

60-day CIRT review report

Case Name: Bravo-Hamilton
Case Number: FQ76460

Date of Sensitive Issue: 9-4-06
Date CIRT Launched: 9-5-06

I. Introduction:

Oregon Department of Human Services adopted the Critical Incident Response Team (CIRT) protocol on November 1, 2004. This protocol was developed for the following purposes:

- To specify the Department of Human Services, child welfare procedures that will be used when a critical incident occurs;
- To increase the Department's accountability to the public;
- To ensure timely responses by the Department with respect to any critical incident in child welfare; and
- To increase the Department's ability to recommend necessary changes to statutes, administrative rules, policies and procedures, practices, training and personnel matters.

The initial findings of the CIRT in the case involving Keyana Bravo-Hamilton were reported in a 30-Day Report on October 6, 2006. The protocol requires that, within 30 days of completing that report, if system issues are identified, the CIRT must:

- Develop recommendations to address the system issues;
- Identify action steps. The action steps will be specific as to timelines, tasks and parties responsible for the tasks; and
- Communicate recommendations, action steps and progress to the public and stakeholders as appropriate.

As per the protocol, the above-identified areas are covered in this report. DHS has completed a comprehensive review and analysis of all child welfare involvement with the family that was the subject of this report and specifically the activities related to the injury and death of Keyana Bravo-Hamilton. The findings and actions described in this report reflect both local office actions as well as statewide efforts to address concerns and improve practice.

II. CIRT Reason: On September 4, 2006, 2-year-old Keyana Bravo-Hamilton was brought to Mt. Hood Medical Center Emergency Department by her relative foster parents, Armondo and Dunia Moreno. The child was not breathing and medical staff were unable to resuscitate her.

Keyana and her 4-year-old half-sister had been placed in relative foster care with the Morenos on June 9, 2006. The Morenos were the paternal aunt and uncle and were recently selected at an adoption committee to be the permanent placement resource for both children. The Morenos had a positive home study both in California and Oregon. The relative foster care placement had not yet officially been designated as the adoptive home.

On September 9, 2006, Ms. Moreno was arrested and, on September 18, 2006, she was indicted on charges including, but not limited to, murder. On September 18, 2006, Mr. Moreno was also indicted on criminal mistreatment charges.

III. CIRT Response and Case Status Update:

a. Criminal Investigation: Gresham Police Department is conducting the criminal investigation. As noted above, on September 18, 2006, Ms. Moreno was indicted on four charges, including: one count of murder by abuse; one count of murder; one count of criminal mistreatment of Keyana's older half sister; and one count of criminal mistreatment in the first degree for withholding medical treatment. On September 18, 2006, Mr. Moreno was also indicted on one count of criminal mistreatment in the first degree and the couple was charged with "intentionally and knowingly withholding necessary and adequate medical attention from Keyana." On November 29, 2006, at a Bail Hearing, the District Attorney presented a detailed account of the evidence that supports the above-noted charges. Ms. Moreno continues in jail, with no bail, and Mr. Moreno was released from jail after he posted his bail. Mr. and Ms. Moreno's trial is set for July 2007. DHS continues to work closely with law enforcement and the District Attorney's Office regarding this matter.

IV. CIRT Review Process:

a. Case Review Process:

The case file review was conducted at the Beaverton child welfare office by technical staff from Central Office. The CIRT Team developed a list of questions and areas of focus for this review related to the Agency's relative search, casework contacts, substitute care placement reviews, children's medical services, the adoption selection process and communication between agency staff. Actions of DHS staff were reviewed for compliance with administrative rule and policy as

well as approved practice. The review process was used to assist in the development of questions for subsequent staff interviews.

b. Staff Interview Process:

A human resources representative and a Children, Adults and Families Division's administrator conducted staff interviews with the caseworker for the case, the certifier/adoption worker and their supervisors. Appropriate actions were taken.

