the support available and strategies offered to help them to deal with their complaints about the older children's behaviors. Their participation in treatment team meetings was sporadic. In August 2020, the continuum service provider reported to the DCF case management team that they believed the family needed ABA services, a service the provider did not offer.

Prior to reunification, the DCF case management team secured individual therapy for David. David never participated in the therapy because Ms. Coleman would not allow him to have a female therapist based on Ms. Coleman's own assessment of his needs. The DCF case management team did not question this determination by Ms. Coleman despite there being no clinical reasons to support her claim. The DCF case management team also did not identify the lack of immediate therapeutic support for David upon his return home, or refusal of Mr. Almond or Ms. Coleman to comply with therapeutic support, as a risk to the child and family. As a result, David also did not receive any necessary therapeutic services.

The DCF area office management and case management team appeared to be focused on getting some services in place for the family prior to reunification but was unwilling to wait for the right services to be available. ABA services should have been in place before any transition plan or reunification occurred; this service was never secured for the family. The absence of this service was of significant detriment to David and Michael and compromised any chance of a successful reunification home.

FINDING #4: The DCF Fall River Area Office management failed to recognize that the physical environment of the home did not meet the needs of the triplets. This concern was expressed by the DCF case management team, Mr. Almond, Ms. Coleman, Mr. Almond through his legal counsel, legal counsel for David and Michael, and several provider agencies.

The Almond family lived in a small one-bedroom apartment leased to Ms. Shadburn. During the DCF Fall River Area Office utilization review in June 2019, discussion of reunifying the triplets occurred, but one of the main concerns was "insufficient housing." In July 2019, the DCF case management team began discussions with Mr. Almond and Ms. Coleman about securing a bigger home. Mr. Almond reported

What is Applied Behavior Analysis (ABA)?

ABA is a therapy based on the science of learning and behavior. The goal is to increase behaviors that are helpful and decrease behaviors that are harmful or affect learning. ABA therapy programs help:

Increase language and communication skills.

Improve focus, social skills, memory, academics.

Decrease problem behaviors.

Autism Speaks

that he did not have personal identification (a driver's license or state issued ID) and that this was the barrier to securing housing other than the apartment leased to Ms. Shadburn. The DCF case management team tried but was unsuccessful in their attempts to help Mr. Almond resolve this issue. In September 2019, the DCF case management team asked the triplets' congregate care provider to write a treatment letter advocating for larger housing for the family. The congregate care provider wrote the letter stating that it was therapeutically necessary for the triplets to have their own separate bedrooms, or at least have the triplets have two bedrooms between them, prior to any reunification. In October 2019, the parenting support service provider helped Mr. Almond and Ms. Coleman complete the necessary housing applications. Documents reflect that in December 2019, the congregate care provider was under the impression that the triplets would not return home until the family had appropriate housing.

On January 20, 2020, the family's landlord wrote a letter indicating the family would face eviction if the triplets returned to the one-bedroom apartment leased to Ms. Shadburn. The DCF case management team consulted with the DCF housing specialist and planned for the family to secure emergency housing if the family got evicted. Nonetheless, DCF area office management continued to be unwilling to slow or stop the reunification plan based on the threat of eviction. DCF area office management expressed that although larger housing was ideal, the current one-bedroom housing scenario was not a barrier to the triplets reunifying. This was misreading of the clinical needs of the triplets.

The DCF case management team and the parent support service provider continued efforts to assist Mr. Almond and Ms. Coleman with their housing challenges, including the purchase of mattresses and bedding for the triplets. However, Mr. Almond and Ms. Coleman were not dedicated to securing larger housing and provided numerous excuses for not following-up on housing applications. Both Mr. Almond and Ms. Coleman expressed concerns about reunifying the triplets in their current housing situation, but DCF area office management continued to dismiss these concerns.

Despite the documented and expressed need for the family to have larger space prior to reunification for the triplet's well-being, David and Michael were returned to the same one-bedroom apartment they were removed from in October 2017. **In their decision-making, DCF area office management interpreted concerns from the various professionals as an inappropriate consideration of the family's financial means. As a state agency, DCF does not and should not equate poverty with child abuse or neglect concerns, so they dismissed the physical housing space as a valid reason to delay reunification. However, in this situation housing was identified as a safety risk, not in terms of a material disadvantage, but in terms of how physical space is used to assist in management of dysregulation and sensory sensitivities for children with autism – and how stress resulting from the limitations of the physical space may be a stress trigger for Mr. Almond and Ms. Coleman.**

The DCF area office management decision-making lacked an understanding of the contribution the small physical space had on the family dynamics and stress, which no doubt contributed to the neglect and physical abuse of the children in 2017, and the potential for this history to repeat itself with the return of the triplets in 2020 who were now three years older, larger in size, and going through adolescence in

addition to their special needs.⁴⁷ Reunification itself is a transition that was destabilizing for Michael and David but with the added stress of a small one-bedroom apartment, the family home environment was not physically conducive for a successful reunification. To maintain emotional regulation and reduce becoming overstimulated, the children required a living environment where they have opportunities for privacy and a quiet place to manage their emotions, behavior, and sensory sensitivities.

FINDING #5: The DCF Fall River Area Office Family Assessment and Action Plan listed David’s primary task as “learn to keep himself safe.” As a state agency, DCF does not conduct consistent safety awareness education or planning with children before or post-reunification and there is no evidence this was done with David.

It is not the responsibility of children to keep themselves safe. It is the responsibility of the adult caregivers to keep children safe. David’s caregivers did not treat him with the respect and dignity every child deserves and needs to thrive. Children with disabilities face an assortment of risk factors that put them at higher risk of abuse or neglect than children without disabilities. These may include feeling isolated or helpless, which may prevent them from avoiding or reporting maltreatment. Children with disabilities may also have a limited ability to understand what abuse or neglect is, if they are experiencing maltreatment, and/or how to protect themselves.⁴⁸

David was described by his former congregate care provider and collaborative school as a child who was trusting, eager to please, who had no defiant behaviors and was almost too compliant and agreeable. Based on these characteristics and his needs attributed to his autism, David was at significant risk of maltreatment.

The DCF case management team should not have tasked David with keeping himself safe. Safety awareness as a skill is different than an obligation to keep oneself safe. Safety awareness should be taught to all children and should consider the ways in which a child learns best. In this way, it would have been appropriate for the DCF case management team to educate David about distinguishing between appropriate and inappropriate interactions, and how to communicate with a trusted adult if he believed he was mistreated.⁴⁹ The DCF case management team should have worked with David directly to develop a concrete plan with strategies to communicate any concerns. The DCF case management team could have used this plan as a conversation tool with David during monthly home visits to gauge his safety and care.

Safety awareness education and planning should be an ongoing conversation between the DCF case management teams and the children whose safety and well-being they monitor. It is the obligation of DCF to work with an entire family to ensure successful reunification. As a state agency, DCF cannot

⁴⁷ At the time the housing decision had been made by DCF, DCF and the family were under the belief that Noah would be reunifying home as well. This would have meant that the one-bedroom apartment would have housed three adults, a toddler, and the three triplets.

⁴⁸ Center for Disease Control: The Risk and Prevention of Maltreatment of Children with Disabilities. [CDC Kids with Disabilities Bulletin.pdf](#)

⁴⁹ Center for Disease Control: The Risk and Prevention of Maltreatment of Children with Disabilities. [CDC Kids with Disabilities Bulletin.pdf](#)

and should not ignore the value of safety awareness planning with children, particularly when DCF is transferring physical custody.

FINDING #6: Between March 13, 2020 and David's death on October 21, 2020, there was a progressive deterioration in his behavioral and emotional presentation. Information about David's deterioration was communicated to the DCF Fall River Area Office, who failed to identify that this deterioration was out of character for David and a warning that he was being abused and neglected by Mr. Almond and Ms. Coleman.

When David returned home on March 13, 2020, he was an earnest, kind, happy, vibrant youth. David was consistently described to the OCA during this investigation by his former congregate care provider and collaborative school as having good social interaction skills, as being communicative, as having no significant behavioral issues or self-injurious behaviors, as having no aggression toward others and as having the ability to take care of his own activities of daily living.

Within weeks of reunification, Ms. Coleman began reporting to the DCF case management team and the continuum service provider that David would purposely not listen to directions, was self-harming, was aggressive and was dependent on a high level of support for his daily care, especially toileting. While the DCF Fall River Area Office understood David to have autism and perceived he functioned at a higher level than his siblings, the DCF Fall River Area Office perceived him as having limited ability to communicate and socialize, and echoed what Ms. Coleman reported: that he was aggressive, defiant, and purposefully non-compliant. Sometime in May 2020, the DCF case management team consulted with DCF area office management about David's reported behaviors. DCF area office management decided that while Mr. Almond and Ms. Coleman were not consistently using the continuum support providers services offered, that there were no abuse or neglect concerns. DCF area office management recommended that Mr. Almond and Ms. Coleman be instructed to further engage with the continuum service provider. **The OCA recognizes that this is one of the many times the DCF case management team brought concerns about the Almond family to DCF area office management, and one of the many times their concerns were dismissed. The OCA believes the constant dismissal of the DCF case management team by the DCF area office management negatively impacted their confidence to assess safety and risk, and their analysis would be supported by the DCF area office management.**

The continuum service provider was unaware this portrayal of David was uncharacteristic because they had no prior experience serving David before he transitioned home on March 13, 2020, and the continuum services were assigned to Michael. Due to Ms. Coleman's ongoing complaints about David's behavior, in July 2020 the continuum service provider reached out to the former congregate care provider to ask if the behaviors Ms. Coleman were reporting were also observed when David was placed in their program. **The congregate care provider responded that Ms. Coleman's complaints about David's behavior were not characteristic of David. The DCF case management team was included in this email communication, but no action was taken by the DCF case management team to investigate the discrepancy between David's presentation before and post-reunification.**

As the months passed, Ms. Coleman continued to report to the DCF case management team and the continuum service provider that David's behaviors were getting more and more extreme. During the DCF case management team's monthly virtual home visits with the family, documentation reflects that David was always observed in the same area of the house, clothed, seated, and noticeably quiet. He minimally communicated with the DCF case management team. Ms. Coleman controlled the entire visit, often berating and shaming David for his behaviors and defiance. Again, the DCF case management team accepted Ms. Coleman's narrative that David's behaviors were purposefully defiant and did not consider his presentation, which was different than his baseline as described by his former congregate care provider and collaborative school, as out of the norm.

Ms. Coleman's behavioral portrayal of David and the DCF Fall River Area Office perception of David starkly contradict the description of both the former congregate care provider and the collaborative school and demonstrate a lack of awareness and understanding. Had there been a baseline understanding of David as an individual and of his abilities, the DCF case management team would have recognized that the behaviors Ms. Coleman reported were a significant regression from his baseline, out of character, and a cause for serious concern. Instead, his behavior was interpreted as defiance rather than what it was – distress. **The OCA believes if David did have the behaviors described by primarily Ms. Coleman, it was in response to the extreme stress, neglect, and abuse he suffered while in the care of Mr. Almond and Ms. Coleman.**

David was reportedly in good health when he was reunified with Mr. Almond and Ms. Coleman in March 2020. His last known weight was taken in December 2019, at which time he was considered to be a healthy weight. At his death in October 2020 he, a fourteen-year-old boy who should be routinely gaining weight as he grew, had lost approximately 60 pounds from his last recorded weight in December 2019. At the time of his death, he was well below the first percentile for body mass. On March 17, 2021, the Office of the Chief Medical Examiner ruled David's cause of death as *Failure to Thrive and Malnutrition due to Starvation and Neglect in an Adolescent with Autism Spectrum Disorder* and the manner of death is *Homicide*. The DCF case management team did not report any concerns with David's physical deterioration between March and September 25, 2020 (DCF's last virtual home visit before his death). The OCA cannot determine how such a drastic change in physical presentation was not observed or not noticed by the DCF case management team.

THEME #3: The DCF Fall River Area Office did not adequately identify and adjust to the complications the COVID-19 pandemic presented for the family and for service provision to this family.

It is widely recognized that in times of crisis and economic stress there is an increase in child abuse and neglect. On March 10, 2020, Governor Charlie Baker declared a State of Emergency in Massachusetts due to COVID-19.⁵⁰ This pandemic has created an unprecedented strain on the Commonwealth's

⁵⁰<https://www.mass.gov/news/declaration-of-a-state-of-emergency-to-respond-to-covid-19>

children and families, and on the public and private entities that provide support to them. Many families are earnestly struggling during this time trying to keep themselves and their children safe from harm while the state is working hard to meet those families' needs. The pandemic has required that state agencies and entities continuously pivot and alter their operating procedures to continue their work in a manner that is safe. This shifting has resulted in confusion regarding policies and procedures, prioritization of some policies and procedures over others, and numerous guidance for practitioners to wade through in trying to meet the requirements of their roles.

The OCA notes that an individual investigation such as this one cannot provide an adequate lens to analyze the effectiveness of the DCF administration's guidance provided during COVID-19. However, the OCA notes that DCF as a state agency does not appear to adequately take a child's disability into account when assessing risk to that child or the capacity of caregivers to adequately provide for that child. Further, the Fall River Area Office's failure to formulate an adequate clinical formulation about the Almond family was compounded when they failed to consider the possible effects of the COVID-19 pandemic on this family and failed to adequately weigh the risks to the children's safety.

FINDING #1: The DCF Fall River Area Office did not treat the COVID-19 pandemic as a cause for reevaluation of the appropriateness of David and Michael's reunification and did not consider the implications of the pandemic on the safety or well-being of the children.

During supervised visits while David and Michael lived at their congregate care program, Mr. Almond and Ms. Coleman required a high level of coaching and support to facilitate the interaction with the children. It was to be expected that Mr. Almond and Ms. Coleman required that same level of coaching and support, if not more, when David and Michael returned home to an unfamiliar setting on March 13, 2020. More importantly, David and Michael required in-person individualized support to help them adjust to being home on a full-time basis, and to adjust to a new school environment.

Mr. Almond and Ms. Coleman took advantage of the quarantine and social isolation effects of COVID-19 to keep the DCF case management team, the Fall River Public Schools, and service providers at arms-length. Mr. Almond and Ms. Coleman repeatedly claimed that they or people they knew had been exposed to COVID-19 and that the potential exposure was a reason to refuse all in-person contact, including visits outside their dwelling from well over six feet away. They also claimed to have various technology challenges and used this claim to manipulate the DCF case management team into limited oversight at a time when such claims were true for many other families.

From March to David's death on October 21, 2020, Mr. Almond and Ms. Coleman restricted and controlled who observed the children, when the children were observed, how they were observed and what information was provided during those observations. These calculated and deliberate efforts were evident through document review and interviews conducted by the OCA and should have been recognized by the DCF Fall River Area Office as a red flag indicating concern for the safety of David and his siblings. Although acknowledging that the family was always putting up barriers to communication, the DCF Fall River Area Office did not contextualize these barriers considering the family's history or risk potential.

The COVID-19 state of emergency coincided within days of David and Michael's return home on March 13, 2020 and the shift of state agency and community-based organizations providing services remotely. This created a significant barrier to the DCF Fall River Area Office's ability to monitor the safety and welfare of the children and should have caused the DCF area office management to quickly pivot and reevaluate the appropriateness of reunification soon after it occurred, if not before. This family required a high-level of post-reunification supervision and monitoring from the DCF case management team due to the complexities of David and Michael's special needs and the long history of abuse and neglect by Mr. Almond and Ms. Coleman.

FINDING #2: The DCF administration's high-risk demographic criteria provided to the DCF area offices, including the DCF Fall River Area Office, did not include children with disabilities. As a result, the Almond family was not identified as high-risk and not prioritized for in-person home visits between March 2020 and David's death on October 21, 2020.

An on-going challenge faced by all child protection agencies is determining which children need increased monitoring to ensure their safety and well-being. This challenge has been further complicated by the COVID-19 pandemic. The ability to physically see a child in their home environment, both scheduled and unannounced, is critical to DCF's monitoring of the safety and well-being of children. In this absence, the DCF area offices are extraordinarily dependent on the caregiver's cooperation, truthfulness, and access to effective technology. The absence of these factors creates an opportunity for caregiver control, avoidance, and manipulation of DCF – as evidenced by Mr. Almond and Ms. Coleman's behavior and the devastating consequences it had on David and his brothers.

In June 2020, the DCF administration provided all 29 DCF area offices criteria and training on identifying high-risk families and required these high-risk families be visited in-person. The DCF involved families that were identified as higher-risk were prioritized for in-person home visits to ensure the safety of the children involved. The Fall River Area Office followed the directive and prioritized in-person home visits for those high-risk families that met the criteria. The Fall River Area Office has consistently exceeded the state average for a recorded credible monthly contact (virtual or in-person home visits) and recorded in-person contact. This family was not identified as high-risk because the COVID-19 high-risk criteria from the DCF administration did not clearly articulate any risk consideration tied to a child's disability.

While this family did not meet the DCF administration criteria for high-risk prioritization of in-person home visits, based on the long-standing history of abuse and neglect of David and his siblings, this reunification should have been identified as a high-risk reunification that took place at the beginning of the global pandemic. It was obvious once David and Michael reunified in March that Mr. Almond and Ms. Coleman deliberately avoided contact with DCF case management team. Also evident was Ms. Coleman's extreme control of the information discussed, particularly what David and Michael were permitted to say, when virtual visits did occur. Additionally, Ms. Coleman was reporting that David was having concerning behaviors and was, at times, injured or sick. All these factors, in addition to concerns

about the size of the home particularly during a period of social isolation and quarantining, were cause for alarm.

While the DCF case management team did ask to visit the family in-person in July, August, and September, Ms. Coleman continually refused, alternately citing fear of COVID-19 exposure by non-family members, or alleging that Mr. Almond or Ms. Shadburn had been exposed to the virus, thus causing fear on the part of the DCF case management team for their exposure. Ms. Coleman frequently reported contradictory information to DCF that the family was out in the community shopping and dining at restaurants and that they had left their apartment to take a family vacation. Between March and October (the period when David and Michael were home and during the COVID-19 pandemic), this family was not identified as a priority for in-person visits because the DCF Fall River Area Office lacked a foundational understanding of the risks facing this family, the avoidance tactics of Mr. Almond and Ms. Coleman and the increased risk of maltreatment based on David and Michael's disability.

FINDING #3: The DCF Fall River Area Office did not have a complete or consistent understanding of the COVID-19 guidance provided by the DCF administration.

The pandemic has required that state agencies and entities continuously pivot and alter their operating procedures to continue their work in a manner that is safe. This shifting has resulted in confusion regarding policies and procedures, prioritization of some policies and procedures over others, and numerous guidance for practitioners to review, assess, and implement to meet the needs of their roles. Since March 2020, the DCF administration has provided extensive statewide COVID-19 guidance and training to the 29 DCF area offices about COVID-19, case practice expectations during COVID-19 and safety protocols for conducting in-person home visits. All new guidance is posted on the DCF intranet, disseminated via email to all DCF personnel from the Commissioner, and relayed at all levels of DCF area office meetings.

