

CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT R.H.

November 22, 2010

Executive Summary

On March 26, 2010, the Department of Human Services (DHS) received a report from law enforcement officials that 9-year-old R.H. had been hospitalized with serious physical injuries. At the time he was injured, R.H. was in the care of his adoptive parents who had previously been certified foster parents. DHS had received referrals concerning this child and this family prior to this incident. On April 7, DHS Director Dr. Bruce Goldberg declared that a Critical Incident Response Team (CIRT) be convened. This is a discretionary CIRT, not mandated by the Oregon Statute known as Karly's Law. This is the final report of the R.H. CIRT team.

This case raised several issues, which can be summarized as follows:

- On multiple occasions, the Department received information regarding concerns about this foster home that was not adequately considered during the screening process, investigation of abuse reports, foster home re-certifications and the adoption review process; and
- The Department's foster home case review process at the local office level did not ensure the concerns about this foster home – including those evaluating the foster family as an adoptive family -- were comprehensively or objectively reviewed and acted upon.

As a result, the CIRT team is recommending the implementation of the following actions:

1. Create a model using specialized staff to perform CPS assessments on abuse allegations that occur in certified foster homes;
2. Develop and implement statewide a formal structure and process – like the foster home case review process that occurred in this case -- that would include reviewing certification exceptions, reports of alleged abuse, certification violations, or other areas of concern regarding certified foster homes; and
3. Institute a mandatory review process when two abuse allegations or certification concerns have been raised or documented, regardless of their outcomes.

Because this was the second CIRT in Lane County within a very short time period, the agency sent a Rapid Response Team to Lane County in April 2010 to review files, observe branch processes and engage staff and community partners in an improvement plan for the county.

These actions were in addition to the CIRT process and resulted in several action items, including:

- Central Office consultation and review of multiple cases involving foster homes identified by staff where concerns had been identified.
- Enhanced foster home staffings by improving the communication structure to ensure that all staff involved with the home had input at the staffing, knew what the results were, and were accountable for follow-through on action items.
- Created a process with Central Office foster care consultant to review homes having three or more staffings due to certification issues.
- Enhanced training and practice discussions with staff to ensure that comprehensive assessments and ongoing safety assessments were being done by staff in accordance with the Oregon Safety Model.
- Worked with local School Districts to set up Student Care Teams to staff cases and improve communication between schools and child welfare caseworkers.

The Department has also separately addressed any necessary personnel actions involving individual employees or their supervisors.

Summary of Reported Incident

On March 26, 2010 the Department of Human Services received a report that nine-year-old R.H. had been hospitalized after suffering multiple, serious physical injuries. R.H. sustained the injuries while in the care of his foster/adoptive family. Upon receipt of this information, a referral was generated and assigned to a Child Protective Services (CPS) worker. Law enforcement was notified by cross-report from department staff, and they began a criminal investigation.

On May 28, 2010, R.H.'s adoptive parents, A.H. and R.E.H., were both arrested. On July 28, 2010, A.H. pleaded guilty to one felony charge of first-degree assault and three felony counts of first-degree criminal mistreatment. She was sentenced to a prison term of 10 years, 10 months in prison, with no chance of early release. On the same day, her husband, R.E.H. pleaded guilty to a felony charge of second-degree assault. He will serve a prison term of five years, 10 months.

Background

R.H.'s adoptive family had been involved with the Department of Human Services for nearly seven years becoming a certified foster home in 2003. For the purpose of this CIRT document R.H.'s adoptive father will be referred to as R.E.H., and R.H.'s adoptive mother will be referred to as A.H. R.H. was first placed with this family as a 4-year-old foster child on February 10, 2005. This family subsequently adopted R.H.

The CPS review in this case included nine child abuse reports, the first of which was received by DHS on October 30, 2003. Five of the nine reports were assigned to a CPS worker for a safety assessment, two of the reports were documented and Closed at Screening and two were assigned for assessment but closed prior to conducting any interviews. Of the five reports that were investigated, the allegations included Neglect, Physical Abuse, Mental Injury and Threat of Harm. Each of the five assessments ended with a disposition of Unfounded. Unfounded means there was no indication of abuse or neglect. The four reports that were not investigated by DHS included concerns of Physical Abuse, Neglect and Threat of Harm.

In addition to the CPS review, there was a review of the certification file for this foster adoptive family.

