

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT

Report of a Complaint Investigation
DHS Child Welfare Services

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Investigation conducted by April Simmons

Introduction

The Office of Juvenile System Oversight (OJSO) received a complaint on May 14, 2007, alleging the Department of Human Services (DHS) Child Welfare Services failed to follow policy in the handling of the past referrals. The family had history with the DHS regarding other children in the home, which included a previous child death investigation. There now have been two child deaths in the home of this family.

Interviews Conducted

DHS Child Welfare Field Liaison
DHS Supervisor
Assistant District Attorney

Documents Reviewed

DHS KIDS system case file

Findings

According to the DHS KIDS system documentation, at 3:00 pm on May 3, 2002, the DHS received a referral (referral 1) alleging a two-year-old child was in danger due to drugs in the home, domestic violence in the home, and other failure to protect allegations.

Referral 1 was accepted for an investigation and assigned on May 6, 2002, as a Priority II with a five day response time. According to the documentation in the Report to the District Attorney, the DHS investigator initiated the investigation at 2:30 pm on June 12, 2002. Although the time frame for initiation was five days,

the investigation was initiated thirty-seven days later. One child was in the home during the investigation of referral 1. The investigation was closed with the finding of "Services Not Needed".

At 4:13 pm on October 25, 2005, the DHS received a second referral alleging the four-month-old baby in the home was found unresponsive by the mother. According to the Report to the District Attorney, EMSA arrived at the home and transported the child to the local hospital. The child was pronounced dead at the hospital. It was also alleged that there were two other children of the mother in the home, which included an eighteen-month-old and a five-year-old. The referral also noted in the narrative of the allegations that the cause of death could be Sudden Infant Death Syndrome (SIDS).

The referral was accepted and assigned to a DHS investigator as a Priority I (within 24-hour response time) investigation on October 25, 2005. The child welfare investigator made contact with a detective from the local law enforcement agency at 2:00 pm on October 26, 2005. The documentation for the interview with the detective in the Report to the District Attorney, did not contain information in regard to the criminal investigation or information regarding the cause of death. It contained limited information.

At 3:00 pm on October 26, 2005, the investigator documented a failed home attempt. The Report to the District Attorney documentation showed the second failed attempt occurred at 9:00 am on October 27, 2005. The third attempt occurred at 1:50 pm on October 27, 2005, in which the child welfare investigator, "mailed [a] contact letter" to the family. The next contact entry in the Report to the District Attorney occurred at 12:30 pm on November 15, 2005. The investigator documented a face-to-face visit with the eighteen-month-old child and mother at the home. However, according to the report, the father of the children was not interviewed due to he "was reportedly in jail". In addition, there were no other attempts to locate and interview the father until June 12, 2006, (six months later).

The Report to the District Attorney for referral 2 documentation did not contain another contact regarding the investigation until May 24, 2006, at 2:38 pm (six months later). This contact was from the Medical Examiner's office, which included the cause and manner of death. The report contained the manner of death as "natural" and the cause of death as Sudden Infant Death Syndrome (SIDS). At this time the only contact was made to the mother and the child.

At 6:00 pm on June 12, 2006, the Report to the District Attorney documented a face-to-face failed attempt with the father. The documentation indicated several computer searches were completed and the father could not be located.

The Report to the District Attorney for referral 2 did not contain any other collateral contacts or documentation that the safety of the remaining siblings was

assessed. In addition, the father of the children was not interviewed. The investigation was closed on June 22, 2006, with a finding of "Services Recommended".

According to the DHS KIDS system, at 1:16 pm on August 23, 2006, (just two months after the referral 2 child death investigation was closed), the DHS received a referral (referral 3) alleging the mother was "intentionally inflicting trauma as a means of drug seeking behavior." Also, "the child's father walked in on the mother in the bathroom cutting her leg." It was also alleged, "the water has been turned off in the home", and the mother "was hearing voices telling her to do something to her child." In addition, the allegations included, "the parents lost a child at 4 months of age due to SIDS." It also stated the father took the child and does not plan on returning the child to the mother. However, in referral 2, the father was never interviewed regarding the child death due to his alleged incarceration and other outstanding warrants; he was unable to be located.

According to the documentation in referral 3, it was screened-out (not assigned for an investigation or assessment and closed) with the following information, "There is no history and the father took the child with him and stated he was not going to return the child. Not C/N on this child". Not only was there history on the children, there was a previous child death investigation that was later determined as SIDS.