Despite the ongoing efforts of the DCF administration to provide and inform their 4,000 person workforce about the COVID-19 related guidance since March 2020, the OCA determined through its investigation that the Fall River Area Office did not have a uniform understanding of the requirements and implications of the guidance. **This is no doubt in part due to the complexity of the following factors: (1) the Fall River community has been in the COVID-19 "red zone" since March 2020 and this level of toxic stress has had a significant impact on the DCF Fall River Area Office, (2) the fear, panic, and ultimate burn-out that many DCF Fall River Area Office personnel experienced, and continue to experience, in continuing to work under the pressures presented by COVID-19, and (3) the unpredictable shifting job requirements due to the complications of COVID-19.**

FINDING #4: The DCF administration has not issued statewide guidance that provides DCF personnel instructions about how to assess safety and risk during virtual home visits.

From the beginning of the COVID-19 pandemic, there has been and continues to be uncertainty about when in-person home visits can resume both for the DCF area offices and its providers. The COVID-19 pandemic required the DCF administration to greatly alter standard case practices. Although COVID-19

related guidance and training have been provided to DCF personnel, the DCF administration has not issued any statewide guidance on how to alter assessments of safety and risk to children and families to account for the change in case practices for visitation. The DCF administration has not provided any statewide guidance on what constitutes effective virtual home visitation or virtual interviewing of children and families. Although DCF shifted its operations, it did not account for the inevitable shift in the content and context of its work.

DCF must prioritize developing guidance and training for dissemination statewide that addresses when virtual visits are appropriate and when in-person visits are required, how to determine the safety and well-being of a child during a virtual visit, how the COVID-19 pandemic may exacerbate certain risk factors already present for families, and how to identify and evaluate indicators of abuse and neglect during remote case management. A foundational expectation of virtual assessment of child safety could make the difference for other children whose lives have been completely upended and hidden from sight as an effect of the ongoing pandemic.

DEPARTMENT OF CHILDREN AND FAMILIES RECOMMENDATIONS

Child protective service work is among one of the most difficult lines of work in part because the families who come to the attention of DCF bring complex problems and often multi-generational histories of trauma, poverty, and discrimination. The decisions made by and recommended to courts by child protective workers carry life-long consequences for the children and their families. The difficult nature of the work is reflected in the inherent tension of the mission: a simultaneous requirement to protect children and to preserve families.⁵¹ Although neglect cases far outnumber cases of abuse children can be seriously injured or die if their caretakers do not have the capacity to care for them.

The child protective system has many built-in safeguards, both internal and external to DCF. All of these safeguards failed David and resulted in his untimely death. This report contains recommendations to strengthen these safeguards across the system. The most critical area for systemic improvements must begin with DCF, the Commonwealth's designated child protective service agency.

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 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.⁵²

⁵¹ The OCA recognizes that not all cases of child abuse and neglect involve parents or family members as alleged perpetrators.

⁵² This includes investigations into the deaths of Jeremiah Oliver and Bella Bond. During FY20, DCF submitted 295 statutorily required critical incident reports, representing a 105% increase compared to FY19. Of these 295 reports, the OCA identified 464 individual critical incidents involving 449 children and young adults. The OCA received critical incident reports from every one of the 29 DCF area offices, including one report from DCF's central office Special Investigations Unit (SIU). Of the 295 critical incident reports submitted by DCF, the OCA provided case-specific written and/or verbal feedback about identified concerns in 139 of them. The identified case practice concerns did not always contribute to the critical incident, but the concerns that the OCA identified warranted the attention of DCF.

RECOMMENDATION #1: The DCF administration should revise the DCF *Supervision Policy*⁵³ and workforce training curriculum to ensure all levels of the DCF workforce receive frequent and structured supervision that supports the development of task-oriented skills, but also the essential clinical formulation skills needed to accurately assess the safety and risks to a family.

Per the DCF *Supervision Policy*, supervision is a meeting between a social worker and supervisor that is “a forum for reflection, critical thinking, connection, professional growth, learning and organizational improvement.” Supervision is “conducted in a manner that prioritizes child safety, aligns with the values and principles of the Department’s Case Practice Model and ensures compliance with the Department’s policies and procedures.” While the DCF *Supervision Policy* provides minimum standards for the frequency of supervision between a social worker and a supervisor, it is missing three critical pieces that the OCA recommends be incorporated into a revised DCF *Supervision Policy*:

- Requirements regarding the frequency and basic content of supervision of DCF supervisors and managers.
- Requirements that the social worker’s articulated clinical formulation about a family is documented and reflects how the social worker developed the clinical formulation and how the clinical formulation will be used in the ongoing assessment of safety, risk, case planning and management of the family.

In our oversight function, the OCA has repeatedly identified that DCF case management teams take a task-oriented approach to case management, often missing the focus on safety and continuous risk assessment. This task-oriented approach is a part of good case practice, but it cannot be the sole approach to case management. Clinical formulation is the precursor to safety planning. Clinical formulation is a skill that requires continuous work and improvement at all levels of DCF area office personnel, and supervision should be designed in such a way that supervisors can review the quality of the supervisee’s clinical formulation, identify opportunities for improvement and promote and aide in the development of those skills.

The OCA believes that there is a pervasive lack of substantive consideration and documentation of the social worker’s synthesis and clinical formulation of risks, safety, and progress on a case. Other than the requirement that social workers document their clinical formulation in the DCF Family Assessment and Action Plan section of the DCF electronic database, there is no requirement for the documentation of the ongoing clinical formulation about a family in any other part of the case record.

⁵³ DCF Supervision Policy: <https://www.mass.gov/doc/supervision-policy/download>

RECOMMENDATION #2: The DCF *Ongoing Casework and Documentation Policy*⁵⁴ and *Family Assessment and Action Planning Policy*⁵⁵ should be revised to expand guidance and direction regarding social workers' contact with caregivers, service providers, educators, other professionals, and natural family supports.

Collateral contacts are made for the purpose of obtaining, clarifying, or verifying information DCF has gathered or received concerning a family or child. A collateral contact can be a professional, a non-professional, or kin.⁵⁶ The DCF *Ongoing Casework and Documentation Policy* and *Family Assessment and Action Planning Policy* do not provide minimum standards for the frequency of collateral contacts and are both missing two critical pieces:

- 1.) Both policies do not provide the social worker with tools to elicit information from collateral contacts relative to a specific family's needs and functioning.
- 2.) Both policies do not provide social workers with tools to interpret information from individual collateral contacts into the social worker's comprehensive clinical formulation.

The DCF case management team responsible for this family had frequent and consistent communication with providers but did not elicit information during this communication that would help assess child safety or parental capacity. No information was gathered prior to reunification of Aiden or David and Michael that showed Mr. Almond and Ms. Coleman were benefitting from the services they participated in, or that showed their behaviors had changed because of their engagement with services. Rather, the DCF case management team obtained information regarding attendance or compliance with services but missed opportunities to gather pertinent information from professionals providing services to the family. DCF area office management had full access to information obtained from collateral contacts via the DCF case management team and the DCF record. DCF area office management did not request, probe, or require that more information be obtained to inform the clinical formulation.

After David and Michael were reunified, the DCF Fall River Area Office did not put all the information received from various collaterals together (also referred to as "clinical formulation"), which was a missing link in identifying the indicators of danger that David and Michael were experiencing. Clinical formulation requires that DCF case management teams and DCF area office management explicitly link the concerns that brought the family to the attention of DCF, and the improved parental capacity based on participation in the family's action plan. To increase the DCF workforce capacities, the DCF administration should update their *Ongoing Casework and Documentation Policy* and *Family Assessment and Action Planning Policy* to specifically include:

⁵⁴ DCF Ongoing Casework and Documentation Policy: <https://www.mass.gov/doc/ongoing-casework-policy/download>

⁵⁵ DCF Family Assessment and Action Planning Policy: <https://www.mass.gov/doc/family-assessment-action-planning-policy/download>

⁵⁶ DCF Protective Intake Policy: <https://www.mass.gov/doc/dcf-protective-intake-policy-june-2020/download>

- requirements regarding frequency of contact with collaterals,
- the minimum important information to be obtained from the collateral depending on the role of the provider, agency, or natural support,
- how this important information should be integrated into the protective assessment and clinical formulation of the individual family,
- guidance for the social workers in determining what information they need to elicit from collateral contacts based on the specific issues outlined in the safety assessment of the family and how to develop an accurate and effective clinical formulation of the information received.

RECOMMENDATION #3: The DCF administration should create guidance that provides: (1) specific criteria for when and why parental assessments are needed from external providers; (2) a standard process for parenting assessment referrals that includes relevant DCF and family history; and (3) a mandate that the DCF case management team provide the parenting evaluator specific parental capacity questions that are related to the protective concerns of the case and the individual needs of both the children and caregivers.

To adequately inform a clinical formulation, a parenting evaluation must determine whether a caregiver can meet the specific needs of the children involved. In this case, the DCF Fall River Area Office did not ask the parenting evaluator to assess parental capacity in the context of the triplets' specific needs or with the younger sibling Aiden's needs. The two parenting evaluations measured Mr. Almond and Ms. Coleman's parental capacity by their ability to follow the direction and coaching from the professionals supervising the visits. The parenting evaluation was not structured in a way that provided the evaluator an opportunity to determine how Mr. Almond and Ms. Coleman would respond to, or care for, the triplets in a less structured, more chaotic, or more stressful environment where the children might be overwhelmed, and where the caregivers would be challenged by conflicting demands on their attention. Yet, in the OCA's interviews with the DCF Fall River Area Office, heavy weight was placed on this parenting evaluation in the decision to reunify David and Michael with Mr. Almond and Ms. Coleman.

For any DCF area office to obtain a parenting or other evaluation from a DCF contracted provider agency that will influence their evaluation of parental capacity, the DCF area office must ensure that the evaluation is based on relevant family history, including the concerns that led to DCF involvement. The DCF case management team must frame the evaluation to ensure that it addresses questions and concerns about the parental capacity to meet the specific needs of the children involved. The DCF case management team must also take intentional steps to ensure that the evaluator is able to observe and assess the family's behavior and functioning in every relevant environment to address the concerns and questions.

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

The DCF Fall River Area Office returned educational decision-making to Mr. Almond prior to David and Michael’s reunification and transfer into Fall River Public Schools, while DCF retained legal custody.⁵⁷ The transfer of educational decision-making in this case appeared to prompt the DCF case management team’s complete disengagement from the educational needs of these two special education students. Once David and Michael were reunified with Mr. Almond and Ms. Coleman, the DCF case management team completely disengaged from educational issues, including the children’s need for special education services. At the time David and Michael were returned home, schools had been closed due to the COVID-19 pandemic. The Fall River Public Schools was providing virtual education which the children did not access from the very first day they were eligible to attend. Despite still being in DCF’s legal custody until July 2020, the DCF Fall River Area Office made no effort to rectify David or Michael’s failure to receive any education, and all special education services. Given that concerns about school engagement was one of the reasons for the children’s removal from Mr. Almond and M. Coleman’s care in 2017, this should have been an area of intensive monitoring and family support.

Education needs to be recognized as a fundamental right and need for all children. When children are not in the custody of DCF but under their supervision, DCF is responsible for ensuring that the risks to the children’s welfare and education are adequately addressed. When children are in the custody of DCF, regardless of who has educational decision-making rights, DCF is responsible for confirming that the essential needs of the children are met to ensure the children’s safety. To the detriment of these children, the DCF Fall River Area Office failed in their responsibility in this case.

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

Workforce Development and Training

DCF currently has no policies, standard practices, or training curriculum about individuals with disabilities. The DCF Fall River Area Office did not understand Autism Spectrum Disorder, or the individual needs of the triplets in relation to how autism presented in each of them. This prevented the

⁵⁷ For more information, refer to the **Findings and Recommendations: Department of Elementary and Secondary Education (DESE) and Fall River Public School (FRPS)** section of this report. Educational decision-making rights can be transferred from one adult to another adult. The person or entity who has legal custody of a child has educational decision-making rights unless those rights are specifically transferred to another adult or entity.

Fall River Area Office from understanding the significant issues raised by the education and treatment providers, the dangerous consequences of the decision to reunify the triplets with Mr. Almond and Ms. Coleman, and the inadequacy of the monitoring of David and Michael's safety and well-being post-reunification.

David's death and the serious bodily injury to Michael is a devastating example of the fact that children with disabilities are at least three times more likely to be abused or neglected than their peers without disabilities.⁵⁸ According to estimates from the Center for Disease Control Autism and Developmental Disabilities Network, as of 2016 approximately one in 54 children have been diagnosed with Autism Spectrum Disorder.⁵⁹ It is critical that child welfare professionals understand the vulnerabilities of individuals with disabilities and the manner in which children and families are impacted by disabilities.

The OCA recommends the DCF administration hire Regional Disability Specialists, who will be available to all staff for consultation and who will provide mandatory training to DCF personnel responsible for the oversight and management of cases that involve children with disabilities. In addition, the OCA recommends the DCF administration collaborate with the Department of Developmental Services, the Department of Public Health and the Department of Elementary and Secondary Education to identify and develop opportunities to increase the DCF workforce capacity in the minimum following areas:

- how to identify or explore with a caregiver if a child or caregiver has a disability
- how to identify if a child or caregiver needs to be evaluated for a disability, including how to request an evaluation in the educational (child only), behavioral health and/or medical sectors
- how to identify if the DCF case management team and/or DCF area office management need to seek out additional training and guidance and where to go for that guidance and training
- best practices for effective child and family assessment and of safety and risk, engagement, case clinical formulation, decision-making, management, and monitoring
- the signs and symptoms of abuse or neglect of a child or caregiver with disabilities
- the special considerations necessary when removing or reunifying a child with disabilities or to a caregiver with identified disabilities

Mapping Policy and Practice Needs

Gathering information about the disabilities of any population, through appropriate means or self-identification, is an extremely complex task because of the legal considerations including the confidentiality limits set by the Americans with Disabilities Act. These legal restrictions prevent barriers to DCF's collection of information about disabilities. In addition, DCF does not have the capacity in its electronic database to collect information about individuals with disabilities in a way that can be used to inform policy, practice, training, and allocation of resources. Critical to effective intervention and assessment of the safety and well-being of any child with disabilities, including a child with autism, is

⁵⁸ Children's Bureau The Risk and Prevention of Maltreatment of Children with Disabilities: <https://www.childwelfare.gov/pubPDFs/focus.pdf>

⁵⁹ Center for Disease Control and Prevention: <https://www.cdc.gov/ncbddd/autism/addm.html>

foundational knowledge about the scope of DCF involved children with disabilities, the needs of these children, and the parental qualities and environmental elements needed for that child to be safe. The OCA recommends that the DCF administration explore their ability to develop the capacity to elicit, collect, document, and analyze information about DCF involved individuals with disabilities that can be used (1) as criteria for assessing risk to a child and family, (2) to inform needed workforce training areas of focus, and (3) to determine allocation of resources for children with disabilities.

RECOMMENDATION #6: The DCF administration should develop a reunification policy that includes, at a minimum (1) an assessment of safety and risk using a research or analytical based or actuarial tool that is used prior to a child’s return and as a support in DCF’s reunification decision-making; (2) area office management administrative case record review prior to any internal case review meeting (e.g. Foster Care Review, Permanency Planning Conference); (3) area office management consultations with the DCF case management team, educational provider, probation officer, relevant service providers and subject matter experts prior to any internal case review meeting; (4) area office management discussions with the caregiver(s) to elicit their input and participation in formulating a reunification transition plan that takes into considerations their strengths and needs; and (5) a documented family-centered transition plan that takes into consideration the individual needs of the child and caregiver, outlines the pre-and-post reunification caregiver expectations, and the DCF oversight and monitoring of the family to ensure child safety.

When a child is removed from their caregiver, DCF is mandated to provide reasonable efforts to help the family resolve the concerns that led to removal and make efforts to reunify that child with his/her family. DCF uses a Family Assessment and Action Plan (action plan) to outline the path toward reunification. This action plan lists the services that the family must engage in prior to reunification to mitigate or eliminate the risk to the children. Although DCF monitors progress on the tasks outlined in the action plan, there is no formal process to analyze the effect of the action plan on parental capacity prior to a decision to reunify a child with his/her family.

The decision to begin the reunification process is extraordinarily complex as it requires a balancing of the risks to a child and the strengths and needs of the family unit. The decision requires a clinical formulation that considers the initial reasons the child came into DCF custody, the progress the family has made to increase their capacity to be safely together, and the safety structure and any services that need to be in place to support the family through a reunification transition. In this case, the internal process resulted in poor documentation for the reunification decision, poor transition planning, and a disregard of concerns about reunification from service providers and from within DCF itself.

The DCF administration should create a standardized process for determining whether reunification of a child with their family is appropriate and how that reunification should be accomplished to be successful. This process should be integrated into DCF’s decision-making records and should require specific documentation from a manager. The review should include the use of an evidence-based

reunification assessment tool. Based on the outcome on the risk assessment tool, the family history, and participation in the services outlined in the action plan, DCF should determine whether the caregivers have shown measurable progress and change to mitigate the abuse and neglect concerns that initially led to removal of the child from their care. If so, and reunification is deemed appropriate, DCF should develop and document realistic and individualized pre-and-post reunification transition plans. The post-reunification plan must include that DCF will increase monitoring to more than the minimal standard of an in-person monthly visit and will require the social worker to speak with the children alone on a regular basis. The frequency of monitoring should be reviewed continuously to support successful reunification. This entire review should be well documented in the family's DCF case record to reflect how and why decisions were made.

To be successful, this process should require that the DCF area office clinical manager review the entire case file and convene a reunification meeting with the DCF case management team, DCF area office management, the DCF attorney, and all the relevant service providers, subject matter experts, and other applicable DCF specialists. This reunification meeting is a critical piece that will help DCF synthesize the pieces of information they have about a family into a complete picture of the child and family's needs and inform the decision making about whether reunification can happen, should happen, how it should happen.

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

A safety assessment is the collection of information about a family to determine the degree to which a child or youth is likely to suffer maltreatment in the immediate future. Many child welfare agencies use safety or risk assessment instruments to help social workers evaluate a family's capacities. These tools can provide a structure for determining current and future harm to the child. However, used alone they do not provide a comprehensive picture of the family or help engage them in problem solving. These tools are most effective when they are directly connected to service planning and monitoring ongoing progress of a family.