Chronology

The history of DHS contacts with the family leading up to the most recent injury of R.H is shown below:

CERTIFICATION: R.E.H. and his wife, A.H. were first certified as foster parents in January of 2003. They were certified to have as many as 5 children in their home, and the family requested to start with just one child and do short term respite for up to four children. Background checks were completed, and no criminal history or child welfare history was located.

Closed at Screening: Allegations of Physical Abuse. On October 30, 2003, the department received a report that a 4-year-old foster child had a dime-sized bruise on his chest that was caused by physical abuse. The documentation indicates the report was closed at screening because the injury was minor and could have been caused in a variety of ways. The CIRT team concluded that this report should have been assigned for an assessment.

RECERTIFICATION 2004: The initial Recertification was positive, and there were no CPS or certification issues noted in the recertification. The CIRT team concluded that some discussion regarding the Closed at Screening from October 30, 2003 should have been noted during this recertification. It is unclear from the recertification documents whether the certifier knew about or even considered the closed at screening incident.

REFERRAL 001: Allegation of Neglect – Disposition: Unfounded. On July 13, 2004 the department received a report that a 3-year-old developmentally delayed foster child had been losing weight while in the foster home. Additionally, the child had multiple injuries including a black eye, multiple scrapes and sores on his body, shoes that were too small and blood blisters on his feet. As part of the assessment, collateral contacts were made regarding the child's weight loss and the allegation of neglect was unfounded. However, there was no inquiry into the cause of the child's physical injuries. The CIRT team concluded that this assessment was incomplete due to the lack of investigation into the child's injuries. The team noted that if this report were to have come in today, Karly's law would have required more in terms of investigation and assessment by both DHS and law enforcement due to the visible injuries on the child.

REFERRAL 002: Allegation of Physical Abuse – Closed without contact. On July 29, 2004 the department received a report that a 2-and-a-half-year-old foster child had a small bruise on his penis from where his mother hit him with a hairbrush. This report was initially assigned for a CPS assessment but it was then closed without contacting the child. The CIRT team concluded that a CPS assessment should have been completed. The team again noted that if this report were to have come in today, Karly's law would have required more in terms of investigation and assessment by both DHS and law enforcement due to the visible injuries on the child.

REFERRAL 003: Allegation of Neglect – Closed without contact. On November 12, 2004, the department received a report that a 2-year-old foster child had a scratch on her shoulder and multiple bruises on various parts of her body, including a fading black eye, what looked like finger print marks on her leg, and a fading bruise on her lower back. The foster parent provided a possible explanation for some of the injuries but not others. The report was initially assigned for a CPS assessment but it was subsequently closed without contacting the child. The CIRT team concluded a CPS assessment should have been completed. The team noted here, too, that if this report were to have come in today, Karly's law would have

required more in terms of investigation and assessment by both DHS and law enforcement due to the visible injuries on the child.

RECERTIFICATION 2005: The second Recertification was positive. The Certifier documented that the three previous referrals were unfounded, but did not clearly identify certification issues or whether follow-up was needed. Certifier documents in re-certification study, that one child lost weight in their care, but gained weight when placed out of the home. The certifier noted that the while that child had been in their care, the family had been working with various doctors and dieticians.

PLACEMENT: In February, 2005, R.H. was placed in foster care home of A.H. and R.E.H. They would later become his adoptive parents.

REFERRAL 004: Allegation of Physical Abuse – Unfounded. On April 26, 2005, the department received a report that a child had disclosed that his previous foster mother, A.H., beat him while he was a foster child in the home. The screener documented the child's disclosure and the history of concerns about the foster home as the reason for assigning the report for a CPS assessment. The referral was assigned for a CPS assessment. Initially the child disclosed that A.H. would "beat him by biting him." The report did not clarify what the child meant by this statement. Later he reported that A.H. never beat him and that he lied about the abuse. The child never said why he lied but did say he was afraid of A.H. There was no documentation that A.H., R.E.H. or any of the other children or adults in the home at the time the abuse was alleged to have occurred were interviewed as part of the assessment. The CIRT team concluded that the unfounded disposition was issued prematurely because additional interviews were necessary to complete the assessment, and A.H., R.E.H. and the other children should have been interviewed about the allegation even though the child recanted.

