

**OKLAHOMA COMMISSION ON CHILDREN AND YOUTH  
OFFICE OF JUVENILE SYSTEM OVERSIGHT**

**Report of a Complaint Investigation  
DHS Child Welfare Services**

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**Introduction**

The Office of Juvenile System Oversight (OJSO) received a complaint on July 26, 2006, alleging a three-year-old child had died as a result of child abuse and that the Department of Human Services (DHS) had not intervened appropriately, prior to the child's death. The child's family was previously known to DHS Child Welfare Services.

The OJSO initiated an investigation of the entire DHS case history from March 30, 2005, until July 23, 2006, when DHS received the final referral notifying them of the child's death. The OJSO reviewed DHS KIDS system documentation, including referrals received, the Comprehensive Home-Based Services (CHBS) provided to the family, and the DHS case record, and judicial proceedings.

Documentation Reviewed

- Four referrals regarding the family
- KIDS system case file
- DHS case record

**Findings**

Referral 1 (March 30, 2005)

On March 30, 2005, DHS received a referral stating law enforcement had investigated a domestic incident regarding the child's maternal grandfather and his live-in girlfriend. Reportedly, the biological mother had left the two-year-old child with the grandfather. The grandfather reported that the children's mother stated she was "needing a break." Reportedly, the biological mother had done this before. DHS documentation stated, "The grandfather was intoxicated and fighting with his live-in girlfriend who was mentally unstable. The two-year-old had soiled [himself/herself] and had no diapers. [He/she was running around with feces all over [him/her], wearing only a towel."

The DHS assigned the referral as a Priority I and began its investigation on March 30, 2005. Documentation stated that when DHS contacted the mother regarding the child being placed into emergency custody, she “did not appear to be upset that the father [child’s maternal grandfather] allowed this to happen.” The DHS made a finding of Confirmed-Services Recommended regarding Exposure to Domestic Violence and Failure to Protect.

Law enforcement placed the child into protective custody. The DHS KIDS system documented the child was removed from the grandfather’s home on March 30, 2005. The DHS KIDS court screen documented the child was placed in emergency custody, and an Emergency Show Cause hearing was held on April 1, 2005. The district attorney’s office filed a petition to adjudicate the child as deprived on April 14, 2005. At the hearing regarding adjudication on April 29, 2005, the child was returned to the biological mother’s home, as voluntary services (CHBS) had been applied for and a voluntary safety plan was being followed. The court case was dismissed at this point. On May 12, 2005, a CHBS intake was completed.

#### Referral 2 (May 18, 2005)

On May 18, 2005, the DHS Child Abuse Hotline received a second referral alleging the two-year-old child had two olive-green-colored bruises on the forehead. The referral was assigned as a Priority I investigation, and DHS initiated contact with the family on May 18, 2007. Four collateral witnesses and the biological mother, when interviewed, stated that they did not know how the child received the bruises and reported the child was an active child. The referral also alleged the child had limited verbal skills and presented unkempt most of the time. The DHS made a finding of Services Recommended. The mother agreed to receive services (parenting classes and individual and family counseling) through a provider. In addition, the child continued to have cradle cap and the mother agreed to provide treatment for the cradle cap.

During the time of May 12, 2005, through June 29, 2005, the family was receiving CHBS services in the home. The family continued to receive CHBS services in the home, until they moved and could not be located after June 29, 2005. CHBS staff attempted several times to contact the family in July 2005. Finally, CHBS staff submitted a critical incident report to DHS Child Welfare Services. The DHS addressed the critical incident report in the May 18, 2005, referral, and the DHS case was closed on July 26, 2005. The DHS recommended that the mother participate in services with another provider.

#### Referral 3 (September 24, 2005)

On September 24, 2005, the DHS received a third referral regarding the family, alleging neglect of the two-year-old child. Reportedly, the child attended day care inconsistently or arrived late, and since July 2005, “things had not been consistent.” The reporter stated the child had been removed from the home previously. In addition, the referral alleged the child was dirty, was lethargic for a few days, and had vomited two times in

the last two weeks. The DHS screened out the referral without investigation. This was approximately three months after the family had moved during CHBS services.

#### Referral 4 (July 23, 2006)

On July 23, 2006, the DHS received a fourth and final referral on the child. The referral alleged abuse of the three-year-old child, due to severe head trauma. The DHS assigned the referral as a Priority I and initiated an investigation on July 23, 2006. The DHS made a finding of Confirmed-Services Recommended as to Failure to Obtain Medical Care, Failure to Protect, Threat of Harm, and Abuse-Child Death on the biological mother's boyfriend. The DHS made findings of Services Recommended regarding the biological mother and the biological father of the now-deceased child. The remaining child in the home, whose biological father was the boyfriend of the deceased child's mother, was placed with the child's biological mother, who agreed not to allow unsupervised visits with the child's biological father, the alleged perpetrator in the three-year-old child's death. Law enforcement arrested the boyfriend of the deceased child's biological mother. In August 2006, the boyfriend was charged with First Degree Murder in the death of the three-year-old child, and approximately one year later, he was convicted of First Degree Murder.

#### **Summary**

After the review of the case, the OJSO listed the violations of DHS policy relevant to the safety of the now-deceased child. The OJSO was unable to determine if the outcome of the child's life would have been different if the DHS had appropriately assigned the September 24, 2005, referral as an investigation regarding the then two-year-old child and had taken a more cautious approach in its decision-making regarding the family.

#### **Violations**

1. The DHS inappropriately screened out the referral of September 24, 2005, which alleged neglect of the two-year-old child. DHS policy OAC 340:75-3-7, Screening of reports, Instructions to Staff, (a), Criteria for screening reports, (1), states, "Great care is taken in making screening decisions. The Child Welfare (CW) supervisor considers the potential risk factors described by the reporter as well as the age and vulnerability of the child. Even if the report does not have clear cut allegations of abuse or neglect these factors are considered in making screening decisions. Reports regarding children three years of age and younger are screened with extreme caution because of vulnerability of this age group to serious and life threatening consequences resulting from abuse and neglect."
2. The DHS failed to complete a timely investigation of the allegations in the May 18, 2005, referral, which alleged possible physical abuse and neglect of the child. DHS policy OAC 340:75-3-13, Completion of the investigation or assessment process, (c), Time frames for completion of investigations or assessments, (2) states, "All paperwork in Priority I, II, and III referrals is completed and documented within 60 calendar days of the date the report is received."

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