Key elements of a safety assessment framework should include:

- key indicators and components of family-centered safety
- specific child-centered safety considerations and safety indicators that:
 - are realistic to the age, developmental, and special needs of a child
 - include safety awareness education to children about abuse and neglect, distinguishing between appropriate and inappropriate interactions, and how to communicate with a trusted adult if a child believes he/she is being maltreated

- include expectations about conversations with a child to monitor their safety
- expectations around documentation of safety assessment and use in family case planning and monitoring

It is not the responsibility of children to keep themselves safe. It is the responsibility of their adult caregivers to keep children safe. DCF cannot and should not ignore the value of safety awareness education and planning with children and caregivers, particularly when DCF is reunifying children. In the DCF Fall River Area Office's involvement with this family, successful case management would have meant that the DCF case management team work individually with Mr. Almond, Ms. Coleman, David, and Michael to develop a safety plan that centered on the family's strengths, supports and areas of need. In this way, it would have been appropriate for the DCF case management team to educate David and Michael about distinguishing between appropriate and inappropriate interactions, and how to communicate with a trusted adult if they believed they were mistreated. The DCF case management team should have worked with the children directly to develop a concrete plan with strategies to communicate any concerns. The DCF case management team could have used this plan as a conversation tool with both David and Michael during monthly home visits to gauge their safety and care. Safety awareness education and planning should be an ongoing conversation between DCF social workers and the children whose safety and wellbeing they monitor.

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

The COVID-19 pandemic required the DCF administration to greatly alter standard case practices, and while many COVID-19 related guidance and trainings have been provided to DCF personnel, the DCF administration has not issued any statewide guidance on how to alter assessments of safety and risk to children and families to account for the change in case practices. The DCF administration has not provided any statewide guidance on what constitutes effective virtual home visitation or virtual interviewing of children and families. Although DCF shifted its operations, it did not account for the inevitable shift in the content and context of its work.

A foundational expectation of virtual assessment of child safety could make the difference for other children whose lives have been completely upended and hidden from sight as an effect of the ongoing pandemic. The DCF administration must prioritize developing guidance and training for statewide dissemination that addresses when virtual visits are appropriate and when in-person visits are required, how to determine the safety and well-being of a child during a virtual visit, how the COVID-19 pandemic may exacerbate certain risk factors already present for families, and how to identify and evaluate indicators of abuse and neglect during remote case management. Key elements of these guidance should include, at a minimum:

- a differentiation between assessing safety and risk virtually versus in-person
- strategies to mitigate or overcome barriers to assessing safety and risk virtually (i.e. unknown level of privacy for interviewing children)
- strategies to overcome the limitations of conducting unannounced virtual home visits
- COVID-19 related barriers to conducting in-person visits and related stressors on children and families (e.g. economic stressors, social isolation)

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

The reduction in resources to DCF because of the 2008 Great Recession resulted in a series of child deaths, several of which were the subject of OCA investigations.⁶⁰ In response to these tragedies, the Governor and the Legislature have supported significant increases to DCF funding to enable the agency to rebuild its operations. The OCA has monitored the progress that has been made to increase licensed staff, reduce caseloads, update policies, improve training, and restore and increase public reporting. The progress that has been made has undeniably resulted in the better provision of protective services to children. **However, this investigation mirrors concerns the OCA has identified through its reviews of critical incidents regarding both the need to improve and document clinical formulations and to develop a robust system of quality review over DCF area office actions.**

In DCF, services are delivered primarily at the area office level. DCF area offices are responsible for intake, investigation, and case work. This work is conducted under standards in the form of DCF's established policies and procedures. The DCF administration needs to ensure that the DCF area offices are implementing these policies as they were designed. Appropriate evidence-based assessment tools need to be utilized to assist in developing clinical formulations. In addition, the DCF administration needs to verify that these policies are effective in achieving the outcomes of their statutory mission to protect children and preserve families.

Although the OCA recognizes that it is not possible to prevent all errors in delivering human services, systems can be put in place to monitor compliance with policies and to review the quality of efforts to detect and correct any potential errors. The DCF administration has monitored the implementation of new policies when such policies are put into effect. However, the DCF administration does not continually monitor the fidelity to these policies to detect error in policy interpretation or inconsistent implementation. The DCF administration also cannot systematically detect problems with the policies themselves without continuous monitoring and evaluation. Since these policies represent DCF's operationalized best practices and standards for the agency, it is imperative that the DCF administration has information on DCF area office compliance with and the effectiveness of the policies.

⁶⁰ <https://www.mass.gov/service-details/investigations>

Among the deficiencies that the OCA found in this investigation was that the DCF Fall River Area Office staff did not establish a proper clinical formulation nor did they identify the Almond family and their children as needing in-person visitation. **The OCA recommends that the DCF administration establish a robust quality assurance system that prioritizes the identification of critical decision-points in a case, such as the decision to reunify children or to recommend termination of parental rights.** The DCF administration must develop processes that will ensure that the decisions made by DCF case management teams and DCF area office management are evaluated through multiple lenses. A quality assurance case review policy and process would standardize the methods for reviewing decision-making and establish a data gathering and feedback mechanism that would allow the DCF administration to evaluate DCF area office decision-making across the state.

Although we recognize that every child with DCF involvement is a child that is at risk who needs attention, there are children who, because of their age or disability or some other factors, require additional expert attention to ensure the best decision-making. The DCF administration should also design processes that can be implemented at the DCF area office level to identify how the needs of these higher-risk children will be properly analyzed and addressed.

Continuous learning needs to be de-stigmatized and embedded in the DCF culture. Concerns regarding the reunification of the children in this case were voiced by the assigned DCF case management team, but the DCF area office management did not address those concerns. The identification and correction of errors, miscalculations, or misinterpretations in clinical assessments, clinical formulations, and service delivery needs to be encouraged and commended. Questioning assumptions and potential biases should become the norm within DCF. Outside agencies, including the OCA, can never monitor DCF as well as the DCF administration can monitor itself because of their expertise and access.

The OCA recommends that the DCF administration develop a more robust quality assurance process that focuses on creating a culture of continuous learning and additional monitoring of decision-making at critical points in cases and for higher-risk cases. This quality assurance process should address decision-making at the DCF area office level and be designed to provide critical data for the DCF administration's trend analysis and policy monitoring.

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION (DESE) AND FALL RIVER PUBLIC SCHOOL DISTRICT (FRPS)

Students are required by law to attend school in the Commonwealth.⁶¹ The beginning months of the COVID-19 pandemic fundamentally altered what attending school was and is in the Commonwealth. School closures in the Spring of 2020 sent districts and families into chaos and it was unclear at that time how schools would need to change their operations to cope with the COVID-19 pandemic and for how long such operational changes would be necessary. School districts and their staff had to quickly pivot to provide learning opportunities to students remotely as families juggled their own schedules and commitments to accommodate learning and teaching from a home environment. The trauma and anxiety that accompanies the pandemic and the personal experiences of loss were also at the forefront of families' challenges in engaging with educational expectations. The challenges faced by school districts were complicated by the uncertainty about the length of school closure as the shifting health and safety information during the first few months of the pandemic made it difficult to determine how and when schools could reopen safely. As was true prior to the pandemic, there was no uniform policy across the Commonwealth directing districts how to provide educational services during the spring of 2020 when schools initially closed.⁶² Fall River Public School District (FRPS) and their staff worked diligently to create effective plans for the district to provide remote and hybrid learning in the pandemic. It is this diligent work by the district that makes the experience of David and Michael particularly distressing from a systems analysis viewpoint because these children fell through the safety net at every critical juncture.

David and his brother Michael qualified for special education services under their diagnoses of Autism Spectrum Disorder. They were entitled to educational programming to meet their unique needs. Special education services are provided via an **individualized education program (IEP)**.⁶³ At the time of his reunification and subsequent return of custody to his father, David's IEP required "substantially separate programming," meaning that he would receive special education services outside of a general education classroom for more than 60% of his school day. David's IEP indicated that he would receive all his functional academics in a special education setting and that he would receive occupational therapy once a week. David was also entitled to extended school year services, which means that he would attend special education programming four days a week at his school over the summer. David's father, Mr. Almond, was entitled to consultations with school staff monthly about David's progress and any challenges in occupational therapy or with communication skills. David's IEP and school services

⁶¹ M.G.L. c. 76 § 1. Children ages 6 to 16 are required to attend school in Massachusetts.

⁶² For some information regarding how remote learning was delivered during the spring of 2020, see "DESE Research Brief August 2020, Spring 2020 Remote Learning Survey: A Summary" available at: [Spring 2020 Remote Learning Survey Summary \(mass.edu\)](https://www.doe.mass.edu/research/brief/202008/spring-2020-remote-learning-survey-a-summary)

⁶³ Department of Elementary and Secondary Education: <https://www.doe.mass.edu/lawsregs/603cmr28.html?section=all>

utilized a behavior support plan to assist him in improving self-regulation skills, independence, and decision-making skills. Michael Almond qualified for similar special education services.

While David and Michael were in DCF legal custody and prior to their reunification with Mr. Almond and Ms. Coleman, both David and Michael attended a collaborative school. Collaborative schools provide intensive educational programs and services for students with disabilities. By all accounts, the collaborative school was a positive environment for both David and Michael, and they flourished there.

David and Michael transferred from the collaborative school to FRPS upon reunification with Mr. Almond and Ms. Coleman in March 2020. This transfer was planned by the collaborative school and FRPS and met the expectations of transitioning special education students. They were enrolled in Henry Lord Middle School upon their transfer from the collaborative school, though they never physically attended Henry Lord Middle School because of the closure of in-person learning due to the COVID-19 pandemic. In September 2020, they were promoted to Durfee High School. Out of respect for Michael’s privacy this section will focus primarily on David though the themes, findings, and recommendations draw on information about, and are relevant to, both children.

What is an Individualized Education Program (IEP)?

IEP means a written statement, developed and approved in accordance with federal special education law in a form established by the Department of Elementary and Secondary Education that identifies a student’s special needs and describes the services a school district shall provide to meet those needs.

Department of Elementary and Secondary Education

The Department of Elementary and Secondary Education (DESE)

Massachusetts has a history of strong local control over school districts whereby local school committees oversee the public schools including educational goals and school district policies. The Department of Elementary and Secondary Education (DESE) implements state education policy as set by the Board of Elementary and Secondary Education. DESE provided school districts detailed and extensive guidance from the start of the COVID-19 pandemic school closures in Massachusetts (starting with the Governor’s *Order Temporarily Closing All Public and Private Elementary and Secondary Schools* on March 15, 2020)⁶⁴ to the date of the publication of this report. The guidance has covered numerous topics providing an in-depth discussion of the factors and priorities that districts should consider when setting district policy to deal effectively with providing education during COVID-19.⁶⁵ The guidance provided by DESE during this time largely operated within the expected borders of local control that Massachusetts schools had experienced prior to the pandemic.

⁶⁴ Available here: <https://www.mass.gov/doc/march-15-2020-school-closure-order/download>

⁶⁵ Guidance and information can be found at: [COVID-19 Information and Resources - Student and Family Support \(SFS\) \(mass.edu\)](https://www.mass.gov/doc/covid-19-information-and-resources-student-and-family-support-sfs-mass-edu). The relevant time period discussed in this report does not extend to the March 5, 2021 emergency amendments to student learning time regulations adopted by the Board of Elementary and Secondary Education.

The entire landscape of the educational guidance is too broad a topic for this report, but the guidance addressed, and continues to address, the multitude of complex considerations and challenges that schools and school staff face in this ongoing state of emergency. The OCA has investigated how guidance provided to districts and within districts affected David and Michael and has determined that the safety net meant to protect these students and provide them with the opportunity to be educated failed and that it is incumbent on DESE and FRPS to take steps, as outlined in these recommendations, to remedy that failure. The OCA's analysis of the systemic concerns in this case resulted in three overarching findings related to DESE:

FINDING #1: DESE did not have the resources to monitor the provision of a free and appropriate public education to individual students in real-time during the COVID-19 pandemic.

Individual school districts are responsible for providing students with disabilities a free and appropriate public education (commonly referred to as FAPE). This means that districts must ensure that special education students are provided with an individualized education plan (IEP) which reasonably enables a child to make progress appropriate considering that child's circumstances.⁶⁶ DESE exercises oversight over school districts in the Commonwealth to ensure that districts are providing FAPE to students.

The COVID-19 pandemic is an unprecedented experience in the Commonwealth and all state agencies were faced with quickly pivoting to address changing health and safety information. DESE was confronted with the monumental task of coping with statewide closure of in-person learning for public schools across over 400 school districts for the Commonwealth's 351 municipalities. DESE chose to provide guidance to school districts during the early months of the pandemic in the manner that DESE traditionally provided such guidance, in the form of a communication of guidance which included standard-setting expectations. DESE did not seek any legislative or regulatory changes that would empower DESE to explicitly direct how education should be provided to students during the closure of in-person learning.⁶⁷ Districts across the Commonwealth were responsible for creating their own plans for how to effectively educate students in a remote environment in accordance with the guidance provided by DESE. This meant that students across the Commonwealth received education differently depending on the district they attended and that there was no uniform approach to providing special education students with FAPE during the initial months of the school closures.

In line with DESE's guidance to districts prior to the pandemic, DESE's guidance to districts during the pandemic was not operational in nature. For example, DESE informed districts at the start of the pandemic that they were required to "...support students to engage in meaningful and productive

⁶⁶ Andrew F. v. Douglas County School District Re-1, 137 S. Ct. 988, 1000 (2017).

⁶⁷ In the summer of 2020, DESE did seek, and the Board of Elementary and Secondary Education did approve, amendments to 603 CMR 27 which defined the minimum requirements of remote learning models which required that districts establish certain procedures for attendance, required that academic work align to state standards, required districts to issue a policy addressing grades, and required that teachers and administrators regularly communicate with students and families. These amendments required that districts establish the standards applicable to that district and did not standardize these policies or procedures across the Commonwealth.

learning for approximately half the length of a school day.⁶⁸ **However, this guidance did not explicitly model what an appropriate attendance policy should look like during the closure of in-person learning nor how that attendance policy would account for the complications of technology barriers, barriers to families being able to provide supervision of schooling from home, equity concerns, and the many other real complexities that districts needed to navigate.**

DESE's oversight responsibilities of districts in the Commonwealth, including their oversight of the provision of FAPE to special education students, relies primarily, though not exclusively, on individuals to bring concerns about the provision of a child's individual education to the attention of DESE.⁶⁹ **DESE does not, to the OCA's knowledge, routinely track data in real-time metrics across the Commonwealth to determine trends and patterns in the provision of special education to students. As such, DESE has no infrastructure to monitor whether individual school districts implemented, or are implementing, policies and procedures that meet the standards set by the DESE guidance.**

In this case, FRPS frontline staff did not adequately implement DESE guidance regarding special education, student outreach efforts, or remote learning expectations. It is highly unlikely that David or Michael would have ever come to DESE's attention because Mr. Almond and Ms. Coleman were not advocating for the children's education and therefore not identifying in-district issues for DESE to review. DESE's system of oversight relies primarily on districts adequately implementing DESE guidance and relies on parents or caregivers to actively elevate concerns. This approach to oversight did not create a sufficient safety net to ensure that these children with disabilities were provided with FAPE during the COVID-19 pandemic.

FINDING #2: DESE provided guidance that districts should prioritize certain groups of high risk students for in-person learning even when a district was operating in a fully remote or hybrid model. When high risk students declined in-person learning and opted for fully remote education, there were no explicit standards for remote learning that applied solely to the high risk students.

Upon the start of the 2020-2021 school year in September 2020, DESE clearly, appropriately, and aptly identified that high risk students should be prioritized for in-person learning in all school districts regardless of the type of learning model (remote, hybrid, in-person) that a district implemented. The high risk categories included students with disabilities, students who do not have reliable internet or suitable learning space in their homes (particularly students experiencing homelessness or housing insecurity and students in foster care or congregate care), students who are behind academically, students who are disengaged and/or who struggled during previous remote learning periods, and early learners (prekindergarten to grade 5).⁷⁰ However, under this guidance all families were provided the

⁶⁸ See "Remote Learning Recommendations During Covid-19 School Closures" [Coronavirus/COVID-19: Remote Learning Recommendations During COVID-19 School Closures \(mass.edu\)](https://www.doe.mass.edu/coronavirus/COVID-19-Remote-Learning-Recommendations-During-COVID-19-School-Closures)

⁶⁹ For more information see: <https://www.doe.mass.edu/sped/cc.html>.

⁷⁰ See Remote Learning Guidance for Fall 2020: DESE July 24, 2020 available at: <https://www.doe.mass.edu/covid19/remote-learning/?section=guidance#view-list>

option of choosing to opt-in to a fully remote learning model in any district in the Commonwealth. DESE indicated that this policy was intended to accommodate the health and equity concerns facing families. Such accommodation is necessary during the COVID-19 pandemic. However, health and equity concerns were not clearly articulated as the acceptable reasons for choosing to opt-in to a fully remote learning model. Families could choose the fully remote option for any reason and without a stated reason. In fact, districts were instructed not to counsel families of high risk students to choose in-person learning even if the district felt that remote learning would not be successful for a particular student.

Distinctions for high risk students should have been made across all aspects of educational service provision plans and expectations during the time-period discussed in this report. Expectations for remote learning could have been differentiated based on the risks to education loss and instability of these already-identified high risk groups. Expectations could have included an additional number of student check-ins with staff, higher standards for return of paper packets to evaluate learning loss, explicit participation levels required for attendance, differentiated support to families based on the individual needs of those families, increased communication plans with DCF for the students who were in DCF custody, and social-emotional planning that directly addressed the reasons that high risk students were deemed high risk.

FINDING #3: Although DESE guidance issued during the pandemic repeatedly stressed the importance of safety and wellbeing of students, particularly students’ social-emotional health, the guidance did not provide explicit information to school staff about recognizing signs of child abuse or neglect in remote and virtual learning environments.

The OCA has been highly concerned about the effects of the pandemic on mandated reporting in the Commonwealth. School personnel who, as a subgroup of mandated reporters, typically file the majority of child abuse and neglect reports in the Commonwealth, had to completely alter their typical modes of operation to provide instruction in a virtual and remote manner to students. This was a fundamental change in how students and teachers interacted with each other and this resulted in a steep drop in the filing of reports of child abuse and neglect at the start of the pandemic. This decline in mandated reports occurred across the country. **The OCA submits that teachers and administrators needed explicit and operationalizable information about how to translate their analysis of the safety of their students from an in-person environment to a virtual or remote environment.** There was recognition that the pandemic was bringing additional stresses to families. In addition to needing to serve as teaching assistants, families were under financial and other emotional stress.

The majority of DESE guidance focused on the efforts that educators needed to make to connect with families, or be available for connection with families,⁷¹ but it was not until January 2021 that DESE issued guidance on its *Covid-19 Mental and Behavioral Health* webpage that specifically addressed

⁷¹ See, for example: “All members of the outreach team [providing supports to engage students] should be clear that the purpose of collecting this information is for support, not compliance. Students should never be shamed or disciplined for lack of engagement. Instead, the purpose of the calls is to understand the needs that are preventing the student from engaging in schoolwork, with the goal of ultimately providing support to meet those needs” “Strengthening Our Remote Learning Experience” <https://www.doe.mass.edu/covid19/learn-at-home.htm>.

attendance in the context of child abuse and neglect.⁷² This apt guidance provided a much needed answer to the question regarding school attendance that districts had been grappling with since the pandemic began what the districts should consider for next steps if their outreach to engage students in learning was unsuccessful. As outlined in the recommendations below, more detailed information needs to be provided regarding mandatory reporting during remote learning.