According to the DHS KIDS system, at 1:45 pm on August 24, 2006, another referral (referral 4) was received at the DHS office. The allegations contained more detailed information as referral 3 with a different reporting party. According to the documentation in referral 4, the referral was screened-out to close with the following information, "The father has taken the child over to his sister with him. Police left child with the biological father. [Father's name] stated his wife [mother's name] is at [listed address]."

According to the DHS KIDS system, a referral (referral 5) was received at 12:05 pm on January 14, 2007, alleging the two-year-old child was found dead at the home of the father. Referral 5 was accepted as an investigation and assigned to an investigator as a Priority I. Presently, there are no other children in the homes of either parent. The DHS is waiting on the Medical Examiner's report to complete the investigation. In addition, according to the investigator's supervisor, it is still unknown if any criminal charges will be requested by the local law enforcement agency. Law enforcement has indicated they are waiting on the Medical Examiner's report.

The OJSO contacted the District Attorney's office and asked if criminal charges will be filed. The Assistant District Attorney informed the OJSO that they were unaware of the specifics of the case and will wait to review a report from local law enforcement.

The OJSO contacted the DHS area Child Welfare Field Liaison (CWFL) for further answers that were not included in the KIDS documentation regarding the violations. The CWFL advised that the case had been reviewed and there were concerns regarding how the county screened out referrals and how assignments were made.

Violations

1. According to the Report to the District Attorney for referral 1, the DHS did not initiate the Priority II five-day-response investigation until thirty-seven days later. DHS policy OAC 340:75-3-8.6. General protocols for investigations and assessments, (b) Timeframe for initiation, states, "Investigations and assessments are prioritized using the priority guidelines in OAC 340:75-3-7.1. The priority guidelines are utilized to determine the response time required to ensure safety for the alleged child victim. Generally, the reported allegations that necessitate an investigation require a higher priority than an assessment."
2. The documentation in referral 1 indicated the investigation was not completed within thirty days. DHS policy OAC 340:75-3-13, Completion of the investigations or assessments process, (c), Time frames for completion of investigations or assessments, (1), states, "All investigative or assessment interviews with the child victim and PRFC(s) in Priority I and II referrals are completed and documented within 30 calendar days of the date of the report is received."
3. According to the DHS KIDS documentation for referral 2, the Priority I was initiated timely on October 26, 2005, but the investigator did not make face-to-face contact with the child until November 15, 2005 (twenty days later). The report documentation contained two failed attempts to the home and a letter was then mailed. The report does not document the details of how the face-to-face interview was finally arranged. In addition, the father's failed attempt occurred when the home visit occurred on November 15, 2005, and there was not another attempt until June 12, 2006, (seven months later). The documentation does not provide how the safety determination was assessed as to the risk of the remaining siblings in the home. The documentation does not indicate the investigator evaluated the safety of the child in order to perform the main function of Child Welfare. DHS OAC 340:75-3-10.1 Safety determination and responses, (a) Evaluation of the child's safety, states, "Evaluation the safety of the child is a primary Child Protective Services (CPS) function."
4. Referrals 3 and 4 were both screened-out inappropriately and did meet the criteria for an assignment of an investigation. In addition, the supervisor documented there was no history on the family. At the time of both referrals 3 and 4, the family had two investigations, one of which was

a child death investigation. DHS 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 factor described by the reporter and the age and vulnerability of the child." In the same section under (B) it states, "Reports regarding children three years of age and younger are screened with extreme caution due to the vulnerability of this age group to serious and life-threatening consequences resulting from abuse or neglect." DHS OAC 340:75-3-7 Screening of reports, (a) Criteria for screening reports, (3), states, "Reports that meet the definition of abuse or neglect and have sufficient information to conduct an investigation or assessment are assigned, including: (C) reports concerning a family with a history of previous reports. There may be a legitimate explanation why previous investigations or assessments did not reveal enough information to confirm the report."

Areas of Concern

- In referral 2, the investigator made contact with a detective from the local law enforcement agency prior to the initiation of the investigation. The documentation in the Report to the District Attorney did not contain information in regard to the criminal investigation, or information regarding the cause of death during the interview with the detective. In addition, there was no other contact with the detective later in the investigation.
- The documentation in referrals 3 and 4 also indicated the reasons for the screen-outs were due to the father took the child with him. However, the father was never interviewed in the previous child death investigation (just two months prior) because of his alleged incarceration and other outstanding warrants. Regardless of whether the child went with the father, that does not constitute a screened-out referral. The mother would have access to the child or even custody again at some point, and the father may or may not have been a suitable placement.

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