

Sensitive Case Review Report
T Foster Home
September 2, 2009

Introduction:

Four years ago in December 2005, six children were removed from the T foster home after it was reported that the children in foster care in the home (medically fragile infants and toddlers) were spending hours unattended in their cribs in a small cluttered storage room.

The T foster home had been certified by DHS for over 38 years and served only infants and toddlers with significant developmental and/or medical needs. In response to the events in December 2005, all six children were removed from the T home and no other foster children were placed in the T foster home.

Background and Purpose of Sensitive Case Review:

In May, 2009, following the conclusion of a legal settlement, the Children, Adults and Families (CAF) Assistant Director requested a sensitive case review of the Department's most recent experience with the T foster home, focusing on the 10 years between 1995 and 2005. Sensitive case reviews frequently occur within the Children, Adults and Families Division when requested by the CAF Assistant Director, Administrator of the Office of Safety and Permanency for Children, or a District or Program manager. (OAR 409.192 and OAR 409.194.)

The purpose of this review was not to re-visit specific department practice or decision-making by particular staff who had responsibility for the T home and the children placed there, but to take a new look at the issues raised by that historic practice and decision-making within the context of current department practices and policies, and to use the lessons learned from this case to identify any additional improvements that are needed to ensure the safety of children in foster care.

Summary of Issues Identified and Recommended Next Steps:

Some of those most significant issues identified in this review include:

- Lack of on-going assessment of the functioning of the T foster family over the years, including inadequate documentation of family

changes and insufficient attention to the ability of the individual caregivers to meet the needs of the children in their care.

- Lack of face-to-face contact by the foster care certifier, and insufficient documentation during the re-certification process that the skill level of the foster parents was adequate to meet the individual needs of the children placed in the home and that the totality of home environment was reviewed and evaluated against the department's requirements.
- Failure of medical and developmental professionals involved with children in the home (and not affiliated with DHS) to report concerns to the Department about the care children were receiving.

Next Steps:

The issues identified in this report are significant and cause for serious concern. It is not clear, however, whether all of the issues are systemic in nature (i.e., whether they were unique to this case or more widespread) and, if systemic in nature, whether actions in the past 10 years that the Department has taken to strengthen its work regarding the safety of children in foster care have adequately addressed the issues identified in this case.

Accordingly, the CAF Assistant Director is convening a Foster Care Safety Team to closely review additional data and case-specific information involving long-term foster parents and reports of abuse by foster parents and, based on the data and case reviews, make recommendations of any additional improvements (including resources, changes in policy or practice, etc.) that may be needed to ensure the children in foster care are safe.

Sensitive Case Review Report:

Scope of Sensitive Case Review:

DHS originally certified the T foster home in 1967. Because of the limitations surrounding access to case records and information going back that far in time, and to ensure relevance of case work and case practice involving the family, this sensitive case review focused on the department's interaction with the T family for the 10-year period prior to 2005. Specifically, the following three components of the DHS case file were reviewed and analyzed:

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- 1.) The Child Protective Services (CPS) Allegations and reports involving children in this foster home from 1994-2005.
- 2.) The T foster home Certification file from 1995-2005
- 3.) Casework practice regarding the “G” children (two of the children removed from the home in December 2005).

Identified Issues in Reviewer’s Analysis of CPS Reports

Reviewers were asked to review and assess all CPS allegations on children placed in the home that the Department received between 1994 and 2005. During that time period, there were a total of four documented screening reports regarding the T foster home. Three of the four referrals were prior to 2003. The first three were “logged” and the last one was regarding the incident of concern in December 2005 which was “founded”.

The CPS assessment that was completed regarding the December 2005 referral that prompted this review was comprehensive, thorough and well documented. The workers involved spoke to numerous collateral sources, arranged for the children to receive full medical assessments, and worked with other entities during the assessment process.

The primary concerns regarding CPS reports involving the T foster home involved the referrals received before 2003 that were “logged.” The category of “logged” referrals was eliminated from DHS policy in 2005 due to ongoing confusion regarding the use of this category. Prior to its elimination, policy allowed referrals to be “logged” when a screener determined that the information alleging child abuse does not constitute a report of child abuse, but the information is from a mandatory reporter or the information may be significant if future, related calls are received.

In this case, two of three “logged” referrals met the criteria for “closing at screening”. Cases are “closed at screening” if the information alleging child abuse constitutes a report of child abuse, but there is no current safety threat, the safety threat has been resolved, or the safety threat is from a person outside the child’s family and the child’s caregiver is protective.