THEMES AND FINDINGS: FALL RIVER PUBLIC SCHOOL DISTRICT (FRPS)

As noted in the sections below, Fall River Public Schools failed to provide David and Michael with a free and appropriate public education (FAPE) during the period discussed in this report because David and Michael never received any academic instruction or related special education service. This failure to provide these students with the education that they were entitled to is a direct result of the complexities that the COVID-19 pandemic presented. This situation occurred despite the belief of the Fall River Public Schools administration that they were following the DESE guidance provided to the district. **The disconnect between the guidance that DESE provided and the lack of the implementation of any education service provision suggests that there must be a statewide reevaluation of what the baseline requirements are for students to receive education in the Commonwealth and the resources and legal authority for DESE to enforce those baseline requirements on a timely basis.**⁷³

THEME #1: The complexity of shifting to remote learning during the initial school shutdown period of March to June 2020, coupled with the simultaneous transfer of David to FRPS, resulted in amplified risks to David that went unaddressed by FRPS.

David was never seen by, or spoken to by, any school employee from March 2020 to the time of his death in October 2020.

The transfer of David to in-district schooling at FRPS from the collaborative school in March 2020 coincided exactly with the closure of in-person learning due to the COVID-19 pandemic. As part of his planned transition home David had visited Henry Lord Middle School on a physical tour approximately a month earlier, but he never physically or virtually attended school after reunification. David returned home the weekend before schools were closed. Although David had attended FRPS prior to his 2017 removal, the staff responsible for his education upon his return did not have the opportunity to work with him or get to know him because schools closed before he could attend in-person. His teachers did not know him personally, so they did not have first-hand knowledge of his strengths or needs. FRPS staff identified that it was this lack of knowledge that resulted in FRPS relying on Fall River DCF case management team and Ms. Coleman's descriptions of the students. This reliance extended to DCF and Ms. Coleman's characterizations of the needs of the students; FRPS staff did not make an independent analysis of the needs of the students. However, FRPS did have access to the students' special education

⁷² "Promoting Student Engagement, Learning, Wellbeing and Safety During Remote and Hybrid Learning (Winter 2020)" available at: <https://www.doe.mass.edu/covid19/mental-health.html>

⁷³ The DESE Public School Tiered Focused Monitoring System reviews school districts every three years. More information is available at: [Public School Tiered Focused Monitoring System - Office of Public School Monitoring \(PSM\) \(mass.edu\)](https://www.doe.mass.edu/psm/)

plans and information which adequately described David and Michael, their needs, and their ability to communicate and self-advocate.

FRPS staff admittedly never attempted to speak to David or Michael over the phone to gauge for themselves how the students were faring. DESE guidance provided throughout the pandemic period did stress that schools should be engaging in active communication outreach to both parents and students. FRPS solely communicated with Mr. Almond and Ms. Coleman on this case; because FRPS staff received some response back from Ms. Coleman, they did not consider the need to speak directly to David or Michael even though there was no evidence of school participation by them. However, it was clear from the available guidance that schools should be seeking to engage students in academic work and in social and emotional check-ins through any means available to the staff which would have included solely over the phone. Prior to the COVID-19 pandemic, students were seen in person by teachers every school day. **Schools should have made contact directly with students through whatever means were available as that would be the closest approximation of the type of contact a teacher would have had before the pandemic. Schools should not have waited until remote learning was established and technology was in place prior to making efforts to connecting directly with students.**

Once the 2020-2021 school year began in September 2020, the family opted for David and Michael to receive their education, including special education services, through remote participation only. During COVID-19, this option is available to all families in the Commonwealth whose children are enrolled in public schools.

There is also no evidence that David ever did any schoolwork virtually or through paper packets from March 2020 to October 2020.⁷⁴ The OCA believes, without reservation, that Mr. Almond and Ms. Coleman took active and persistent steps to keep David out of sight from any school official. FRPS failed to understand that avoidance of all school contact with David was a purposeful effort by Mr. Almond and Ms. Coleman intending to conceal the severe neglect David suffered. Mr. Almond and Ms. Coleman used the complexity of permissible in-person contact during COVID-19, the school shut-downs, and remote learning challenges to manipulate FRPS. **Although FRPS sometimes raised red flags about the lack of David's participation to the DCF case management team, they never elevated any concern above the regular communication with the DCF case management team by filing a report of abuse or neglect for the school absences nor did they initiate any truancy action within the schools or the Juvenile Court.**

FINDING #1: FRPS did not consider how attendance measures should be tied to student participation levels.

Although FRPS pivoted to remote learning through online platforms with live middle school classes available starting on April 27, 2020, FRPS did not issue any written guidance to staff about the expected participation level of students, expected work-output from students, expected communication from

⁷⁴ Two very short quizzes were completed virtually in early October 2020, one for David and one for Michael. Both FRPS and the OCA believe that these quizzes were completed by an adult in the home.

families, or attendance standards. In line with DESE guidance, staff at the middle school level where David was enrolled were keeping a daily spreadsheet of family contacts. This included whether the school had sought to connect with the family via some form of technology and whether the connection had been made. This spreadsheet was being reviewed by senior school officials. FRPS did not equate family contacts with attendance, but this did not matter because according to FRPS staff there was no formal attendance taking from March 2020 to the end of that school year. FRPS did not adequately operationalize the tracking of attendance during the first months of the pandemic, and no directions on how to track attendance was provided by DESE guidance.

Numerous attempts were made by school staff to communicate with Mr. Almond and Ms. Coleman with extremely limited response. Mr. Almond declined online meetings intended to discuss David's IEP and engagement in school. The district offered Chromebooks to assist the students with engaging in remote learning in early May. That offer was refused by the family in favor of the children participating through the completion of paper packets. Paper packets were never completed and never submitted to FRPS. This evidence of no participation did not trigger any appropriate response from school officials.

In line with DESE policy, FRPS reached out multiple times to Mr. Almond and Ms. Coleman in the spring of 2020 to offer the family support and access to services provided by the school. The tone of the school's communication at this time did not indicate any concern for the apparent absence of the children from any learning or related services nor indicate to the family that there would be any type of consequence for the complete failure to engage with the school. Similarly, school staff informed DCF of the family's failure to engage with the school but did not explicitly raise concerns with DCF at that time. The school district was prioritizing families who had not responded at all to any outreach by the school. By comparison, this family did not trigger any alarm.

FRPS staff did not appear to place the failure of the transition to Henry Lord Middle School, as evidenced by a complete lack of engagement with the school, into the context of David's individual needs and vulnerabilities. This was in part due to the district's need to quickly deal with all the complexities of school closure, and partly due to the lack of any connection that staff had to David. It is particularly troubling that special education staff did not take any action to mitigate David's doubly destabilizing experience of transitioning to his home environment after years in residential placement, and suddenly losing all educational structure and supportive contact. For children with autism, transitions are especially difficult and need to be monitored extremely closely to ensure success.

Without explicit attendance requirements or participation requirements tailored to the COVID-19 pandemic environment, David fell through the gaps created by COVID-19 and was inexplicably promoted on paper to Durfee High School without any individualized attention. **As FRPS was providing remote learning for students during the school closure in Spring 2020, a complete disengagement from all work, all services, and all meaningful school contact should have been unequivocally viewed as failure to attend school. David should have been given no credit due to lack of engagement and a report of child neglect should have been filed based on the family's unreasonable refusal to facilitate any educational engagement for David or Michael.**

THEME #2: DESE and FRPS guidance did not adequately filter down to staff at FRPS who were responsible for educating David.

DESE issued its *Initial Fall School Reopening Guidance* on June 25, 2020⁷⁵ and *Remote Learning Guidance for Fall 2020* on July 24, 2020.⁷⁶ This guidance required school districts to prepare reopening plans for three learning models: in-person, hybrid, and fully remote. The July guidance brought districts' attention to recent amendments to DESE regulations which required that remote learning models include procedures for all student to participate in remote learning including a system to track attendance and participation, aligning remote academic work to state standards, a policy for issuing grades for remote work, and a requirement that teachers and administrators shall regularly communicate with students and their parents and guardians.⁷⁷ These changes to the DESE regulations occurred at the end of June, approximately three months after schools initially closed due to the pandemic, and approximately two months before schools would begin the 2020-2021 school year.

FRPS issued a comprehensive reopening plan approved by the Fall River School Committee on August 10, 2020 in which the district outlined a hybrid model for the 2020-2021 school year. The comprehensive reopening plan met the standards of the DESE guidance and indicated that attendance would be taken whether students were participating in-person or remotely. Although the district operated in a hybrid model, per DESE guidance all families had the choice to opt-in to a fully remote model. The district's plan for the fully remote option included an expectation that students would participate in synchronous instruction, follow assigned schedules, and follow a virtual program that aligned with state and local curriculum. The district plan makes clear that all special education students, whether they are remote or in-person, will receive the services on their IEPs. The district indicated that all service providers had participated in the necessary training for telehealth services so that special education services could be provided remotely. The district also laid out a plan for social and emotional learning and supports including virtual morning meetings and monthly progress monitoring meetings.

The first day of high school for David was September 16, 2020. DESE's guidance required that high risk students should be prioritized for in-person learning regardless of whether a district was operating in an all-remote or hybrid model. **David met *all but one* of the categories of DESE's high-needs students who should be prioritized for in-person learning: students with disabilities, particularly those with more intensive needs; students whose parents/caregivers report that they do not have reliable internet or a suitable learning space at home; students who are significantly behind academically;⁷⁸ and students who are disengaged and/or struggled significantly during previous remote learning periods.⁷⁹** However, families in the Commonwealth had, and continue to have, the option to opt their children into

⁷⁵ Available at: <https://www.mass.gov/doc/dese-fall-reopening-guidance/download>

⁷⁶ Available at: <https://www.doe.mass.edu/covid19/remote-learning/?section=guidance#view-list>

⁷⁷ June 30, 2020 emergency amendments to 603 CMR 27.08(3)(b).

⁷⁸ David could be considered significantly behind academically in terms of their failure to complete any learning from March 2020 to the end of that school year, and the family's refusal to engage in extended school year services that he was entitled to on his IEP.

⁷⁹ The last prioritization group that David did not meet was early learning (grades PK-5).

a fully remote learning model, regardless of the district’s chosen model. This option was designed to accommodate medical and equity concerns facing families. DESE’s guidance made clear that:

Even if a student is prioritized for in-person learning, **parents/caregivers have the option to choose a district’s remote learning program for their child’s instruction if they prefer – with the understanding that the remote learning program may not provide as robust offerings as, or replace the full benefits of, learning in person.** At no point should schools or districts “counsel” students into a particular program due to behavior challenges.⁸⁰

Not only had David’s father declined in-person extended school year services that would have provided David with special education programming throughout the summer, Mr. Almond also chose to have David attend Durfee High School via the fully remote option.

FRPS administration has expressed concerns and dismay that students in the high-needs categories were given the option by DESE to attend school remotely, without any need to justify that decision with documented health concerns, despite DESE indicating that in-person schooling was safe if the proper protocols were followed.⁸¹ The expectation was that families and districts would have productive conversations about the reality of the barriers to providing adequate special education services in a remote environment and that families and districts would together make reasonable plans that gave students the best opportunity to thrive successfully during the pandemic. This expectation presupposes that the family is advocating for the best interests of their children and does not consider the possibility that a family would be utilizing the remote learning environment as an opportunity to disengage from education or from the view of mandated reporters. That most families are advocating for the best interests of their children is a reasonable and appropriate assumption by educators, however that presumption should be questioned when there are identified risks to the student and student wellness is endangered. DESE guidance during the pandemic did not provide explicit instruction about identifying concerns of abuse or neglect until January 2021.

DESE provided school districts with ten professional development days at the start of the 2020-2021 school year. These days were intended to provide districts with the time and opportunity to train their administrators, teachers, and staff on the new health, safety and well-being guidance and policies. This additional time for training did not result in the successful implementation of DESE guidance or FRPS guidance in this case.

⁸⁰ Emphasis in original. “Remote Learning Guidance for Fall 2020” page 4 available at: <https://www.doe.mass.edu/covid19/remote-learning/?section=guidance#view-list>.

⁸¹ “In this guidance, we: Clearly state our goal for this fall: the safe return of as many students as possible to in-person school settings, to maximize learning and address our students’ holistic needs. If the current positive public health metrics hold, we believe that be following critical health requirements, we can safely return to in-person school” Initial Fall School Reopening Guidance, June 25, 2020 page 2 [Initial Fall School Reopening Guidance, June 25, 2020 \(mass.edu\)](https://www.mass.gov/info-details/initial-fall-school-reopening-guidance-june-25-2020)

FINDING #1: FRPS staff tacitly accepted that alleged technology access barriers were a legitimate reason to delay the provision of education, including special education.

Despite the expectations set by DESE and the school district for immediate and comprehensive engagement of students and families in remote learning, and despite FRPS’s assurance that IEP services would be provided to special education students in a remote setting, FRPS staff interpreted the complete disengagement by David as a natural consequences of the apparent technology barriers facing the family. **At no time was any school service or academic support offered to David verbally over the phone (the one form of technology the family clearly had). Neither of the two schools David was enrolled in adequately followed-up with work via paper packets. There was no effort to reach out to David to address any of his social or emotional needs. In short, David was never provided with any special education services.**

David was enrolled at Durfee High School for a little over a month prior to his death. During that time, FRPS made significant attempts to work with the family to provide them with technology and achieve engagement. FRPS was under the impression that Ms. Coleman was advocating for David by repeatedly reaching out to the school to complain about technology barriers, even though she was not David’s biological parent and not the person legally responsible for his education. Unfortunately, FRPS was too focused on resolving the immediate barrier of Chromebook allocation⁸² and the subsequent immediate barrier of apparent lack of internet access,⁸³ to pivot to provide services and academics promptly to David in a more creative and individually tailored manner. The short-term focus on the technology barriers also did not account for the recent history of the family at FRPS which demonstrated a pattern of excuses for non-engagement, no substantive engagement in learning via the paper packets that were individually tailored to the learning level of the children, failure to consistently communicate with the school, troublesome attempts to falsely report virtual attendance, and expressions by Ms. Coleman that David’s behaviors were increasingly deteriorating and the situation in the home was escalating. Extraordinary damage is likely to occur to a child with autism who requires substantially separate programming and a behavior modification plan who does not receive any of the interventions or support to which he is entitled for months on end. Neither the DCF case management staff nor FRPS appeared to consider how the continuous delays in providing critical special education services to these children may affect the risks to the children’s safety in the care of the family who had only recently been reunified.

FINDING #2: In September and October 2020, FRPS attendance procedures were not clearly defined or communicated to staff. This created risks for students whose lack of engagement was not escalated due to lack of clarity about participation requirements.

⁸² Despite initially refusing Chromebooks offered by Henry Lord Middle School, the family did request and receive chrome books from Durfee High School once the pressure to engage in remote learning increased during the start of school in fall 2020.

⁸³ As noted elsewhere in this report, Ms. Coleman was able to engage in hour long virtual sessions with early intervention providers and with other individuals through WhatsApp and Facebook Messenger in the home at the time she was reporting a lack of internet access.

During Fall 2020, FRPS instituted a dual attendance keeping system for in-person class attendance and virtual flexible attendance accounting for asynchronous work. The virtual attendance was marked by the student or parent who signed onto the virtual learning platform, not the teacher. Someone in the household, presumably Ms. Coleman, began logging onto David's account and marking him virtually present despite David not engaging in any work synchronously or asynchronously. Staff at FRPS noticed the incorrect attendance markings and switched the attendance markings back to "absent." There was confusion at FRPS as to whether lack of technology access was a valid reason to mark a student absent and what being "present" in a virtual or remote environment required. Further, there was confusion regarding whether the school had the authority to correct the virtual attendance record and how that should be accomplished. No guidance on these attendance issues was promulgated at FRPS though questions had been raised by individual staff members. Due to the lack of clarity on the attendance requirements, the back-and-forth attendance struggle between staff and the family did not rise to the level of a red flag and therefore did not trigger the typical review of attendance issues for purposes of filing a child abuse or neglect report, a failure to send filing, or a truancy filing.

FRPS failed to follow its own attendance policy about investigating repeated absences. Staff did not know whether lack of access to technology to facilitate remote learning was a valid excuse for absenteeism. Staff also were not clear what the connection was between student engagement and participation level when calculating attendance in the remote model the family had selected. Perhaps above all, the DCF case management staff actively advocated to school staff that Ms. Coleman not be held accountable for David and Michael's absenteeism. The DCF case management staff felt that the absences could be excused by the reported lack of technology access in the home. The DCF case management staff also warned and advised Ms. Coleman that she should work to prevent the school from filing a child neglect report against her by encouraging her to repeatedly contact the school to explain that technology was the barrier to David and Michael's participation. It is unfortunate that the DCF case management staff reinforced that Ms. Coleman's excuses regarding technology access were deemed a permissible reason for the children's absences.

The DCF case management staff failed to investigate the purported technology barriers which were highly questionable. However, school staff have an independent responsibility to find a way to provide some education to the students even considering the reported technology access barriers. Although imperfect, staff could have sought to provide some education to these students through creative avenues such as paper packets that were actually completed and collected and frequent check-ins with staff, possibility of verbal-only lessons over the phone, providing direct instruction to Ms. Coleman to assist the children in completing coursework, creation of behavior management plans and social stories for the home environment, taping lessons on DVDs and delivering them to the family, etc. Ms. Coleman's outreach to the school prevented most staff members from raising red flags. The OCA is not aware that the DCF case management staff expressed any concerns to FRPS about the lack of schooling or the lack of IEP services provided to David. The FRPS staff did not know that attendance issues were one of the reasons for David's prior removal.

Because the issue of school attendance had been dismissed by some staff members as a combination of a natural consequence of the COVID-19 pandemic's effect on families and the lack of technology access, David was never identified as needing follow-up from an attendance officer or the school resource officer regarding his failure to engage. When the school attendance officer went to the family home in October 2020, she was sent there solely for the purpose of dropping off technology and not for any discussion with the family regarding David's engagement, his behavior, the challenges the family was facing other than technology, and without a requirement that she physically see or speak to David. When Ms. Coleman denied the attendance officer access to the home, this also did not raise a red flag with the attendance officer that something may be wrong. With the COVID-19 pandemic, it was not uncommon for families to deny physical access to their homes for fear of spreading the virus. However, speaking to or seeing the children at a safe distance, perhaps from the doorway, would not have been an unreasonable request. Given the presumed deteriorated physical state of David at the time of the attendance officer's visit, this may have resulted in immediate medical intervention.