RECERTIFICATION 2006: The third Recertification was positive. The report did include behavior and possible medical issues of R.H., including enuresis, mood swings and a statement that R.H. has a hard time doing homework. At the time R.H. would have been about 6 years old. There was no documentation of what strategies the foster parent was given or had discussed to manage R.H.'s behaviors. There were no CPS assessments or certification issues noted. The CIRT team concluded that this recertification should have provided some notation of referral 004 from April 26, 2005.

RECERTIFICATION 2007: The fourth Recertification was positive. The certification file noted that R.H.'s caseworker had been to the home and witnessed him being well cared for. It also noted that R.H. had never disclosed any mistreatment to the certifier. The certification record also included notation that there had never been a concern about maltreatment of any of the children in the A.H. and R.E.H. foster home. The CIRT team concluded that this was an inaccurate reflection of the record and past concerns should have been noted in the report

REFERRAL 005: Allegation of Mental Injury and Neglect – Unfounded. On June 12, 2007, the department received reports from multiple people of seeing 6 year old R.H. dressed inappropriately for the rainy weather. Other family members were observed to be dressed in warm clothing. Additionally, R.H. was not allowed to eat and was made to stand for hours. R.H. appeared to have lost weight and his demeanor and affect had changed. According to one reporter A.H. admitted she made R.H. stand for several hours as punishment. The report was assigned for assessment, and a CPS worker interviewed R.H. and two other children, who made no disclosures of abuse. The CPS worker also interviewed A.H. who denied the allegations. There was no documentation that A.H.'s husband, R.E.H. was interviewed. R.H. was seen by a physician who reported no concerns about weight gain/loss or child abuse. The documentation indicates the children were interviewed together. The CIRT team concluded that in order to be consistent with policy, children should have been interviewed separately, if possible and in a neutral location. It is unclear whether interviewing the children separately would have changed the disposition of this referral.

REFERRAL 006: Allegations of Neglect – Unfounded. On January 12, 2008, the department received a report about R.H. being emotionally abused and neglected. Also, that A.H. used food as a way to discipline R.H. The reporter commented that "R.H. is beaten down mentally and maybe physically." The reporter stated that R.H. may be made to go days without food as punishment. The report was assigned for assessment. The children, including R.H., were interviewed and made no disclosures of abuse, nor did A.H. admit to abusive behavior. The file information does not indicate whether R.E.H. was ever interviewed nor does it indicate that the children were interviewed separately. As part of the assessment, R.H. was seen by a physician who reported no concerns for abuse. To be in compliance with policy, R.E.H. should have been interviewed. Policy is also clear that if possible children should be interviewed separately in a neutral location. It is also unclear whether this referral was considered comprehensively, in the context of the previous referrals and reports concerning R.H. The disposition was

unfounded. The CIRT team concluded that it was unclear whether an interview with R.E.H., or interviewing household members separately would have supported a different disposition. In addition, during the assessment the CPS worker learned that R.H. was now the only child in the home being home schooled, another indicator of his disparate treatment. Although not evidence of abuse, isolation from teachers and other mandatory reporters may have made R.H. more vulnerable than the other children to abusive situations in the home.

REFERRAL 007: Allegations of Mental Injury, Neglect and Threat of Harm - Unfounded. On August 6, 2008 the department received a report about the poor treatment of 7-year-old, R.H. by A.H. The family had been at a wedding and R.H. looked scared to death of A.H. The reporter said that A.H. may have been withholding food from him as well. R.H. was dressed inappropriately for the weather. It was a hot day and he was wearing a long sleeve shirt. The reporter also indicated that over the past winter, R.H. was made to stay outside in freezing conditions. The report was assigned for a CPS assessment. R.H. was interviewed at the same time as two other children. None of the children disclosed abuse. As part of this assessment the worker interviewed A.H. and her husband, R.E.H. The documentation indicates they were interviewed separately and provided no concerning information. The disposition was coded as unfounded. The CIRT team concluded that this referral should also have considered prior CPS history including Referrals 005 and 006. In addition, to be in compliance with policy, children should be interviewed separately, if possible. It is unclear whether interviewing the children separately would have ended in a disclosure of abuse or in a different disposition.

Closed at Screening: Allegations of Neglect and Threat of Harm.