The first logged call that should have been “closed at screening” involved a concern that an infant in the home had a significant diaper rash. There is not indication that any action was taken based on this call. If it had been “closed at screening”, the screener would have to have indicated how the concern

was addressed. The second report involved a concern that one of the children was returned home from the T house with scratches on his face. In that report, the mother took the child to the doctor who found nothing “of notable concern.”

However, one of the “logged” referrals met the policy criteria for a “response required”. This report involved a concern that the foster parents were fighting in front of the children and that there had been a drive-by shooting at the residence. Although police later faxed a report about the shooting to the DHS office, there was no information in the file about why the decision was made not to refer this report for a CPS assessment.

Arguably, eliminating the ability of a worker to “log” a report of abuse or neglect has addressed the inappropriate use of that criteria in this case. However, the K.T. Critical Incident Response Team (CIRT) report (published September 2, 2009), also raises concerns regarding the Department’s response to abuse allegation involving DHS-certified foster parents and whether those responses consistently follow policy. The K.T. CIRT report recommends that the Foster Care Safety Team also referenced in this report (see below) examine that issue further to determine what, in addition to more training for CPS and Foster Care Certification workers and supervisors, should be done to address this issue.

Identified Issues in Certification File Review

Reviewers were asked to review home studies, certification compliance, certification renewals and any safety plans in place with the T foster parents between 1995 and 2005. Pursuant to Department policy, the T foster home was recertified each year during that time period. The recertification process includes a “homestudy” by the Foster Care certifier, the purpose of which is to assess whether the individuals providing foster care continue to be qualified and to assess whether the home in which the care is provided continues to meet department requirements for certification.

In this case review, each home study regarding the T home was very positive. Some of the studies provided minimal information about the qualifications of the foster parents, but stated that the family was a highly skilled medical home. Each recertification included a completed “Safety Home Checklist” that included checking that “Bedrooms must have safe and adequate space and a bed for each child.”

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Issues raised in the review of the certification file include:

- **Number of Children Placed in Home And Qualifications of Mrs. T:** Throughout the 10 year review period, certification rules allowed for no more than eight total children in a foster home, and no more than two children under the age of two. The T foster home regularly required an exception to the rule. The certifier did obtain approval for those exceptions. The justification for the approvals included the high level of experience and skill that the foster parents possessed.

Several of the foster home certification approvals stated that Mrs. T was a Registered Nurse (RN) and could take care of medically needy babies. A different home study renewal, however, stated that Mrs. T was “highly skilled, but **not** a nurse.” Many of the renewal studies and approvals for placement of more than two children under the age of 2 stated that the foster home was a “Tier IV medical home.” The Department’s protocol for tier IV homes includes that the foster parent is a “licensed RN”. Mrs. T. is, in fact, not a Registered Nurse.

- **Medical Issues of Children**

The babies and toddlers placed in the T foster home had significant developmental and/or medical needs. At the time of the removal there were six children in the home; four under the age of two, and two just over the age of three. Four of the children had personal care rates, meaning they had significant developmental and medical needs requiring additional training and expertise to address.

The certification file, however, consistently lacks clear documentation regarding the foster parents’ abilities to meet each child’s individual needs (for example, there was no clear documentation as to how the foster parents could physically meet the needs of each of the very young, medically and developmentally needy children placed in the home in December 2005). The file documentation also fails to recognize the challenge of not just meeting the individual needs of each of these children, but of meeting the needs of this many children, combined, on a day-to-day basis.

- **Layout of the Home**

The certification rules during the review period only required safety and standards checks of foster home bedrooms “occupied by foster children.” In this case, the foster parents represented to the certifier that the foster children only occupied two of the four bedrooms inside the home. The file reflects that the certifier physically inspected only the four bedrooms in the house for compliance with Department regulations.

The certification file is less clear about the room adjacent to the home where it became clear in the December 2005 investigation foster children were also being placed. Although the file suggests that the certifier was aware that the room existed, it appears that the certifier relied on the representation that that room (which was an addition or modification to the home structure) was occupied by one of the T foster parents’ adopted children and, therefore, did not visually inspect the room.

Current rules require foster care certification workers to examine **all** rooms in a certified foster home, including modifications, additions and free-standing structures, such as garages.

In addition, it also does not appear that the certifier took into consideration whether the number of children placed in the foster home could physically be accommodated in the rooms that actually were inspected. Again, better communication between the staff responsible for placement of children in the home with the certification worker likely would have brought this issue to the forefront.