A great many families face technology access difficulties even in non-pandemic times, but that access to technology has become an even greater hurdle for families during COVID-19. Lack of access to technology does not equate with absenteeism at school, but complete disengagement from school for multiple months may be neglect depending on the circumstances and should prompt greater school intervention than simply waiting for technology delivery.

FINDING #3: Despite DESE and FRPS guidance on special education processes during COVID-19, FRPS staff members did not adequately implement the guidance and missed the opportunity to use the special education process as a method to engage the family.

FRPS would normally hold an IEP team meeting 30-60 days after a student transfers into the district. FRPS did not hold such an IEP team meeting for David and never offered one to the family. FRPS staff were managing the backlog of annual IEP meetings and special education evaluations which had been delayed due to the pandemic. Many districts were struggling with the legal deadlines for special education meetings and evaluations as the federal government did not offer districts any relief from these deadlines. Although there was a meeting backlog, the transition meeting to determine whether the school was adequately implementing David's IEPs and whether the transition to FRPS was successful should have been prioritized, particularly for this new high-needs student who had transitioned at the start of the pandemic shut-down.

No school officials identified the IEP team meeting process as a means of engaging the family on attendance issues, possible school avoidance issues, or in response to the concerns that Ms. Coleman reported to the school about David's increasingly challenging behaviors. This included reports that he was acting out at home, that he was purposefully urinating when not getting his way, that he needed physical therapy, and that the schoolwork sent home for him was too difficult.

The DESE issued guidance *Remote Learning Guidance for Fall 2020*⁸⁴ indicated that for the school year starting in September 2020, paper packets and frequent communication with families (the “resources and supports” model) could only be used as the sole method of education for up to two weeks until the school could implement the “instruction and services” model which requires structured learning time, teletherapy, and videoconferencing. FRPS staff responsible for direct education of David did not identify that he was not receiving the correct educational model within the expected time period. Staff members did not appear to identify the inadequate provision of education to David as a violation of his right to a free and appropriate public education (FAPE) which should have triggered intervention by the IEP team or special education administrators.

FRPS did contact Mr. Almond regarding the creation of a Special Education Learning Plan as required during the COVID-19 pandemic. A staff member had a phone call with Mr. Almond describing how services on David’s IEP would be delivered differently due to COVID-19. However, the plan to provide services was never adhered to, and there was never any effort by FRPS to readdress the plan and coordinate with the family to design a plan that would work for them or that would provide David with some level of educational services even while the family reportedly awaited technology access.

FRPS special education administration provided special education teachers and service providers with instruction on how to measure student progress for the purposes of IEP monitoring during COVID-19, how to problem solve with families who were unable to access virtual learning or unable to access synchronous learning, and how to consider and address compensatory services for children who had not been provided, or who had not been able to access, their IEP services.⁸⁵ Despite these efforts, teachers who are the front-line in trying to manage the complexity and unknown terrain of teaching in the time of COVID-19, with all the technological changes, the social-emotional upheaval, the shifting expectations, and their own health and safety to consider, did not implement the expectations of the special education administration at FRPS. Staff did not identify the issue of lack of any information on educational progress for David as a trigger for intervention.

THEME #3: FRPS was unable to consistently monitor and interpret risks to David concerning his ability to engage with education and his social-emotional well-being. Lack of a consistent internal narrative describing David and his family resulted in an over-reliance on the DCF Fall River Area Office interpretation of the family which put David at risk.

FINDING #1: Documentation of educator concerns were not recorded and transmitted between schools within FRPS.

Teaching staff at Henry Lord Middle School recognized in late March 2020 and early April 2020 that the family had not responded to the school’s outreach since David’s enrollment and reported concerns

⁸⁴ Available at: <https://www.doe.mass.edu/covid19/remote-learning/?section=guidance#view-list>

⁸⁵ See “Coronavirus (COVID-19) Special Education Technical Assistance Advisory 2021-1” available at: <https://www.doe.mass.edu/covid19/sped.html>

about the lack of familial contact to the DCF case management team and internally up through school administration.

Staff at Henry Lord Middle School recognized that David's IEP had not been adequately uploaded to the record keeping system, that they did not have current contact information for the family, and that Mr. Almond had not signed David's most recent IEP. These concerns were expressed at the administrative level internally and to the DCF case management team. Many efforts were made by school staff to engage Mr. Almond and Ms. Coleman. However, none of the concerns that school staff had about the family were ever recorded in the internal record keeping system for the district. There was no documentation that the family did not participate in any meaningful way with school communication, education, special education services, or that the family refused an offer of Chromebooks. Similarly, there was no record of the efforts to engage David with extended school year services. Therefore, when David was promoted to Durfee High School for September 2020, there was no documentation available to staff at the high school detailing the pattern of communication avoidance or the pattern of refusal to engage in remote learning that had already occurred within the district.

FINDING #2: Mr. Almond and Ms. Coleman raised access to technology as the barrier to David's participation in school. Both FRPS and DCF failed to interpret this barrier as the avoidance tactic it was.

Many families faced technology access barriers prior to the COVID-19 pandemic, but these barriers have become more critical during the pandemic as they are necessary in order to ensure access to education. School districts in the Commonwealth have worked exceptionally hard to obtain and distribute technology to students who need it to engage in their education. This monumental effort required that districts overcome multiple logistic complexities. In the rush to meet the technological demand, FRPS failed to see that the technology narrative provided by this family was intended to delay and prevent David's educational engagement.

Starting in April 2020 the family presented multiple conflicting reports about the reality of the family's technology access, including that there was a laptop in the home that David had access to for learning purposes, that work be sent home via email, that the technology access issues had been resolved, that technology is used in the home for only gaming so it would be difficult to direct David to use it for educational purposes, that paper packets are preferred, that after the delivery of the Chromebooks David will get online the following day, that David had started his virtual schooling, and that there was no internet access in the home. These multiple conflicting reports were communicated to various FRPS staff. However, since this caregiver contact was not required to be recorded in a centralized place, it was impossible for FRPS to question the conflicting stories of technology access in the home and to also question the motivations of Mr. Almond and Ms. Coleman.

Of note, the DCF Fall River Area Office appears to have made no effort to resolve issues related to the family accessing technology. The children remained in the legal custody of DCF until July 2020 and under DCF supervision until David's death. The DCF Fall River Area Office indicated that they believed

that technology access for school was the sole responsibility of the district. When children are in the custody of DCF, even if they are placed in their familial home, DCF should serve as a legal guardian to the child and should ensure that the child is adequately attending school and that barriers to school attendance are resolved. When children are in the custody of their caregivers and DCF has supervision and planning responsibilities for the family, DCF should take an active role in alleviating legitimate barriers to engagement in school. Further, the DCF Fall River Area Office could have sought greater technology access for the family to facilitate virtual visitation with the family and the children during the pandemic.⁸⁶

FINDING #3: FRPS staff relied on the DCF Fall River Area Office and court involvement with the family as a sign that David’s safety was being adequately monitored. This reliance resulted in FRPS choosing not to pursue other protective measures.

FRPS staff were aware of the DCF Fall River Area Office and Juvenile Court involvement with the family. FRPS staff relied on involvement as an indication that the family was being monitored. FRPS believed that if the family was not doing well, the DCF case management team or the Juvenile Court would take the needed additional action. The lack of concern or action from the DCF case management team when FRPS staff shared information about the family’s non-participation was deemed by the school to mean that there was no risk to David’s safety.

Although FRPS engaged in communication with the DCF case management team, informing them of concerns about lack of educational engagement, they did not escalate their concerns further when the DCF case management team seemingly took no action to address or alleviate the school’s concerns. **Additionally, FRPS staff expressed hesitancy about filing a child neglect or abuse report when the DCF Fall River Area Office was already involved with the family because historically school personnel had received negative reactions from DCF intake workers when they try to file such reports on open DCF cases.** Mandatory reporters have an independent obligation to file a child abuse or neglect report when they have reasonable cause to believe a child is harmed from abuse or neglect. This obligation is not altered or mitigated if a family already has DCF involvement, and this obligation is a necessary additional safeguard in the child protective system.

FRPS did not, counter-intuitively, appear to consider the DCF Fall River Area Office and Juvenile Court involvement with the family a warning sign of potential risk to David. This was likely the case because there was never a meaningful conversation between the DCF case management team and school staff about David which would have provided context for his ability to transition successfully and be prepared to learn. FRPS and the DCF case management team also did not discuss the strengths and needs of the family as a unit. Neither DCF administration nor DESE currently has a policy to delineate what information can and should be shared between DCF and education professionals. The failure to share such pertinent contextual information results in the possibility that both DCF and school professionals

⁸⁶ For example, in 2020 the OCA worked with the Supreme Judicial Court’s Court Improvement Project to secure 200 Chromebooks for DCF involved children to assist in dealing with the effects of the pandemic.

may misinterpret or discount certain facts to the detriment of children’s safety. In this particular case, the DCF case management team advised Ms. Coleman to repeatedly call the school about the lack of technology access in the home in order for Ms. Coleman to avoid the risk that the school would file a child neglect report due to lack of educational engagement. Simultaneously, the school was reporting concerns to the DCF case management team about the lack of educational engagement, believing they had met their burden of informing DCF. As noted above, mandated reporter responsibilities do not change based on whether the family is already DCF involved.

There are legitimate privacy concerns associated with the sharing of child protective information. However, there is no statutory prohibition that would prevent DCF from establishing policy directives sharing general information that would provide school authorities the context for DCF involvement with the family so that the school can support the children, and can adequately interpret information about student safety. School staff’s overreliance on the DCF case management team to determine when concerns should be elevated, coupled with their lack of context for DCF’s involvement with the family, results in school staff failing to serve as an additional safeguard for the children as required by the mandatory reporter law.

EDUCATION RECOMMENDATIONS

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

The DESE and FRPS COVID-19 specific guidance regarding the expectations of student attendance, participation, and the requirement of providing special education services in remote learning settings, did not adequately filter down to the educators responsible for David’s education. School staff accepted technology barriers as an adequate explanation for complete non-engagement instead of using the situation as an opportunity to shift tactics to ensure that David and Michael were provided with some level of educational services.

Educational services for any student, general or special education, are a primary source of stability in children’s lives. The upheaval of COVID-19 has affected students in profound ways because of the instability it has caused. Detachment from school should signal to educators that students are at higher risk of harm due to abuse or neglect, risk of inadequate resources in the home, possible illness, as well as possible grief and emotional turmoil. Not all detachment from school signals abuse or neglect, but detachment from school, particularly now that students are experiencing such intense social and emotional isolation, should be interpreted by educators as a significant warning sign. None of the DESE or FRPS guidance available at the time of David’s death (October 2020) communicated explicitly about mandated reporter responsibilities in the context of student engagement.

In January 2021, DESE issued guidance on its *COVID-19 Mental and Behavioral Health* webpage that addressed attendance in the context of child abuse and neglect for the first time since the pandemic

began.⁸⁷ This guidance is particularly critical for this period of continued public emergency and aptly links the concept of student engagement to possible student safety concerns. The guidance notes that “[s]chools and districts should clearly communicate and make readily available policies and processes to support individual school staff in fulfilling their mandated reporter responsibilities” but does not elaborate on what those policies and processes should be or should include. The guidance also notes that schools and districts “must” establish clear policies and procedures for how to respond in cases where there are persistent concerns regarding student engagement but goes no further in discussing what specifically the policies and procedures should address, how they should operate in practice, or how they should be implemented. This guidance should be expanded to be more operational and therefore more descriptive of the steps that districts need to take to adhere to the guidance.

DESE’s guidance is not operational in nature and does not set explicit statewide standards for district policies. DESE guidance, which is sincerely and zealously designed to provide students with the most education possible during the complications of the COVID-19 pandemic and to address the social and emotional wellbeing of the student population, was not implemented as expected by FRPS. To better understand how widespread this challenge is, DESE should conduct a qualitative assessment of a representative sampling of school districts to assess, in an in-depth manner, how DESE COVID-19 guidance was received, interpreted, and implemented by districts and what lessons can be learned from this experience. This assessment should particularly focus on whether districts would benefit from more explicit and operational guidance, including model policies designed by DESE. DESE and the Commonwealth should consider what resources, including legal resources, would be necessary for DESE to create a system to monitor and enforce statewide standards. Further, both DESE and school districts must address the volume of guidance being produced and how to effectively communicate the critical expectations to the front-line staff who are responsible for implementation.

Similarly, FRPS should conduct an assessment of why the trainings and guidance provided by FRPS administrators, including special education administrators, were not put into practice by frontline staff in this case and determine how to design internal feedback processes to ensure that expectations are met for the education of each student enrolled at FPRS. These internal feedback processes should address the current pandemic experience but should also be applicable to a post-pandemic environment. FRPS should consider how instances where students are not being provided FAPE will rise to the level of the district’s attention even if parents or caregivers are not advocating on their behalf.

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

⁸⁷ “Promoting Student Engagement, Learning, Wellbeing and Safety During Remote and Hybrid Learning (Winter 2020)” available at: <https://www.doe.mass.edu/covid19/mental-health.html>

Districts should update their attendance policies to indicate minimum daily contact requirements between students and staff, including a minimum requirement for visual contact if students have the capability. DESE should issue a model attendance policy to standardize these requirements across the state and support the models used by districts if attendance concerns are brought to the Juvenile Courts. DESE should also issue a model truancy policy to standardize the expectations of addressing school engagement concerns across the state. These model policies should address emergency concerns such as the COVID-19 pandemic, but this recommendation is that these model policies will also be in place in non-emergency situations.

The recent amendments to the Student Learning Time Regulations⁸⁸ establish minimum levels for live instruction and synchronous instruction for districts operating in the hybrid model or that are providing education to students remotely. These regulations require that students have an “opportunity” to interact with educators each school day including a “live” check-in which could be via video, phone, email, text, and other means. There have been no changes to DESE’s attendance policy which only requires that students be engaged in a school related activity for at least half of a school day. The opportunity to have a live check-in with an educator should be translated into an explicit requirement that students have a live check-in for attendance purposes. There should be continued flexibility of how these live check-ins can be accomplished, but any effort by any person to leverage that flexibility into an avoidance of school contact should be immediately elevated as a red flag for possible engagement concerns. If students have the capability to be seen visually by staff, that is the best possible option. Recognizing the equity concerns with visual contact, districts should develop robust individual communication plans with any family that reasonably needs to be excluded from visual contact. Districts will likely have to leverage all school staff support, including administration, to be able to adequately implement attendance policy changes, but the commitment to student well-being, including social emotional stability, is paramount and requires the additional effort.

FRPS boldly accepted this challenge after the tragedy of David’s death and the serious bodily injury to Michael. Beginning in November 2020, the district instituted a camera-on policy that required that students be visible to staff during the beginning of synchronous learning (at the start of class) and at the end – though cameras could be off for the majority of the substantive learning time. School staff, including administration, are out in the community on a regular basis attempting to contact students who have been missing from these visual connections. This effort is a testament to the commitment that FRPS has made to ensuring that its students are ready and available for learning in even the most difficult of situations, including that they are safe physically, emotionally, and mentally. This model, or one similar to it, should be the expectation across the Commonwealth and should be specifically tied to the requirement of school attendance. These changes should be instituted through a forward-looking lens that will accommodate the likelihood that there will be some level of continued remote participation in school once return to full-time in-school learning becomes possible across the state.

⁸⁸ 603 CMR 27.00

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

School districts have internal record keeping systems that link educational records to individual students. Districts should require, and institute processes to ensure, that educators record all concerns that they have for students and families in the internal record keeping system. This does not just include concerns for abuse or neglect of children but concerns regarding possible resource shortages the family may face, court involvement, concerns regarding bullying, and so on. The internal record keeping system should be utilized in this manner to ensure that crucial information about students, their wellbeing, their readiness to learn, and the possible barriers to their educational achievement, are adequately communicated when they make vital transitions such as transitions to the next grade or another school within or outside of a district. The creation and utilization of a consistent narrative will help schools to better work with families who may find it difficult to retell their family narrative to each school official they encounter year after year.

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

The DCF administration and DESE should work together to determine the contours of the confidentiality concerns that govern communication between DCF social workers and schools. Confidentiality should remain a paramount concern for both agencies. However, information can be shared between DCF and school personnel that will benefit the student and the family. The confidentiality concerns that must be evaluated will depend in large part on whether DCF has custody of a child as schools are restricted from sharing some student information by federal law to individuals and entities who are not legal guardians. The two agencies should work swiftly to issue joint guidance that indicates what type of information can and should be shared between schools and DCF in a variety of custodial arrangements. DCF involvement should provide the school with context about the student and the family that is vital to the student's ability to be available to learn and ensure that the school is providing DCF with updates that speak to the case planning efforts and family stability efforts made by DCF. It is a benefit to families and children to have state service providers sharing valuable information with one another to minimize miscommunication, misunderstandings, and lack of coordination. In some areas of the Commonwealth the working relationship between school districts and DCF is positive and productive, while in other areas the relationship is less effective. The collaboration of school and DCF efforts to support children and family success should not depend on where a child lives or which district they attend joint guidance should clearly delineate what information can and cannot be shared, how to request information, and how to provide information.

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

As noted in this section, when a child is in DCF’s legal custody, regardless of whether that child is physically placed with their family or in an out-of-home setting, DCF should act as a legal guardian to that child. School districts should also treat DCF as the legal guardian of that child. DCF’s case management responsibilities are complex and gathering updated attendance records on all children in the custody of DCF on a case-by-case basis is burdensome enough that it is unlikely that front-line workers have the capacity to adequately and routinely meet the expectation. DCF does receive attendance data from DESE periodically when districts report that data to DESE. That data is not reported in real-time so there is no way for DCF to be alerted systematically when children in its custody fail to attend school. DESE and DCF should collaborate to find a feasible way for DCF to obtain regular (monthly or twice-per-month) attendance updates for all children in DCF’s custody so that attendance issues can be addressed immediately. This collaboration should result in a process that can be implemented state-wide so that individual DCF area offices are not negotiating these processes independently with school districts resulting in different outcomes for students across the state. School attendance is the minimum measure of student engagement and is a tool that schools and DCF can use to ensure that children are provided the opportunity to receive an education.