On May 12, 2009, the department received a report that 8-year-old, R.H. had weeping sores on his legs, and that A.H. had gone on vacation instead of taking him to the doctor. In addition, the reporter stated that R.H. was made to stand in the rain for extended periods of time as punishment and was force fed when he refused to eat. During a recent holiday, R.H. was made to stand on the porch for hours. The reporter also said that A.H. coached the children on how to answer questions from department staff and did not want family members speaking to R.H. This report was Closed at Screening. The CIRT team concluded that this report should have been assigned for a CPS assessment.

Summary of Child Placement Review

In addition to the contacts with the A.H. and R.E.H. foster family, DHS conducted a file review for each of the other foster children who had lived in this home. The

file review showed that multiple injuries were noted on several different children who were placed in this home, and most of these injuries were not reported to the Child Abuse Hotline as being suspicious for abuse. Therefore, they were not investigated by CPS. Many of the injuries were similar in nature, including: black eyes, bite marks, and scratches.

The CIRT team noted that although a bite mark, scratch or black eye in and of itself is not always indicative of child abuse or neglect, it's important to note the pattern, frequency, and explanation of injuries with the children that resided in this foster home. In several instances, A.H. provided the only explanation of how the injuries occurred. Although the caseworkers may have spoken with these children about their injuries, there was no documentation to support that an interview occurred.

The CIRT team also noted concern that the foster mother reported similar behaviors by many of the children placed in the home -- including incoherence, food hoarding, eating to the point of vomiting, oppositional defiance, withdrawal and out-of-control behaviors. However, in some of the cases that were reviewed, this behavior was documented to have ceased once the children were no longer in that foster home. Some biological parents described out of control behaviors/or withdrawn behaviors during visits that were out of the ordinary for their children.

Issues and Recommendations

Issue #1: The overarching issue in this case is that, in spite of concerning information being reported about this family and the care they were providing to foster children in their home, that information was not adequately considered. It appears that the relationship between department employees (CPS workers and certifiers) and this department-certified foster home impacted the objectivity of the CPS worker, the foster-home certifier, their supervisors and other managers, when determining how to address the concerns and allegations of child abuse.

It is worth noting that the record included information from other professionals providing services to children in the home and to the foster parents. Most of those professionals also did not have concerns about these foster parents or about the children in their care. The CIRT team's consultation with a mental health professional affirmed that it is very difficult for any social worker or social services professional, who must have a relationship with clients to be effective, to also be fully objective about information that may be of concern about those clients.

Issue #2: It appears that the foster home case review process in the local branch office included reviews of the comprehensive record of certification issues and abuse reports. However, in some cases the issues, especially reports similar to those that previously had been Closed at Screening or determined to be Unfounded, were viewed as already assessed and dealt with, rather than identified as a part of a pattern of conduct by the foster parent.

Issue #3: There was a discrepancy between information in the adoption home study and foster care certification file. Despite the information documented in the adoption home study which would have likely adversely affected the family's ability to care for adoptive children, the family was still selected. In addition, foster care certification references raised questions about differences in parenting attitudes and practices toward the family's birth and adopted children that were not considered within the assessment of the parents' capacity to provide safety and nurturing in the adoption home study.

Recommendations:

- 1) To ensure objectivity regarding allegations of abuse in foster homes, the R.H. CIRT team recommends that the Department create a separate unit to investigate allegations of child abuse in family foster homes. The Office of Investigations and Training, which is currently administered under the Office of the DHS Director and will be a "shared service" between the DHS and Oregon Health Authority after the agencies split in 2011, currently conducts investigations of abuse involving children in foster care in residential treatment settings. That assignment could be expanded to include family foster homes as well. Alternatively, CAF could create a separate unit in Central Office to serve this purpose, or it could create a process whereby family foster home abuse investigations were conducted by CPS staff from a district other than the district that certifies the foster home. Additionally, policy regarding investigations of abuse in foster homes should ensure that the Oregon Safety Model's requirement that information be comprehensively assessed, including reviews of prior concerning reports about foster homes – even those that were "unfounded" or "closed at screening" – be included in the assessment process.
- 2) The R.H. CIRT team also recommends that the Department develop and implement statewide a formal structure and process for reviewing concerns or abuse allegations in certified foster homes. That process should include reviewing certification exceptions, reports of alleged abuse, certification violations, or other areas of concern regarding certified foster homes. In addition, to ensure objectivity in that review process, the CIRT team

recommends that those reviews require the inclusion of individuals who have no relationship to the foster family or to the child welfare staff responsible for that foster home's certification or the foster children in the family's care.