- **On-Going Assessment of Foster Parent Functioning**

Finally, reviewers found a lack of on-going assessment of the functioning of this foster family over the years. There was little documentation regarding family changes (during the course of the 10-year review, for example, the foster parents’ adopted daughter turned 18, but it is unclear when she ceased residing with her parents). There was also little documentation about the health condition of the foster parents, how their own age and abilities may have changed over time, and whether that may have impacted their ability to meet the needs of multiple young children with very significant medical and developmental needs. It is especially concerning that the certification

file did not contain more information from the case workers responsible for children placed in the T home, indicating a lack of communication between those workers and the foster care certifier about the individual needs of the children for whom the foster parents were responsible.

Reviewers are extremely concerned about the information uncovered as part of the certification file review in this case. In particular, the following issues are of critical concern:

1. The lack of thorough documentation of the reasoning behind the granting of exceptions to the foster care rules related to how many children of specific ages can be cared for in one home.
2. The erroneous documentation regarding the level of expertise of the foster parent, which became the basis for the decision to grant exceptions and allow more children into the home.
3. The lack of any meaningful, on-going evaluation of the foster home and foster parent functioning.
4. The fact that the certifier did not visually inspect every room in the home.
5. The lack of documentation regarding communication between caseworkers who had children placed in this home and the certifiers responsible for evaluating the foster parents' abilities over time.

Identified Issues of Casework Practice regarding the “G” children

Reviewers found that the ongoing caseworker for the G children was diligent about her monthly face-to-face contacts with the children. With the exception of two months, the worker saw the children in the foster home every month for three years. The worker also had other face-to-face contact with the G children, including supervised visitation with their biological family and attending medical appointments with the foster parents.

Caseworker documentation regarding her contact with the children was thorough. She regularly documented her observations regarding the progress the children were making developmentally, their disposition during the visits, and foster parent concerns. When visiting the T foster home, the caseworker also documented seeing the other children in the home.

Numerous professionals were involved on an ongoing basis with the G children and at least two of them – an early intervention therapist and a Case Review

pediatrician – appear to have made frequent and regular home visits in the T foster home. The early intervention therapist was in the T. foster home approximately one day a week for “6 – 7 years.” It was also documented in the renewal home studies that the pediatrician for the children placed in the home frequently attended to the children’s needs in the home itself, rather than in an office.

The two issues of most serious concern in this section of the Review include:

- 1) All of the home visits by all the professionals (including DHS staff) appear to have been scheduled visits; and

- 2) In the December 2005 investigation, several professionals, and the T’s adult children, expressed concerns about the care the children in home had been receiving, but **none** of those concerns had previously been reported to the Department.

Prior to the December 2009 interviews, the 10-year review only has one record of a physician reporting that the foster parents were not following up on one of the G children’s eye issues. DHS records also show that 20 days after receiving that notice, the foster parents took the child to a retinopathy therapist.

RECOMMENDATIONS/ ACTIONS

It is often difficult when reviewing a single case to determine whether the issues presented in that case are widespread throughout the system, or unique to a particular case. That question is made more difficult to answer in this Review because the events reviewed in this case are old, having transpired between 5 and 15 years ago.

The Department has made and implemented significant changes over the past several years that address many issues and concerns raised in this review. Most notably, these include:

- Implementation of the Oregon Safety Model which focused the Department’s effort on insuring safety throughout the life of a case, including when a child is in foster care, and requires a more

comprehensive assessment of the reported abuse incident, rather than a one-time, incident based assessment;

- A new, more thorough home study process for foster home certification and re-certification;
- A requirement that certifiers examine every space in a home (not just the bedrooms of foster children);
- Additional staff to reduce the number of foster families for which certification workers are responsible;
- Increased requirements for home visits by certifiers (now, in addition to every-other-month visits in a foster home by each caseworker assigned to each child in a foster home, certifiers must visit foster homes every 180 days.)

Nevertheless, the State, when responsible for the care and safety of children who have been the victims of abuse or neglect, should take all reasonable steps to insure their safety. Accordingly, it is imperative that the State act upon the issues identified in this case to protect children in its foster care system.