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

The DCF administration and DESE issued a *Joint Advisory Regarding School District Officials’ Duty to Report Suspected Child Abuse and Neglect* in 2010.⁸⁹ This guidance should be updated to include references to any materials provided by DESE about mandated reporting including COVID-19 specific guidance. This guidance should also be updated to include that ongoing DCF involvement or ongoing court involvement does not relieve a mandated reporter from their obligation to file a report with DCF when that mandated reporter has reasonable cause to believe that the child is subject to abuse or neglect. It became clear during the course of this investigation that mandated reporters often felt disempowered, discouraged, and reluctant to report any suspected child abuse or neglect when DCF was involved in a case and deferred to the DCF case management team’s judgment.⁹⁰ This deferral can perpetuate miscalculations in clinical judgments by DCF and is not permitted under the mandated reporting statute. There is no prohibition on any entity taking child protective steps, including well-child checks, while a family is DCF involved. DCF should internally review the practice and alleged culture of

⁸⁹ “Joint Advisory Regarding School District Officials’ Duty to Report Suspected Child Abuse and Neglect” available at: <https://www.doe.mass.edu/lawsregs/advisory/082010childabuse.html>

⁹⁰ This is not a finding limited to educational providers.

discouraging or dismissing child abuse and neglect reports, or elevated concerns during ongoing case involvement, and take steps to remedy any barriers to effective reporting. Further, districts should meet with their local DCF area offices to determine how best to raise concerns above the level of a social worker or supervision within the area office when such a need arises.

RECOMMENDATION #7: FRPS should explicitly address mandated reporter responsibilities in the district.

FRPS, like all districts in the Commonwealth, is required to ensure that its staff is trained annually in mandated reporter responsibilities. FRPS should ensure that mandated reporter training in the district explicitly addresses the issue of how to appropriately attend to child safety concerns when DCF is already involved with a family. FRPS should work with the DCF Fall River Area Office to determine how to elevate child safety concerns and any concerns about ongoing communication with social workers up the chain of command within the Area Office when that is a reasonable approach. FRPS and the Fall River Area Office should work together to clarify to staff in both entities that mandated reporter responsibilities are not diminished when there is DCF involvement with the family.

FRPS is working diligently to meet the social and emotional needs of the students in the district. FRPS staff should be given explicit instruction on when a student's academic or social emotional needs trigger a consideration of whether a student's safety is at risk for any reason. FRPS should identify how safety concerns that do not rise to the level of a reasonable cause to believe a child is experiencing abuse and neglect should be addressed, how students who are at increased risk for abuse or neglect should be monitored for safety and readiness to learn, and who staff can consult with when concerns appear to rise to the level of a possible report of abuse and/or neglect.

THE MASSACHUSETTS JUVENILE COURT

A Care and Protection petition is the beginning of a legal case in which a Juvenile Court judge determines whether a child is at risk of being, or has been, abused or neglected by a parent or caregiver. If a Juvenile Court judge determines that a child is at risk of abuse or neglect, or has been abused or neglected, then the Court can find that a child is in need of care and protection and has the authority to determine the permanent legal custody of that child.

As discussed in the *Introduction* and *Family Background and Child Welfare Involvement* sections of this report, New York child protective services removed the children David, Michael, and Noah from the custody of Mr. Almond and their mother Ms. Sarah Almond multiple times while the family lived in New York. In 2016 there were termination of parental rights cases pending against Mr. Almond and Ms. Almond, but the case did not proceed and neither had their rights terminated. It is unclear from the records that the OCA was able to review why the terminations of parental rights were not pursued as there appeared to be little, or no, improvement in Mr. Almond or Ms. Almond's parental capacity in 2016. The records appear to show that legal custody of the triplets was returned to Mr. Almond despite the fact that Mr. Almond appeared to have been out of substantial contact with the children and it does not appear that he completed any of the necessary services on his NY service plan. Additionally, the records appear to show that the New York Family Court returned legal custody of the triplets to Mr. Almond without an Interstate Compact on the Placement of Children (ICPC) placement request which is against the law and also against good policy.⁹¹

Mr. Almond did move the triplets from New York to Massachusetts in 2016. Within a short period of time, Care and Protection Petitions were filed with the Bristol County Juvenile Court Department regarding David, Michael, and Noah, as well as their younger half-sibling Aiden on October 5, 2017. These petitions were filed against Sarah Almond (the triplets' mother who continued to reside in New York), John Almond, and his non-marital partner Jaclyn Coleman, the mother of Aiden. The DCF Fall River Area Office affidavit supplied to the court detailed Jaclyn Coleman's own history of involvement with state child protective services. The affidavit indicated that the children David, Michael, and Noah had been previously removed from their father John Almond's care while the family lived in New York due to inadequate supervision, inadequate guardianship, and inadequate shelter and noted that Mr. Almond reportedly had a substance use history.

The 2017 Care and Protection affidavit detailed concerns for the children David, Michael, Noah, and Aiden's safety while in the care of Mr. Almond and Ms. Coleman in Massachusetts. Concerns communicated to the court included physical abuse of the children, the triplets' excessive absences from school, caregiver substance use, unsanitary conditions in the home, inadequate pediatric care, and

⁹¹ The ICPC is a statutory agreement adopted by all 50 states whose purpose is to foster communication and cooperation between states. When one state is considering placing a child in a home in another state, then the receiving state has the opportunity to ensure that the home where the child will be placed is safe and appropriate for that child. In this instance, DCF in Massachusetts should have been notified that a New York Court planned to place the children with Mr. Almond in Massachusetts. DCF would have done an evaluation of the potential placement and communicated any concerns to New York before the placement decision was finalized.

inadequate follow-up on disability evaluations. The Court Investigator Report, available to all parties, indicated concerns for familial history of extensive drug and alcohol use, physical abuse, and neglect. The report also detailed concerns about the parental capabilities of Mr. Almond and Ms. Coleman particularly regarding caring for children with disabilities. The Court Investigator Report noted that without significant guidance and education for the caregivers, the patterns of neglect and abuse evident in the caregivers' histories would repeat time and time again. The Court Investigator Report explained that the family does not know how to appropriately interact with children with autism which can be seen in the difference between the triplets' behaviors when they are in their home environment versus when they are in a therapeutic residential setting. The report further identified that the size of the family residence is of significant concern for the children and that sufficient services would need to be in place before a reunification of the triplets. However, the report indicated that a return of the child Aiden, with services in place, would be more appropriate.

In 2018, the DCF Fall River Area Office reported to the Court that Mr. Almond and Ms. Coleman were partially compliant with their DCF action plan but expressed doubts as to the level of commitment that they had to resolving the issues that brought the children into care. There was an articulated concern that Mr. Almond and Ms. Coleman were just going through the expected motions of participating in services, rather than experiencing and demonstrating real change.

In July of 2019 David, Michael, and Noah were formally found by the Court to need care and protection and remained in DCF legal custody. That same month, Aiden was reunified with Mr. Almond and Ms. Coleman. In January of 2020, the Care and Protection petition as it related to Aiden was dismissed. David, Michael, and Noah remained in congregate care placement with the ultimate plan of reunifying with the family in the next few months after some successful in-home visitation, including overnight visitation. On March 13, 2020 only David and Michael were reunified with their father Mr. Almond and his non-marital partner Ms. Coleman. DCF retained legal custody of David and Michael at that time. On the next court date, July 17, 2020, the DCF Fall River Area Office recommended the return of David and Michael to the legal custody of their father and for Noah to remain in the care of DCF, a plan that was agreed upon by all attorneys and which the Court approved.

[The Pathways Initiative](#)

Throughout Massachusetts the Juvenile Court continues to implement its *Pathways Initiative*, which was rolled out in 2019. *Pathways* is a differentiated case management initiative developed to improve legal permanency through an individualized assessment of each case based on the unique circumstances particular to that child and family. Differentiated case management allows for each county, each court, and each judge to dedicate time and attention to the characteristics of individual cases to ensure expedient resolution based on the needs of that case and that child. *Pathways* also brings together multidisciplinary teams of stakeholders to address issues and outcomes in that court division, identifying challenges and needs while prioritizing inquiry by judges to elicit information necessary for effective decision-making and charging attorneys with providing that specific information crucial to differentiated case management.

THEMES AND FINDINGS

THEME #1: The length and timing of the litigation and custodial decisions in this case colored the substantive issues.

A hearing on the merits of a Care and Protection proceeding is expected to take place within 12-15 months after the filing of the petition with the court.⁹² In this case, a hearing on the merits was never held for Aiden and the petition for the Care and Protection of Aiden was dismissed more than two years after the child Aiden was removed from his parents' custody. The hearing on the merits for David, Michael, and Noah was held well over two and a half years after the children were removed from Mr. Almond and Ms. Coleman's care, and within the same month their permanency plan was changed from adoption to return to parent.

FINDING #1: The long delay between the filing of the petition and the hearing on the merits resulted in a loss of momentum in the legal case which increased the likelihood that the children would be reunified with Mr. Almond and Ms. Coleman despite Mr. Almond and Ms. Coleman's failure to adequately complete the requirements in their action plans.

Mr. Almond and Ms. Coleman fluctuated between minimal compliance and non-compliance with DCF recommended services throughout the life of their legal case. This fluctuation, coupled with the delay in holding a hearing on the merits of the case, caused the Court and the attorneys representing the family members to focus on how to adequately resolve the legal case instead of focusing on the fact that the initial concerns that brought the family to the attention of DCF and the Court had not yet been addressed.

Although Mr. Almond and Ms. Coleman did not initially engage in services in 2017 when the legal case was filed, they began making some progress in their legal case in 2019 by demonstrating their ability to care for Aiden, who had been reunified, and engaging in some aspects of their DCF action plan. Because the case had been open with the Court for so long at that point, any improvement in the caregiver's compliance with the family's action plan was enough of a positive step forward to sway the legal case in the direction of reunification. The DCF Fall River Area Office court reports did not distinguish between action plan compliance such as service attendance and demonstrated improvement in parental capacity for caring for children with autism. Compliance in the form of minimal attendance appeared to be the lane shift necessary to restart the momentum of the case towards a legal conclusion of return of legal custody to Mr. Almond and to the home he shared with Ms. Coleman.⁹³

⁹² Juvenile Court Rules for the Care and Protection of Children: Rule 15(C) Scheduling a Hearing on the Merits "At the pretrial conference, unless previously scheduled, the court shall schedule a hearing on the merits to be heard within twelve months of the filing of the petition unless a later date is necessary in the interests of justice." Available at: [Juvenile Court Rules for the Care and Protection of Children effective November 5, 2018 \(mass.gov\)](https://www.mass.gov/info-details/juvenile-court-rules-for-the-care-and-protection-of-children-effective-november-5-2018)

⁹³ Ms. Coleman is the non-marital partner of Mr. Almond. She had no legal authority over David, Michael, or Noah. However, it was clear to the court and all attorneys involved that Ms. Coleman was an integral part of the family unit and was the de facto primary caregiver for the triplets.

However, toward the end the end of 2019 and the beginning of 2020 and before the older children were returned home, Mr. Almond and Ms. Coleman again became less engaged with services, raising warning signs of risk to the children. Almost immediately upon reunification, Mr. Almond and Ms. Coleman had begun reporting to the DCF case management team that David’s behaviors began to intensify. These behaviors were not characteristic of David and should have signaled that something was wrong. The DCF case management team was also contacted by David’s public school, which expressed concerns about lack of student engagement, one of the concerns that led to the triplets’ original removal. The DCF Fall River Area Office’s court reports, available to the judge and all the attorneys on the case, detailed Mr. Almond and Ms. Coleman’s lack of full engagement with the DCF action plan and the reported behavioral problems within the home. Due to the length of time the children had been in state care and due to the fact that the stated permanency goal was reunification, none of these concerning facts stopped the forward momentum of the case toward the return of custody of the triplets to Mr. Almond.

Once Aiden was returned to the care of Mr. Almond and Ms. Coleman, the analysis of the case appeared to focus on the safety of Aiden as a proxy for the presumed safety of the triplets should they be reunified in the home. Once the reunification goal was set for the triplets, and the legal case had a clear resolution in sight, it appeared that the only event that could prevent that path would have been an allegation of abuse and neglect of Aiden while in Mr. Almond and Ms. Coleman’s care. The DCF Fall River Area Office did not present the court with any calculation of whether the triplets, with their particular special needs and with the exponential increase in parental effort necessary to successfully care for three more children, would be safe and successful with Mr. Almond or Ms. Coleman.⁹⁴ Critically, the Court and the attorneys missed the opportunity to question the DCF Fall River Area Office into articulating, in word or in writing, their analysis of the case as it related to the specific needs of David, Michael, and Noah. The Court and the attorneys on the case, including the attorney representing the triplets and substituting judgement for them, assumed that the DCF Fall River Area Office would have a plan that would ensure that the children were reunified in a safe environment. This assumption was both inappropriate and incorrect, with tragic consequences.

Had the legal case moved more swiftly towards resolution when it was filed in 2017 it is possible, and likely, that the case would have focused more clearly on resolution to the allegations filed against the family and less on the need to come to some agreed upon resolution of the legal case.

FINDING #2: The Court, the attorneys, and the DCF Fall River Area Office all treated Aiden’s “successful” reunification as an indication of the likelihood of a successful reunification of the triplets, which was a grave error that failed to focus on the specific needs of Aiden’s brothers who were all children with autism.⁹⁵

⁹⁴ The plan prior to reunification of David and Michael was for Noah to be reunified with Mr. Almond and Ms. Coleman as well. It was Noah’s own refusal to return to the home that prevented his reunification.

⁹⁵ The OCA notes that Aiden’s reunification was only “successful” until his subsequent removal from Mr. Almond and Ms. Coleman’s care in 2020.

Aiden was reunified with his parents several months prior to the reunification of David and Michael. Prior to February 2020, DCF Fall River Area Office and the family were planning for all three triplets to be reunified with Mr. Almond and Ms. Coleman. In February 2020, due to unsuccessful overnight visitations with Noah, the family plan became a reunification of David and Michael with Noah remaining at his congregate care provider placement. It became more likely that David and Michael would be reunified with the family without the caregivers re-engaging with services because Mr. Almond and Ms. Coleman appeared to be adequately caring for Aiden despite not engaging in services on their action plan. Although there was a recognition that the triplets had higher needs than Aiden, this recognition did not result in any focus on the different standard of parental capability that was necessary to successfully care for children with disabilities. **This was true despite the Court Investigator's Report which outlined that parental capacity for Aiden would be significantly different than the parental capacity needed to ensure that the triplets would be safe with Mr. Almond and Ms. Coleman.**

At the court date prior to the reunification of David and Michael, the Court did make clear that DCF should utilize its clinical skills to carefully structure a reunification plan for David and Michael that took into consideration their particular needs, the possible stress on the family of reunifying the children, the possible trauma to the children if they were not reunified at the same time, and the particular stress of the housing challenges faced by the family. However, the Court did not require that this reunification plan be presented to the Court or attorneys prior to the actual reunification. None of the attorneys objected to the DCF Fall River Area Office reunifying the children between court dates without any presentation of a reunification plan or on the record discussion of how such a plan would ensure the safety of the children and the success of the family unit. Once the reunification of David and Michael had been achieved, there was no discussion or evaluation in Court of the adequacy of the plans and services for the children and the family, or the safety planning necessary to ensure a successful reunification. In this way, the court process did not act as a check on the DCF Fall River Area Office's actions and all attorneys, including the attorney for David and Michael, did not engage in an adversarial process to ensure that the DCF Fall River Area Office was taking the safety and planning steps that the court and the attorneys assumed that they were. Because all attorneys agreed about the placement of the children with Mr. Almond and Ms. Coleman as the means for resolving the legal case, the Court and the attorneys did not question the DCF Fall River Area Office's methods in achieving that goal. The placement and the method of achieving that placement were both errors on the DCF Fall River Area Office's part that were assented to by the Court and by the attorneys.

After David and Michael were returned home, the reunifications were discussed in court in terms of having been "successful" because nothing rising to the level of abuse or neglect had yet happened to the children. This portrait of "success" was contradicted by the DCF Fall River Area Office court reports that contained information from service providers about the family's failure to engage in services. The DCF Fall River Area Office analysis appeared to be, confoundingly, that the family was doing rather well, and the Court and attorneys accepted this narrative ignoring the conflicting information in the court reports.

THEME #2: The DCF Fall River Area Office presented information to the Court without any substantive analysis or clinical formulation. Without this analysis or clinical formulation, the Court and the attorneys involved did not adequately weigh or monitor the risks to the children.

The DCF Fall River Area Office court reports, upon which all persons involved in the legal case rely for relevant facts regarding the family, reflected dates of engagement in services and reasons that the caregivers gave for not engaging in services. Services such as individual therapy, random drug screening, parenting skills with a parenting aide, Applied Behavior Analysis services, and consistent visitation with the children were all never completed, never consistently complied with, or never in place to support the family. The reasons the caregivers gave for non-compliance appear to be accepted without critique, including Mr. Almond's two and a half years without health insurance because he was reportedly too busy to obtain a driver's license or state-issued ID. Although the DCF case management team monitored and reported the status of the engagement with services, it did not appear that the DCF Fall River Area Office presented any information to the Court about how engagement or non-engagement with services related specifically to Mr. Almond and Ms. Coleman's capacity to adequately care for the children. Further, there was no indication of what specific services would assist the family in managing the stressors that led to the original 2017 removal of the children from the home including physical punishment and a reliance on illegal substances to manage stress.

FINDING #1: Mr. Almond and Ms. Coleman did not adequately complete their action plans and, despite some engagement with services for a period of time, no evidence was submitted to the Court that engagement with services resulted in any meaningful change to their ability to successfully parent these children.

Parental capacity is based not only on factors concerning the parent/caregiver's own strengths and needs, but also on their ability to care for a specific child taking into consideration that child's individual needs. It was clear at the time David and Michael were reunified with Mr. Almond and Ms. Coleman⁹⁶ that neither caregiver had an intention to adequately engage in random drug screening, therapy, or parenting skills with a parenting aide. Additionally, there is no evidence available that the sporadic engagement that Mr. Almond and Ms. Coleman did have with services resulted in any change to Mr. Almond or Ms. Coleman's parenting skills, insight, judgment, or temperament, particularly considering the specific needs of David and Michael who required a very calm, consistent, and structured environment to remain safe. **Unfortunately, the Court Investigator's Report at the onset of the case proved prescient, indicating that history would repeat itself if critical steps were not taken to increase the knowledge and skills needed to parent David and Michael.**

⁹⁶ Ms. Coleman's action plan was related to her case with Aiden as she was not a legal guardian for David, Michael, or Noah. However, it is undisputed that Mr. Almond and Ms. Coleman were a caregiving unit and that Ms. Coleman would be the primary caregiver for all the children in the home. Thus, her engagement with services or lack thereof had safety implications for all of the children.

Of note, concerns were presented multiple times in Court regarding the challenges the physical home environment presented for the family. The Court and the attorneys were aware that there was extremely limited physical space in the apartment and that this issue caused stress on the family. The Court and the attorneys appeared to view this information largely in the context of financial means which should not, in the abstract, be a barrier to the reunification of children with their caregivers assuming no other risks of abuse and neglect are present. However, in this case the housing situation should have been seen as a safety risk, not in terms of a material disadvantage, but in terms of how physical space is used to assist in behavior maintenance for children with autism and how physical space may be a stress trigger for Mr. Almond and Ms. Coleman. There was no indication that the DCF case management team ever analyzed or addressed Mr. Almond or Ms. Coleman's concerns about how to effectively parent in their home and no evidence that the DCF case management team ever safety-planned with the family about how to deal with the limited confines of their available physical space. Despite the Court and all attorneys being aware of the risks that the home presented for the family, there was no analysis or discussion of these risks at the time that custody was returned to Mr. Almond.