- 3) The R.H. CIRT team additionally recommends that a mandatory review of a foster home occur when two abuse allegations or certification concerns have been raised or documented, regardless of their outcomes. In addition, the CIRT team also recommends specifying in the policy or rule that creates the review process require a discussion of the cumulative information, including any historical certification exceptions, reports of alleged abuse, certification violations or other areas of concern.
- 4) To improve consistency and increase objectivity regarding foster parent recertification and revocation decisions, the CIRT team also recommends that CAF Central Office create a statewide resource for local offices on certification issues. Policy or rule should require Central Office review and approval of any local decision to revoke or resolve a concern about a foster home by "counseling foster parents out" (i.e., encouraging them to withdraw their request for recertification). Additionally, when a foster home is up for recertification, if that home has been subject to one or more mandatory foster home case reviews (described above), Central Office should be required to approve the recertification of that foster home.
- 5) Finally, the CIRT team recommends that the Department strengthen its policies regarding the assessment of individual adoption applicants when information is discovered about the family that would be considered a "red flag" or would be otherwise concerning regarding the protective capacity of the family. This includes information about the applicant's family of origin, childhood abuse or other traumatic incidents, treatment obtained in the interim period of time, patterns of conduct that may reflect choices driven by prior trauma and life events, that would likely adversely impact their parenting capacity. Because of the skills required to collect and analyze this highly sensitive information and fully implement these new policies, training for certifiers and adoption workers in support of this policy change is critical.

Notably, the findings of the R.H. CIRT team are similar to several findings the Foster Care Safety Team made following a review of multiple foster home case files. The Foster Care Safety Team (FCST) was convened in the fall of 2009, in response to a previous CIRT report about a long-time foster parent who was arrested and convicted of child abuse. The FCST consisted of law enforcement,

child advocates, and other concerned Oregonians and was asked to look not only at cases after abuse has happened, but to help prevent future abuse. The FCST report and recommendations were published in March 2010. Those recommendations are now in the process of being implemented by the Department.

Because the work to implement the FCST recommendations is on-going and could not have impacted the work with the child victim or foster/adoptive family in this case, and because of the extensive systems review the FCST conducted of the foster care system, the Department asked the R.H. CIRT team to specifically examine this case keeping in mind the Foster Care Safety Team report and recommendations. Two members of the FCST were also members of the R.H. CIRT Team. The recommendations of the CIRT team in this case support and enhance several of the recommendations by the FCST.

Audit Points

- 1) By January 30, 2011, CAF, in partnership with the Office of Investigations and Training, will complete an analysis of the different options recommended in this report to create a separate unit to investigate allegations of child abuse in family foster homes. That analysis will include the cost to implement each alternative approach suggested by the CIRT Team and should be presented to the Legislature as part of the 2011-13 child welfare policy, workload and budget discussion.
- 2) By January 30, 2011, CAF will develop a project plan that will outline the timelines, and any associated workload and fiscal impacts, to implement state wide the family foster home “sensitive case review process” and all accompanying policy and procedures changes recommended in this report.
- 3) Also by January 30, 2011, CAF will develop an analysis of the workload and fiscal impact to create the capacity in Central Office to better support consistent and objective recertification and revocation decisions across the state.
- 4) CAF will continue to pursue making permanent the action the Department took in July, 2010 when it adopted temporary rule OAR 413-120-0246 Adoption Applications and Standards for Adoption. That temporary rule now provides that:
 - o All adoptive home studies will assess any concerning history of an individual applicant, to include dynamics reported in the applicant's own

- birth/adoptive family and any patterns of individual or familial conduct, and consider whether that history adversely impacts parenting capacity. It also requires that the assessment of the concerns and how they have been or are being reconciled is documented in the case file; and
- o The home study process will review all prior home studies for foster care or adoption, as well as references, for consideration of any patterns of conduct that require further assessment.

Purpose of Critical Incident Response Team Reports

Critical incident reports are to be used as tools for department actions when there are incidents of serious injury or death involving a child who has had contact with DHS. The reviews are launched by the Department Director to quickly analyze DHS actions in relation to each child. Results of the reviews are posted on the DHS Web Site. Actions are implemented based on the recommendations of the CIRT Review Team.

The ultimate purpose is to review department practices and recommend improvements. Therefore, information contained in these incident reports includes information specific only to the Department's interaction with the child and family that are the subject of the CIRT Review.