Statement from The Office of the Child Advocate Concerning

OCA Review of the Death of Chase Gideika

May 2, 2014

In the early morning hours of July 8, 2013, the Lynn Police Department received a 911 call for an unresponsive child. Police responded to the home of Jennifer Nelson and Anthony Gideika and found three-month-old Chase Gideika bruised and not breathing. Chase was transported to North Shore Children's Hospital, then transferred to Massachusetts General Hospital, where he died that afternoon from severe injuries. Doctors who cared for Chase believed that his injuries had been intentionally inflicted; the medical examiner later ruled his death a homicide caused by multiple blunt injuries to his head and body. Anthony Gideika was arrested soon after and was later indicted for murder and assault and battery upon a child causing substantial bodily injury. Jennifer Nelson was also indicted for permitting assault and battery on a child resulting in serious bodily injury, misleading a police officer, and wanton and reckless endangerment of a child.

The Department of Children and Families (DCF), through a spokesperson, has stated publicly that DCF had been involved with this family since June 2012, after receiving a report of neglect on behalf of Ms. Nelson's then three-year-old son. At that time DCF took custody of the boy and placed him in foster care, where he has remained. Following Chase's death DCF took custody of another son, Chase's twin brother. He is currently in foster care.

The Office of the Child Advocate (OCA) received a Critical Incident Report on July 8, 2013, regarding the death of Chase. Secretary John Polanowicz of the Executive Office of Health and Human Services (EOHHS) requested that the OCA conduct an independent investigation into DCF's work with Chase's family. This investigation included extensive document review and interviews with agency, union, and law enforcement personnel. The OCA is required by law to preserve the confidentiality of the information it receives, although the results of investigations into critical incidents may be shared with the Governor, the Secretary of EOHHS, and other public officials enumerated under Massachusetts General Law Chapter 18C, Section 12(e). The OCA has completed its investigation and has discussed its findings and recommendations with Secretary Polanowicz. Confidential information may not be shared with the public, and for this reason those protected details are not included in this written statement.

Two similar critical incidents occurred between May and July 2013 involving infants whose families were receiving services from DCF. Like Chase, these infants suffered from severe physical abuse allegedly inflicted by their father or mother's partner. Like Chase, one of the other infants was exposed to substances before birth. Like Chase, one of these infants died from the injuries inflicted; the third infant suffered severe and permanent brain damage. The

OCA reviewed DCF actions regarding Chase and his family in the context of the serious injury and death of these other infants.

DCF has taken a number of significant actions to address the safety of young children since Chase and the other two infants were injured. DCF Acting Commissioner Olga Roche took over leadership of the agency at the end of April 2013. In response to these three critical incidents, Commissioner Roche instituted a statewide review of the safety of children. The review began in August 2013 and was completed in October 2013.

Below is a summary of the observations and recommendations identified by the OCA.

OCA Observations

Assessment of Fathers and Other Intimate Partners

The three infants discussed above suffered injuries at the hands of their father or mother's intimate partner, as alleged in criminal indictments. Caring for a newborn through his first year can be demanding under the best of circumstances. New parents must learn how to soothe and tolerate the frustration of a crying baby – in addition to an encyclopedia of other facts and skills to keep their baby safe and healthy. If a new parent or partner lacks the capacity to learn these skills due to immaturity, lack of insight, or aggressive tendencies, the infant may not be safe with that caretaker. Prematurity, substance exposure, and multiple births are a few of the factors that can further complicate newborn care. Gauging the factors that strengthen the family's support system and identifying the complications that create risk are all part of the DCF assessment process. When a family becomes involved with DCF, thorough and accurate assessment of all caretakers is critical to determine whether a child is at risk of suffering further harm or neglect. When a caretaker has been identified as lacking capacity for newborn care, DCF workers must make a difficult decision about the efficacy of safety planning and service provision versus removing the child from the home. During the DCF involvement with the families of Chase and the other two infants, DCF learned concerning information and failed to translate this information into interventions that protected the infants from harm.

Actions Related to Assessment of Fathers and Other Intimate Partners

In the wake of these three incidents, Commissioner Roche directed the immediate review of casework practice on all families with open cases who had children from birth through age five living in the home. The purpose of these reviews was to ensure the safety and well-being of children by re-examining risk factors such as young or inexperienced parents, parental substance abuse, mental health issues, veterans returning from active military duty, and substance exposed newborns. A report of the findings from these reviews was submitted to Secretary Polanowicz.