There appears to be no evidence submitted to the Court that any of the issues or concerns that specifically brought David and Michael into care in 2017 had been successfully addressed or mitigated other than the supposed mitigation that comes with the mere passage of time.

FINDING #2: The Court and the attorneys representing the parties in the case relied too heavily on the DCF Fall River Area Office's determinations of appropriate case direction.

As previously noted, the DCF Fall River Area Office did not provide the court with a clinical analysis of the facts presented in the court reports submitted to the Court and to the attorneys. For example, the court report submitted in January 2020 noted that the family had stopped engaging with the parenting support provider for Aiden but indicated that the plan was to use the same parenting support service provider to assist home visiting with David and Michael, without explaining how DCF would get the family to re-engage or what would happen if the family would not re-engage. The court report also noted that the caregivers were not consistently visiting with David and Michael, and that visitation had not improved even after DCF addressed the issue with them. The court report outlined the lack of engagement with therapy without making any mention of what effect noncompliance with therapy has on family dynamics, personal growth, or parental capacity. The court report did express a concern with lack of compliance, but that lack of compliance is not connected to the serious circumstances that brought the children into DCF custody or that kept them in DCF custody for several years. Although it is understandable and often appropriate that courts defer to DCF's expertise in child welfare and clinical formulation for analysis to assist in guiding a legal case to a positive outcome for a family, in this case the DCF Fall River Area Office did not present any analysis of the information they presented to the Court and the Court did not hold DCF accountable for this deficit.

The court report submitted by the DCF Fall River Area Office at the July 2020 court hearing, which was after the reunification David and Michael, records significantly troubling information about the family's

functioning but counterintuitively recommends return of legal custody to Mr. Almond. The report notes:

- That the continuum service provider is concerned that the caregivers do not allow the children to engage with providers and that the physical home space is challenging for the family.
- That the continuum service provider reached out to David and Michael's previous congregate care provider to determine whether David's reported behaviors, aggression, urination in his bed, defiant behavior, and unresponsive behavior, were typical of his presentation. The report includes the congregate care provider's response which indicated that such behaviors were not typical of David.
- That there was some compliance with therapy for Michael but only four sessions had been completed, and that David had not been engaging with therapy.
- That David had missed his pediatric appointment.
- That Michael's psychiatric evaluation had been rescheduled and had not taken place yet.
- That due to the COVID-19 pandemic the children were not engaging in school. This educational update was so sparse it can only be reasonably described as inaccurate.
- That parenting skills with a parenting aide had been canceled by the provider for non-compliance with the service.
- That the family was not consistent with phone visitation with Noah.
- That the DCF case management team had not requested any random drug screens from Mr. Almond or Ms. Coleman between January 2020 and July 2020.
- That neither Mr. Almond nor Ms. Coleman were involved in any individual treatment.

Despite this extensive list of troubling information in this report, the report appeared to present to the Court that the family was doing well, particularly concerning the COVID-19 pandemic, and that no apparent abuse or neglect had occurred yet to indicate that reunification of the children was not successful. The Court and the attorneys assigned to the case accepted the DCF Fall River Area Office's spin on the information provided and did not question on the record whether the children were at risk in the care of Mr. Almond and Ms. Coleman. The Court noted that the case would stay open and that DCF could monitor the case and bring the case back to court if necessary, but all attorneys consented to the return of legal custody of David and Michael at that court hearing. The only reasonable explanation for this result is that the Court and the attorneys were relying so heavily on the DCF Fall River Area Office's judgement that they failed to make any independent inquiry into whether the facts as presented by DCF warranted the conclusion that it was safe to return custody to Mr. Almond. Further, no one at the July 2020 court hearing made any inquiries on the record as to whether the issues that brought the family to DCF's attention in 2017 had been successfully mitigated, addressed, or resolved.

FINDING #3: There was no analysis of the effect of the increased pressures of the COVID-19 pandemic on the functioning of the family or the risk to the children prior to the return of custody to Mr. Almond.

Aiden had been returned to the home of his parents in July 2019, and David and Michael had been reunified in the home in March of 2020 just as the COVID-19 pandemic hit, in-person schooling was closed, and DCF stopped making in-person visits to families and children. This family was contained in a home that was noted to be too small, had chosen remote learning for David and Michael despite being offered full time in-person schooling because of the boys' special education needs, and refused even sidewalk visits from DCF. As noted previously, the court report notes a lack of engagement with most services on the family's action plan, documents increasingly concerning behaviors from David, does not mention the repeated concerns from the school about lack of engagement, and documents a failure of the family to maintain a meaningful relationship with Noah. The DCF Fall River Area Office court report submitted in July 2020 does not discuss how COVID-19 may be affecting the family, how social quarantine and a lack of in-person schooling (including the summer programming that David and Michael were entitled to) affected the family, or any ways in which the Department may have accessed or assisted the family in facing the challenges of the COVID-19 pandemic, now that no in-person visits were occurring.

The difficulty of parenting in the time of COVID-19, and the particular challenge of parenting two children with autism in addition to a toddler during COVID-19, is an obvious missing piece of DCF's July 2020 court report. The stress that the family may be under as evidenced by their underutilizing available services and living in an apartment that was too small even before social isolation, goes completely undiscussed. The court report also minimizes the technology difficulties or barriers that the caregivers have expressed are part of their inability to comply with services and school. Although COVID-19 is mentioned in Court and in the court report, there is no discussion of how the pandemic has affected family functioning, what additional services would assist the family during the pandemic, and what new risks to the safety of the children may have been brought on by the pandemic. The OCA also notes that Mr. Almond was not even virtually present at the court date where custody of David and Michael were returned to him. **The OCA is concerned that legal custody of two high-needs children was returned to their father during a pandemic without the Court seeking any information or engaging the father directly in a discussion about how the family was doing.**

THEME #3: Critical information was not provided to the Court.

FINDING #1: The Court was not adequately updated on the valid concerns of the service providers, including concerns presented by educational staff from Fall River Public Schools.

Legal custody of David and Michael was returned to Mr. Almond by the Court at the July 17, 2020 court hearing. At that time, Fall River Public Schools had reached out to the DCF Fall River Area Office multiple times and informed them that David and Michael had not engaged in any educational services despite the school's efforts to engage the family. The DCF Fall River Area Office was also made aware of the

school's concerns that the family refused communication with the school. Further, the DCF Fall River Area Office was aware that David and Michael were eligible for extended school year services and in the priority category for in-person extended school year services, but the family refused these options. However, the DCF Fall River Area Office did not relay any concerns about the children's complete lack of educational services, including complete lack of special education services, to the Court. The court report solely noted that because of COVID-19 the children did not start school and the plan was that the David and Michael would progress to the high school in September. There was no concern expressed that the family was repeating the behaviors that lead to the triplets' prior neglect and removal.

This incomplete report did not capture an adequate level of concern for these children, did not reflect an understanding of the school's concern for the children and the family, and did not relay any clinical analysis of the profound effect of the loss of structure, services, and support on two students with significant disabilities. Fall River Public Schools was prepared to educate the children during the pandemic and had made multiple overtures to engage the children and the family. It was Mr. Almond and Ms. Coleman's choice not to engage. The DCF Fall River Area Office did not present this picture to the Court. It is surprising that none of the attorneys, including the attorney representing David and Michael, nor the Court, inquired on the record about David and Michael's education or special education services after the children were reunified during the pandemic. Since excessive school absences had been one of the concerns that brought the family to the attention of DCF in 2017, it is also surprising that no one questioned whether the family was adequately engaging with the children's education prior to the return of custody to Mr. Almond.

FINDING #2: The Court was not provided with relevant information about the paternal grandmother Ms. Shadburn's role in the family including her presence in the home and her own history of involvement with DCF and the justice system.

The paternal grandmother Ms. Shadburn was the lessee of the apartment and lived there with the family. She was an undeniable presence in the life of the family and, at the bare minimum, a member of the household. Ms. Shadburn had an extensive history of involvement with DCF and the justice system that was notable for its similarity with the challenges that faced Mr. Almond and Ms. Coleman. It is unclear what, if any, knowledge the Court or the attorneys had of the paternal grandmother and her role and effect on the family and the household. It is clear that, as noted below, the Probation Officer assigned to this Care and Protection proceeding did not know of the paternal grandmother's presence and involvement in the family and therefore did not provide the Court with any criminal record history related to the paternal grandmother. The DCF Fall River Area Office's court reports do not reference the paternal grandmother, if at all, in any material way. This complete lack of information about, and investigation into, the role of the paternal grandmother in this case left a gaping hole in the Court's analysis of the family and the home.

JUVENILE COURT RECOMMENDATIONS

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

In this case, the long delay prior to hearings on the merits appears to have led to a lack of litigation momentum which contributed to the reunification of the children to the home without Mr. Almond or Ms. Coleman's sufficient adherence to the action plan and without any demonstrated change in their parental capacities. DCF objected in court to the return of custody of Aiden to his parents but was simultaneously not prepared to move forward with a hearing on the merits. By the time the hearing on the merits went forward for David, Michael, and Noah their permanency plan had changed from adoption to return to parent. By 2020, Mr. Almond and Ms. Coleman had spent several years under DCF and court oversight without any known measurable changes to their parental abilities.

The OCA does not know the timeliness challenges courts across the state face for Care and Protection proceedings but understands that courts face resource constraints statewide. Lack of a timely trial in this case appears to have affected the perception of the Court and the attorneys which resulted in the prioritization of length of time without an apparent child abuse or neglect incident over the need for a clinically formulated risk to the family and children. The OCA does not know the effect that such a lack of timeliness may have on other cases. Data should be gathered to determine such effect. Although data has its limitations, determining the number of unsuccessful reunifications after the 12–15-month hearing window has passed will provide a starting point to determine the effect case delays may have on child protection. This data gathering can be incorporated into the *Pathways Initiative* that promotes the use, improvement, and analysis of data in the Juvenile Courts including assessments of permanency that occur before the 12-month mark, after 12 months, and at relevant intervals thereafter.

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

The DCF Fall River Area Office met its burden of providing the Court with a report each time the case was heard before the judge.⁹⁷ This Court also specifically noted that DCF was the clinical expert on the case who was best situated to determine how and when the individual children could be reunified safely. However, the DCF Fall River Area Office's court reports did not place any of the information they described into any context in terms of the family's history, family strengths and areas of need, the functioning of the children, and the capacity of the family to appropriately manage stress, appropriately discipline the children, and create systems of behavior that were suitable for managing children with autism. The DCF Fall River Area Office noted the physical house space as a challenge and the father's

⁹⁷ See Juvenile Court Rules for the Care and Protection of Children: Rule 10 Written Reports by the Department available at: <https://www.mass.gov/doc/juvenile-court-rules-for-the-care-and-protection-of-children-effective-november-5-2018/download>

medical insurance as a challenge but did not connect these two issues to safety risks to the family.⁹⁸ The court reports did not communicate any meaningful information regarding schooling for these children, including no information on special education services and what a lack of services could mean for the children and the family. The DCF Fall River Area Office chose not to prioritize most services on the family's action plan including individual therapy for the caregivers, random drug screenings, and parenting skills acquisition.

It is fundamentally unfair and unproductive to create an action plan for a family without connecting that action plan to the elimination of safety risks for the children. It is also fundamentally unfair to then largely abandon the action plan for a family and to reunify children without adherence to the action plan. Successful care and protection of children requires the expertise and knowledge that only DCF can provide to a case, and the courts do a disservice to families when they do not hold DCF up to a reasonable standard of clinical formulation that provides the court with more than a recitation of what other people have said about the family's compliance or lack thereof.

The Court and attorneys in this case relied so heavily on DCF's assessments, without any apparent questioning of those assessments, that the DCF Fall River Area Office's faulty decision-making went completely unchecked. The courts should take active steps to standardize evaluation of DCF's actions and positions at critical touch points in a care and protection case. This could be done by standardizing questions that DCF must answer whenever DCF is contemplating a change in placement or custody. The courts also rely on the adversarial nature of proceedings, relying on attorneys to play their role in pressing DCF to explain and support their decisions. The attorneys did not appear to play this role in this case.

The *Pathways* Assessment Process tool assesses and identifies the gaps between a child's needs and a caregiver's abilities and identifies a reasonable timeframe for expected demonstration of parental skill acquisition in order to anticipate safe reunification. The *Pathways* leadership team is presenting this information to DCF and attorneys throughout the Commonwealth in order to communicate the expectation that DCF and attorneys will be prepared to provide judges with specific information that will inform meaningful decisions on a case and move a case toward permanency. Data gathering that matches court timeframes and risk levels to children can help to inform this process further.

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

It is widely acknowledged that children with DCF involvement have poor educational outcomes. Changing school environments simultaneously with changing care environments is particularly disrupting to children.⁹⁹ In addition to these universal challenges, David and Michael moved from a

⁹⁸ The special burden that small spaces place on children with behavioral issues and the subsequent isolation of COVID-19 was not seen by DCF or the Court as the safety risk that it ultimately turned out to be. Safety risks must be adequately planned for and dealt with. The challenges of the physical space should have been a key component of the safety assessment and plan for the family in structuring the return of the children and in monitoring and providing services.

⁹⁹ It is disrupting that the federal government requires that states take specific action to try to maintain school stability for children with child welfare involvement: Every Student Succeeds Act.

collaborative school environment (meaning a special education school with programming specifically designed for their educational and behavioral profiles), to a special education program within a public school at the exact time in-person learning was suspended in Massachusetts due to the COVID-19 pandemic. The whole-student approach to special education that accounts for the student's behavioral challenges and life skills acquisition is essential to a child's success in all aspects of their life, including their home environments. That such a large piece of this support for the children and the family was completely unaddressed by the DCF Fall River Area Office, the Court, and all attorneys contributed to the disastrous results of this reunification. Educational stability and success should be a core inquiry for the courts at each stage of the legal case and should be elevated in the courtroom to the essential safety inquiry that it is in the reality of these children's lives.

The Juvenile Court's *Pathways Initiative* has taken critical steps to standardize questions at vital case touchpoints. Currently, *Pathways* has produced and has begun integrating into judicial practice "Essential Questions to Ask at Each Hearing to Promote Permanency" and released "Essential Questions to Ask at Each Hearing to Promote Educational Stability" in October 2020. This type of foundational standard-setting in terms of expectations for substantive issue discussion at court hearings is critical to ensuring that DCF's, or any other parties', analysis does not go unchecked by the courts. This case suggests that there is a need for essential questions for anticipated reunification and essential questions for anticipated change in custody. The essential questions should also consider any external pressures, such as COVID-19, that may place familial stress or needs into a focus that may otherwise not be clear.

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

The fundamental reason that children come into the care of DCF, and the changed circumstances that lead that fundamental reason to no longer be a barrier to familial success, should be addressed clearly on the record by DCF and by the Court prior to the transfer of custody from DCF to any caregiver. This should be done by identifying each concern in the initial petition filed in the case and determining whether circumstances have changed – and, if not, whether the risk to the children continues to outweigh the benefit of them returning to their home environment.

The judge's specific inquiry into the status of the barriers that brought the child(ren) into the custody of DCF will require that DCF explicitly explain the clinical formulation that underlies any determination in favor or opposed to the return of custody. It will also help buttress against the possible detriments to the timeliness delays in hearings by bringing the family's safety challenges to the forefront of dispositional decision-making. Finally, it will record the reasoning that leads to continued family separation or reunification that could assist the court in its continued valuable work in differentiated case flow management.

Of note, the Juvenile Court, supported by Casey Family Programs and in consultation with Evident Change, is in the process of finalizing a tool and judicial training to assist the courts, attorneys, and DCF

in identifying and presenting the danger which brought the child into the court, the risk of future harm, and any safety or actions of protection taken by the caregiver. By creating common understanding around these concepts and expanding them to be revisited at each step of the proceeding, the court will be further able to move cases toward permanency efficiently and safely with the information needed to make effective and informed decisions.

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

This recommendation is intended to provide the Juvenile Court with additional tools to ensure that there is adequate information sharing across state systems, particularly when considering that attorneys in Care and Protection cases are legal adversaries and information from a neutral party is in the best interest of pursuing a realizable permanency plan for a child and family.

This recommendation is two-fold. The first recommendation concerning court investigation reports is intended to provide judges the flexibility to determine when court investigation reports are most effective in a Care and Protection proceeding prior to a hearing on the merits. The second recommendation concerning the appointment of a guardian ad litem prior to a transfer of custody between parties on a Care and Protection case is intended to provide the Court with neutral and factual information after there has been a hearing on the merits and the child(ren) have remained in the custody of DCF. This distinction is made to not impinge on the adversarial nature of, and evidentiary issues involved in, hearings on the merits.

- Currently court investigators are assigned at the time of the filing of a Care and Protection case in Juvenile Court.¹⁰⁰ A court investigator's role is to assist the Court in determining the case management plan through in-depth investigation into the conditions that affect the child and the family. The report written by the court investigator covers information regarding the reason the case came to DCF's attention, the DCF investigation, any foster care review or other case reviews done by DCF, interviews with the parents or caregivers, and interviews with key collateral resources such as physicians, mental health professionals, teachers, police, the Probation Officer assigned to the case, and so on. Court investigators must file their report within 60 days of being appointed to a case. The Court can order a report update from a court investigator (an addendum) in limited circumstances.¹⁰¹

The court investigator's report is an indispensable tool issued by a neutral party in the Court that ensures that the Court is presented with all the relevant information needed for determination of case direction. This level of neutral evaluation may be additionally helpful to

¹⁰⁰ M.G.L. c. 119 § 24

¹⁰¹ See "Guidelines for Court Investigation Reports" available at: <https://www.mass.gov/guides/guidelines-for-court-investigation-reports>

the Court at a time other than the initial filing of the Care and Protection case. The initial filing of a Care and Protection case is when the Court relies most heavily on the initial arguments of DCF and counsel for the parents/caregivers. Hearings on the merits in Care and Protection cases are expected to be scheduled within the first 12-15 months after case is initially filed, but in practice such hearings can take place much later than this 12-15-month window. The court investigator's report issued at the outset of the case may no longer provide the judge with the information that the judge needs to inform the dispositional direction of the case over a year or more later.

The applicable law should be amended to permit Juvenile Court judges to appoint a court investigator to produce a court investigation report at any time in a Care and Protection case's trajectory prior to a hearing on the merits. Court investigative reports should still be required on every Care and Protection case heard in the Juvenile Court, but judges should have the ability to determine when such a report would provide the most relevant information necessary for the judge's consideration. This change would permit the judge to gather information about the status of the child and the parental capacity of the caregivers from a neutral party at times when the Court most requires the information. The Court's *Pathways Initiative* should issue guidance to Juvenile Court judges on best practices in determining when a court investigator's report will yield the most relevant information for judicial consideration and consideration of all parties in the courtroom including DCF, the attorneys for the parents/caregivers, and attorneys representing the children. Utilizing court investigative reports in this manner will provide for a check on DCF's ongoing case analysis.