To determine whether the issues present in this case are unique to this case, or systemic in nature, Reviewers are making the following recommendation:

The creation of a rapid-response, Foster Care Safety Team, comprised primarily of individuals external to the agency, to do the following:

- 1) Review and analyze the data surrounding the incidents of abuse or neglect in foster care in 2008, including but not limited to a review of the types of abuse and factors that cases involving abuse may have in common in an effort to identify issues or factors contributing to the abuse or neglect and any changes in practice or policy that may be warranted;
- 2) Review a sufficient number of foster home certification files involving foster parents who have been serving children for at least 5 years or longer to determine whether the issues presented in this case also are identified in cases in different parts of the state with different foster parents (i.e. are systemic in nature);

- 3) Review a representative sample of child abuse reports relating to DHS-certified foster homes that were “closed at screening” and identify whether there are trends or practices that are inconsistent with statute, rule or policy and to determine whether a systemic issue (or issues) exist regarding the Department’s response to allegations of abuse against foster parents; and
- 4) Review all efforts for the last 10 years, including those currently in process, by the Department to ensure the safety of children in foster care.

Based on the data and case reviews, the Foster Care Safety Team should make recommendations of any additional improvements (including resources, changes in policy or practice, etc.) that may be needed. The Foster Care Safety Team has been asked to complete its review and analysis, as well as develop preliminary recommendations, within the next 90-days, with a final report and recommendations to the department no later than January 30, 2010. *(See also K.T. CIRT, also published 9/2/09, which also references the work of the Foster Care Safety Team.)*

In addition, there are steps DHS should take immediately that will begin to address the following systemic issues that were clearly identified:

1. The criteria for managers to use to make exceptions/approvals for the number of children placed in a foster home needs to be more specific and better documented.

Action: The Foster Care Program Manager will conduct a practice discussion with the Child Welfare Program Managers and clarify existing policy direction so that staff can better document the process for decision-making when they approve an exception to the number of children in a foster home. This practice discussion should occur at the October 2009 program managers meeting (the first meeting of those managers following release of this report) and any updated policy direction should be complete by January 2010.

2. There is no statewide policy regarding “medical foster homes.” One district, District 2 serving Multnomah County, has developed a

protocol including a tier system for homes to help identify the level for medically needy children in foster care.

This year, the Foster Care Program Manger has been conducting a restructure of the foster care program reimbursement rate. That “rate redesign” includes an improved assessment tool specific to children in foster care with medical needs and changes the rate structure to include “levels of care” for individual children depending on the severity of their medical needs and the expertise needed to meet those needs. However, the “rate redesign” does not include an explicit discussion about Department policies specific to “medical foster homes,” namely, foster homes that serve only or primarily children with significant medical needs.

Action: In consultation with Dr. Tina Kitchin, a pediatrician employed by the Seniors and Disabilities Division with expertise serving children with significant medical needs, the Foster Care Program Manager will convene a workgroup to review the “Medical Foster Care program” in District 2; align it with the new screening tool and “levels of care” for foster children with medical needs that now apply statewide, and determine what statewide protocol and rules need to be established that are specific to homes that primarily or exclusively serve children in foster care with significant medical needs. This effort should begin as soon as possible, with changes implemented no later than December 2009.

3. Case workers and certifiers need to communicate with each other regarding the impact on the family as a whole each time a child leaves or enters a foster home.

Action: The Foster Care Program manager will conduct a practice discussion during the October Child Welfare Program Manager’s meeting (the next meeting of that group following publication of this report) and at supervisor quarterlies beginning in October 2009 to establish a procedure for planful communication to formalize the sharing of information between the caseworker responsible for the case and the Foster Home Certifier. That procedure should be finalized by December 2009, and training for all child welfare caseworkers and certifiers should begin in January, 2010.

4. Case workers and certifiers need to make more use of un-announced visits to foster homes. And, although policy has been changed to require this, the expectation that certifiers should review every space in the home when certifying and re-certifying a home should be reinforced.

Action: The Foster Care Program manager will conduct a practice discussion during the October Child Welfare Program Manager's meeting (the next meeting of that group following publication of this report) and at supervisor quarterlies regarding these two issues, using this Report as a foundation for that discussion. This practice discussion and any necessary updated policy direction should be complete by January 2010.

CONCLUSION:

In its strategic planning efforts, as well as in its Program Improvement Plan in response to the 2007 Federal Review of Oregon's child welfare program, the Department has set a goal of becoming one of the safest foster care systems in the country by drastically reducing the rate of abuse in foster care in Oregon. Any abuse by an out-of-home caregiver of a child who already has suffered abuse or neglect at the hands of his or her parents cannot be tolerated. As a state, we must expect that our children in foster care are safe and, in turn, we must support our child welfare system and our foster parents in such a way as to ensure that that expectation is met.