Substance Exposed Newborns

Prenatal substance exposure to both legal and illegal substances can affect a newborn's health and development and increases the newborn's risk for abuse and neglect. Two of the three infants involved in the critical incidents in 2013, including Chase, were exposed to substances before birth. Vulnerable newborns need safe and nurturing care 24 hours a day and parents need support to provide this care. When the demands of newborn care are compounded by prematurity, substance exposure, or multiple births, some parents cannot safely provide this level of care, even with supports and services in place. Parents coping with addiction and recovery present special challenges to DCF workers who must assess the parents' capacity to provide consistent positive care for infants. Making the decision to remove a newborn from his parents is difficult but essential when it has been determined that a family cannot safely manage the needs of an infant.

Actions Related to Substance Exposed Newborns

Commissioner Roche directed that all 51A reports of abuse or neglect involving a substance exposed newborn be screened in for investigation, and that a clinical and legal conference be conducted to explore whether DCF should assume custody of the infant. If a determination is made not to assume custody of the infant but the family would benefit from services, in-home services should be in place prior to hospital discharge. DCF has also added capacity to identify substance exposed newborns and follow their safety and well-being through the agency's data management system, iFamilyNet. The OCA supports DCF's response to the vulnerable population of substance exposed newborns, but recognizes that additional resources will be required to implement this directive, including more social workers, supervisors, and managers, and training in the areas of substance exposed newborns and child development. The OCA recognizes that additional resources have been given to DCF through the supplemental budget, and that further support is under consideration for the upcoming fiscal year.

Family Engagement and Safety of Children

In July 2009 DCF began statewide implementation of the Integrated Casework Practice Model (ICPM). Consistent with national standards, ICPM was designed to identify and use strengths to safely stabilize families so that children could remain at home whenever possible. ICPM established a differential response to reports of abuse or neglect, with two pathways for a response to a screened-in report: investigation or assessment. Investigations are reserved for more serious allegations of physical abuse, sexual abuse, and severe neglect while assessments are reserved for lower risk allegations of abuse or neglect. In 2012 DCF added the additional

pathway of short term stabilization to ICPM to respond to families whose needs could be met by the end of the assessment period.

Since its implementation, ICPM has been criticized by some for promoting engagement of families over the safety of children. This was never the intention of DCF leadership. The ICPM model was not designed as an alternative to child protection, but as an engagement model in which children's safety and well-being remained paramount. However, in the context of decision-making in individual cases, many felt that a shift in values had occurred and DCF was no longer taking custody of children when the agency should have done so, and that children were remaining in their homes when they should have been removed to foster or kinship care. Care and protection petitions are the legal mechanism by which DCF seeks custody of children. The number of petitions filed in juvenile court decreased 30%, from 3,521 in 2008 to 2,460 in 2012, reflecting a change in decision-making. Chase and his twin were identified as substance exposed at birth and were sent home from the hospital despite a clear risk of maltreatment. The personnel in this Area Office erred in their judgment by sending these infants home. However, their decision was affected by a shift in agency focus statewide, and consideration of their actions should incorporate this context.

Actions Related to Family Engagement and Safety of Children

If implementation of ICPM resulted in an emphasis on family strengthening that at times outweighed child safety, Commissioner Roche is committed to correcting this imbalance. Since these tragedies and in the wake of the disappearance of Jeremiah Oliver, the Commissioner has directed DCF to screen in for investigation and intensive case management any report of abuse or neglect in a family with a child from birth through age five presenting any of the following risk factors: young parents or parents of any age who have a history of substance abuse, domestic violence, mental health issues, or unresolved childhood trauma. The OCA supports DCF's response to these tragedies but recognizes that this directive requires additional resources to implement effectively, including social workers, supervisors, managers, and resources for training and case review.

OCA Recommendations

- In January 2014 EOHHS contracted with the Child Welfare League of America (CWLA) to conduct a review of DCF policies and practices and how they align with best practices nationwide. The OCA recommends the CWLA examine current policy and practice related to assessment of fathers or intimate partners and make recommendations for the development of a practice guidance that promotes the optimum safety and well-being of children.

- Three critical incidents involving infants occurred from May through July 2013. Since that time, DCF conducted a statewide review of children from birth through age five and has made changes in policy and practice relating to young children and families with young parents or with histories of trauma, domestic violence, substance abuse, or mental illness. The OCA recommends that sufficient resources be made available to implement these policies, including more social workers, supervisors, and managers, and training in the areas of substance exposed newborns and child development.

- The death or serious injury of these three infants in such a short time frame occurred in three different DCF Area Offices. Optimum change comes only from thoughtful and collaborative examination of assessment and casework practices. The OCA recommends managers and key staff in these three Area Offices convene a joint review to identify missed opportunities and lessons learned, and to make recommendations for improved assessment and casework practice specific to these Area Offices.