- The Juvenile Court has the power to appoint a guardian ad litem (guardian for the purpose of legal action) also known as a "GAL." A GAL is a neutral professional who participates in court proceedings on behalf of a child.¹⁰² This person is not the same as an attorney for a child who represents a child's legal position in case. An attorney representing a child in a Care and Protection case is a legal advocate for a child's wishes. Many children may wish for a legal result in a Care and Protection case that is not in that child's ultimate best interest. Unless an attorney for a child is substituting their own judgment for the judgement of the child, the attorney for the child will litigate a Care and Protection case to seek to accomplish the child's preferred result and not what is in the child's best interest.¹⁰³

GALs are appointed to cases to participate on behalf of children not to directly represent their wishes. GALs can be appointed by the court to make recommendations about medical treatment of children, to monitor compliance and effects of medical treatment for children, to make educational decisions on behalf of children, to enforce or defend some limited legal rights

¹⁰² A guardian ad litem can also be appointed to represent persons who are legally incompetent.

¹⁰³ An attorney representing a child in a Care and Protection case can substitute the attorney's judgement for the child's judgement when an attorney determines that the child is unable to make an informed decision about the child's preferred result in a case because of the child's age, cognitive ability, disability, or any other relevant reason.

of the child (such as the right to waive a privilege), and to serve as an evaluator.¹⁰⁴ A GAL appointed as an evaluator is required to report to the Court on a narrow issue that the judge has discretion to define. In cases where a child or children have been in the custody of DCF after the hearing on the merits in a Care and Protection case, and where the court is considering transferring custody from DCF to another person (parent or other resource), the judge should assign a GAL to evaluate the current status of the child and ask the following: whether the original danger that brought the case forward has been addressed and how has it resolved for the child; what risks, if any, still exist at this time and how will those risks will be monitored; and how have the actions of the parties or services that the parties participated in demonstrated or created safety for the child. The judge will therefore be presented with the legal arguments of DCF, the attorney for the child(ren), and the parents'/caregivers' attorneys, as well as an evaluation by the GAL when determining whether to transfer custody of a child. In addition, the judge should assign a GAL to continue oversight of the child and update the Court on the child's well-being once the child has returned home.

This specific case has shown that the Court would have benefitted from an on-the-record unequivocal statement, outside of the typical adversarial posture of the legal case that addressed the current status of the children in regard to the possible ongoing danger and risks that the children faced when returned home. The Court would have also benefitted from updated reports on the children's condition once returned home in order to minimize risk to the children and ensure an immediate response to new or renewed danger. The Juvenile Court, through its *Pathways Initiative*, should consider how to incorporate this recommendation into its work. The *Pathways Initiative* should also consider what the best practice should be for directing the GAL in their work as an evaluator including requiring that the GAL speak to certain collateral contacts such as the child's direct educators and the Probation Officer assigned to the case.

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

As discussed in the Massachusetts Probation Service (MPS) below, the Juvenile Court has broad discretion to place legal conditions on custodial arrangements in a Care and Protection proceeding at multiple touchpoints in the case. This could mean that a judge may condition reunification of children on parents' compliance with certain services, or on parents maintaining regularly scheduled pediatrician visits, and so on. The express consideration of legal conditions on changes of status to children engages the Court in a substantive discussion with DCF and the other parties about the minimum degree of care necessary for a status change to be successful. In this case, overreliance on the DCF Fall River Area

¹⁰⁴ See: <https://www.mass.gov/info-details/uniform-practice-and-procedure-regarding-the-appointment-of-guardians-ad-litem> for more information.

Office to make its own determinations, even when those clinical determinations were not adequately formulated or communicated to the Court, resulted in allowing the DCF Fall River Area Office's mistaken judgement to go unchecked or unevaluated at the Juvenile Court level. Further, when the Court sets specific conditions on a status change those conditions result in an additional oversight of a case from MPS, a party other than DCF, which can provide an alternative narrative to the court for consideration. The Court should specifically consider the perspective and concerns of each of the parties on the case, including from the assigned Probation Officer regarding the conditions that should be placed on custodial arrangements if the judge determines to issue such conditions.

The OCA does not presume to question whether conditions should have been placed on the status change in this case or in any other case. Those are legal determinations suitable solely for the courtroom. However, requiring an explicit analysis of the consideration, and recording that consideration for the record, could be a standard-setting best practice that results in a substantive change that would serve to better protect children.

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

During the COVID-19 pandemic, DCF greatly altered standard case practices and did not issue any statewide guidance on how to assess risks to families and children in light of these altered case practices. The specific challenges of COVID-19 to any family's successful outcomes should be explored at court dates, particularly if a change in a child's status is being contemplated. Courts should inquire of DCF when they last physically observed the children, the details of those observations, the last time they spoke with the children, and the details of those discussions. Because of the lack of fundamental clinical analysis on this case it is unclear if such questions would have resulted in changed circumstances for David or Michael, but such an inquiry is a baseline expectation of assessment of child safety and could make the difference for other children whose lives have been completely upended and hidden from sight as an effect of the ongoing pandemic.

Similarly, courts should question attorneys representing children when they last physically observed their clients, what specific challenges their clients are facing due to the COVID-19 pandemic, and whether DCF has assisted in addressing those challenges. Such information should be put on the record for the court's consideration even if all attorneys believe they agree about the circumstances and the ultimate permanency plan of the children.

As noted above, the Juvenile Court, supported by Casey Family Programs and in consultation with Evident Change, is in the process of finalizing a tool and judicial training to assist the courts, attorneys, and DCF in identifying and presenting the danger which brought the child into the court, the risk of

future harm, and any safety or actions of protection taken by the caregiver. It is expected that these details of the case will be revisited at each step of the proceeding. Additionally, the Juvenile Court is currently developing a transmittal instructing judges to inquire of parties and attorneys about recent observations of the child.

THE MASSACHUSETTS PROBATION SERVICE

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

During the COVID-19 pandemic, MPS updated its operating procedures to switch from in-person visits with a child and/or family to virtual visits with a child and/or family. MPS routinely updated its guidance regarding the operational changes that affected how Probation Officers completed their obligations.

THEMES AND FINDINGS

THEME #1: The role of MPS in Care and Protection proceedings was not leveraged in this case by the Court or by the DCF Fall River Area Office.

FINDING #1: The Court has the power to place legal conditions on the reunification of children with their caregivers and on custodial arrangements. The Court chose not to place any legal conditions on custodial changes in this case.

The Juvenile Court has the authority to place legal conditions on custodial arrangements in a Care and Protection proceeding at multiple touchpoints in the case. This could mean that a judge may condition reunification of children on parents' compliance with certain services, or on parents maintaining regularly scheduled pediatrician visits, and so on. When a court places such conditions on a case, the assigned Probation Officer has the authority and the obligation to ensure that those court orders are being followed. Placing conditions on the custodial status of the children emphasizes and accounts for the specific concerns of the court and provides an additional layer of oversight and analysis through the Probation Officer's monitoring. These conditions also engage the court more in the direction of the case

and reduce the reliance on DCF as the sole source of case analysis.¹⁰⁵ Conditions on custodial changes can clarify requirements that caregivers must abide by and these conditions in turn can clarify what steps a Probation Officer must take to confirm compliance with court orders. Such explicit conditions would assist in bringing clarity to the roles and responsibilities of Probation versus the roles and responsibilities of DCF.

In this case, unlike many Care and Protection cases in the Commonwealth, there were no conditions placed on the reunification of the children or the custodial determinations in the case. Therefore, the Probation Officer's role in monitoring and enforcing court orders, in this case, was solely a responsibility to ensure that the children were placed where the court ordered them to be placed. Probation Officers¹⁰⁶ in this case still made inquiries to determine the well-being of the children but had no legal authority or direction from the Court to probe into the case any further. Without legal conditions directing Probation Officers how to perceive or analyze a case, their purview is extremely limited. Notably, the Probation Officer assigned to this case at the time of David's death had experience as a substance use counselor. Probation Officers are hindered from leveraging their experience in support of families when there are no conditions that outline a role for their involvement in a case.

FINDING #2: The assigned Probation Officer in this case raised concerns about the family to the DCF Fall River Area Office. The DCF Fall River Area Office downplayed and dismissed these concerns.

MPS, like other agencies and service providers in this case, raised some red flags about the family's ability to function successfully and safely. Like other agencies and service providers, MPS's analysis of the case did not rise to the fever-pitch necessary to alter the direction of this case. However, even with the Probation Officer's limited contact with the family and DCF case management team, the Probation Officer was able to discern that the family's functioning was deteriorating quickly. The Probation Officer discussed with Ms. Coleman the possibility of having David and Michael taken back into the physical custody of DCF after hearing Ms. Coleman discuss the challenges she faced in caring for them and her description of David and Michael's declining behavioral and physical states. Ms. Coleman declined this option and any offers of assistance from the Probation Officer. The Probation Officer also spoke with the DCF case management team about the possibility of bringing David and Michael back into the physical custody of DCF based on what the Probation Officer believed to be the unsustainability of the family's living arrangement. The DCF case management team indicated that the agency was focused not on bringing the children back into care, but on getting services into the home. In this case, the Probation Officer, unlike the DCF case management team, was able to put the information that Ms. Coleman was reporting into the context of the family's challenges.

¹⁰⁵ This is not to say that legal counsel for the caregivers and child do not provide analysis on these cases. Analysis by counsel must always be viewed in light of the adversarial context of litigation.

¹⁰⁶ From the time the case came to court in 2017 until David's death in October 2020, this case was transferred two times resulting in three Probation Officers being assigned at various times throughout the life of this case. This transferring of the case does not appear to have influenced the substantive issues in this case.

FINDING #3: The assigned Probation Officer was not aware of the presence of the paternal grandmother Ms. Shadburn in the home and the role that Ms. Shadburn played in the family.

The probation intake sheet lists all household members in a case and the assigned Probation Officer is responsible for conducting a criminal record check for all household members and monitoring the criminal history and involvement of every household member for purposes of reporting that information to the court.¹⁰⁷ The Probation record did not include the paternal grandmother as a household member even though the paternal grandmother was the listed lessee of the apartment where the family lived and she resided there full-time. Had the Probation Officer known about her presence and role in the family, the Probation Officer would have uncovered a criminal history of relevance to the safety of the family and of the children. The Probation Officer probably would have found continued monitoring of the paternal grandmother's interaction with the children relevant to the case. Despite ongoing contact with the DCF case management team and being present at court dates, the Probation Officer was never informed or understood that the paternal grandmother was a household member who presented a history of concerns that should be evaluated for child protective risk analysis. DCF is the agency that has the greatest access to facts and information about the family and a Probation Officer, due to the limited nature of their role, is almost wholly dependent on DCF for information updates relevant to the case and to the family.

FINDING #4: MPS did not bring this case to the attention of the Court between court dates.

As noted previously, MPS can "advance" a case in court to bring the court's attention to a violation of a court order or a concern for the health and safety of a child. The Probation Officer's final phone discussion with Ms. Coleman, only a few days before David's death, was particularly concerning as Ms. Coleman reported the deterioration of David and Michael, that she found them extremely difficult, that they had regressed to having to wear adult diapers, that David picked at his skin causing sores and bleeding, that Michael had to be hospitalized due to an injury caused by his own actions, and that David and Michael were aggressive towards her and Mr. Almond. The Probation Officer did not have any legal conditions on this case that could be used to advance the case before a judge for violation of a court order. Ms. Coleman's repeated assurances that she had the family situation under control resulted in the Probation Officer not advancing the case for child protection concerns. Further, DCF's lack of concern over the status of the family colored the Probation Officer's understanding of the family functioning and risks to the children. The facts in the case, including the pattern of deterioration in the family, clearly demonstrated that the family was in turmoil and that court intervention was necessary to evaluate the harm to the children.

The OCA's review of this matter identified a reluctance on the part of MPS to advance cases in the Juvenile Courts solely for concerns regarding the safety and well-being of the children. Although the OCA does not, and likely cannot, know the scope of the issue, there appear to be negative reactions from the Court, from DCF, and from counsel on the case when MPS takes the initiative to advance a case

¹⁰⁷ DCF also runs criminal history background checks that are used for DCF case management purposes.

for any reason other than a violation of a court order. Additionally, there is an apparent reluctance on the part of Probation Officers to file child abuse and neglect reports on open DCF cases due to the negative reaction from assigned DCF workers and DCF screeners when Probation Officers seek to escalate concerns. This was the same pattern identified among several state entities and service providers in this report. Probation Officers are mandated reporters and an open DCF case does not in any way alter the requirement that a mandated reporter fulfill their legal duty file a report of alleged abuse or neglect.

Neither the pushback experienced by MPS on advancing a court case, nor the pushback experienced by MPS on filing a child abuse/neglect report on an open DCF case, can be explicitly linked to this situation. It is important to state that in this matter, neither the Court nor the DCF case management team were ever identified as having expressed any such pushback. However, if there is a pervasive culture of dismissing or discounting the perspective of Probation Officers this would contribute to MPS's reluctance to bring these issues to the attention of the court or to take issues up the chain of command at DCF, and such reluctance is detrimental to the well-being of families.

MPS RECOMMENDATIONS

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

As noted in Finding #1 of this section and in the Juvenile Court recommendations, the Juvenile Court has broad discretion to place legal conditions on custodial arrangements in a Care and Protection proceeding at multiple touchpoints in the case. This report recommends that the court explicitly consider placing conditions on custodial arrangements on the record at relevant court hearings. Probation Officers should have a process for conducting an assessment of a child's safety needs and a family's strengths and weaknesses which will provide them with the information necessary to make reasonable and informed recommendations on conditions to place on reunification or other custodial arrangements if the Court seeks the Probation Officer's input. The Probation Officer's safety assessment should include review of the Court Investigator's report, conversations with the family members about their strengths and needs, and discussions with DCF.

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

DCF has the greatest access to information on any Care and Protection case and has the largest, most difficult, and most complex role and obligations of any party in a Care and Protection case. Due to the weight of the obligations required of DCF, DCF has allegedly defaulted to not actively providing information to MPS on Care and Protection cases. Both DCF and MPS would benefit from shared

expectations regarding information exchange by DCF (such as alerting MPS when a child moves from one foster care placement to another). It appears that this type of information sharing differs widely among regions in the state. The more that information sharing can be standardized across the state, the less the accident of a child's geography will determine the collaboration between state agencies working for that child's well-being. DCF and MPS have provisions in their statutes that would permit them to share records with one another when appropriate.¹⁰⁸ The execution of an MOU is an opportunity for both DCF and MPS to utilize their statutory authority to share information for relevant purposes. This MOU should specifically address what records can be shared, how those records should be obtained, and the purposes behind such information sharing. The MOU should be drafted in a manner that clearly outlines the roles and responsibilities of DCF and MPS and how those roles and responsibilities overlap or interact in Care and Protection proceedings.

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

The Juvenile Court, through its *Pathways Initiative*, has worked diligently to map and improve outcomes for child welfare cases across the state. The Juvenile Court and MPS are best suited to review any internal barriers to MPS's ability to adequately execute their responsibilities which require that they bring to the court's attention concerns of violation of court orders as well as concerns for the safety and well-being of children in Care and Protection cases. It is incumbent on the Juvenile Court to take the concerns of Probation Officers as seriously as concerns of any other party in a court case, as MPS plays a very unique role and has a perspective that should not be discouraged or discounted.

MPS should also take stock of the scenarios in which Probation Officers are not advancing cases when they reasonably should be and consider additional guidance and training to rectify any patterns or trends. Of note, Bristol County MPS has instituted a policy during this COVID-19 pandemic that requires Probation Officers to advance any Care and Protection case where a family's inability to access technology impedes the Probation Officer's supervision or the responsibilities of the Probation Officer. Bristol County MPS, in the wake of David's death, has correctly identified one of the central findings of this report that a family's access to technology in the time of the COVID-19 pandemic is, in itself, a safety risk that must be addressed, particularly if there are concerns for a child's well-being.

¹⁰⁸ DCF statute M.G.L. c. 119 § 51(e) and MPS statute M.G.L. c. 276 § 100.

CONCLUSION AND RECOMMENDATIONS

It is tempting to characterize this case as a case resulting from a “perfect storm.” Whether that characterization is apt it is difficult to know; what we do know is that this is the storm that we are currently weathering. We must measure the success of our state systems by the real-life consequences to the most vulnerable in our population. It is the obligation of the OCA to evaluate this case from the position of how best to protect our Commonwealth’s children and to make realizable recommendations to improve the provision of state services. We as a Commonwealth have the capacity and fortitude to learn from this situation and to honor David and his brothers.

RECOMMENDATIONS: DEPARTMENT OF CHILDREN AND FAMILIES

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

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

RECOMMENDATION #3: The DCF administration should create guidance that provides: (1) specific criteria for when and why parental assessments are needed from external providers; (2) a standard process for parenting assessment referrals that includes relevant DCF and family history; and (3) a mandate that the DCF case management team provide the parenting evaluator specific parental capacity questions that are related to the protective concerns of the case and the individual needs of both the children and caregivers.

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

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

RECOMMENDATION #6: The DCF administration should develop a reunification policy that includes, at a minimum (1) an assessment of safety and risk using a research or analytical based or actuarial tool that is used prior to a child’s return and as a support in DCF’s reunification decision-making; (2) area office management administrative case record review prior to any internal case review meeting (e.g. Foster Care Review, Permanency Planning Conference); (3) area office management consultations with the DCF case management team, educational provider, probation officer, relevant service providers and subject matter experts prior to any internal case review meeting; (4) area office management discussions with the caregiver(s) to elicit their input and participation in formulating a reunification transition plan that takes into considerations their strengths and needs; and (5) a documented family-centered transition plan that takes into consideration the individual needs of the child and caregiver, outlines the pre-and-post reunification caregiver expectations, and the DCF oversight and monitoring of the family to ensure child safety.

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

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

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

RECOMMENDATIONS: EDUCATION

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

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

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

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

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

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

RECOMMENDATION #7: FRPS should explicitly address mandated reporter responsibilities in the district.

RECOMMENDATIONS: THE MASSACHUSETTS JUVENILE COURT

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

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

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

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

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

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

RECOMMENDATION #7: During the continued COVID-19 pandemic, the Court should make specific inquiries into DCF safety assessments prior to the reunification of any children or changes to custody. The Court should also specifically inquire of the attorney for the child what particular concerns COVID-

19 presents for a specific child; attorneys representing children should make inquiries independent of DCF to be able to adequately answer this question.

RECOMMENDATIONS: THE MASSACHUSETTS PROBATION SERVICE

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

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

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