V. CIRT Findings and Action Taken:

A chronological analysis of this case indicates the findings that required follow up and additional action are as follows:

- 1. Finding:** File review indicates the number of face-to-face contacts with Keyana and her half sister met or exceeded the policy requirements. However, the timing of the face-to-face contacts sometimes did not meet the policy of once every 30 days. Other DHS staff, including certification, casework and Social Service Assistant staff, also had regular contact with the Morenos, both pre and post placement of the girls with the Morenos.

Analysis:

- Following the review, it was clear that even though the caseworker was late and did not meet policy requirements on three of the monthly face-to-face contacts, he did regularly visit with Keyana and her half sister and he did have a good understanding of their needs. He also exceeded the policy requirements in seeing the children in their foster home every sixty days (OAR 413-080-0055). It also appears the caseworker was late on three of the monthly face-to-face contacts due to increased travel time. It also seems likely the caseworker would have benefited from more direction on what to look for and what to assess during face-to-face contacts.

Action Steps:

- In November 2006, Beaverton Branch's child welfare program manager and supervisory staff discussed and clarified policy on face-to-face contact with all staff. The new child welfare procedure manual will also guide staff on a statewide level on how to best assess for safety of children during face-to-face contacts.
 - **Timeline:** Completed in November 2006

- **Responsible Party:** Beaverton Branch child welfare program manager and supervisory staff and staff from the Children, Adults and Families Division's Office of Safety and Permanency

2. Finding: Information in the case review indicated the Morenos were not in compliance with DHS certification rules, as they were operating a day care business in their home. The fact that this was occurring certainly increased the childcare responsibilities of the Morenos and may have increased the level of stress Mr. and Ms. Moreno were experiencing.

Analysis:

- In their pre-service/core foster parent training (which was provided in Spanish), the Morenos were clearly informed of the need to get approval from their caseworker prior to providing in-home day care. They were also given a copy in Spanish of the "Safety Standards for Foster Care, Relative Care and Adoptive Families."

Action Steps:

- The new child welfare procedure manual will guide staff on a statewide level on how to best ensure that foster and relative care providers are meeting certification rules.
 - **Timeline:** March 20, 2007
 - **Responsible Party:** Staff from the Children, Adults and Families Division's Office of Safety and Permanency

3. Finding: Law enforcement's investigation and interviews indicate there was another adult male relative, who had not been cleared by DHS, living in the Moreno home. When asked, Ms. Moreno denied to DHS staff that the adult male was living in the home. This was also occurring despite the fact that, at the time of their foster parent certification, the file information documents that the Morenos had been given written information that they needed to report changes in the home environment to DHS.

Analysis:

- The Morenos were given information in writing that they needed to report changes in the home environment to DHS. When asked, Ms. Moreno also denied to DHS staff that the adult male was living in the home. While DHS worked within their policy to assess adults living in the Moreno home, the procedures must provide direction for those situations in which conflicting information is presented by the foster parent.

Action Steps:

- The new child welfare procedure manual will guide staff on a statewide level on how to best address conflicting information presented by a foster parent.
 - **Timeline:** March 20, 2007
 - **Responsible Party:** Staff from the Children, Adults and Families Division's Office of Safety and Permanency

4. Finding: Neither the California Interstate Compact Study nor the local branch adoption committee expressed any concerns about the Morenos or their parenting abilities and both recommended placement of the children with the Morenos. However, the case review indicated that it was not well documented which materials had been reviewed in the adoption committee.

Analysis:

- Despite the fact that the California and the local branch adoption committee did not have concerns about the Morenos or their parenting abilities, it was difficult for the review team to determine what the local branch adoption committee had reviewed. It subsequently became clear that the paperwork completed at committee would need to be revised to address this issue.

Action Steps:

- The Adoption Selection Report (CF250) and the Current Caretaker Report (CF 251) will be revised to include: 1) the listing of reports reviewed at committee; and 2) additional space in the hard copy report for documentation under the heading "Summary of Families Presented, Strengths and Concerns."
 - **Timeline:** February 1, 2007
 - **Responsible Party:** Staff from the Children, Adults and Families Division's Office of Safety and Permanency

5. Finding: The Morenos were not given full disclosure from the case file regarding the children and their needs. The caseworker reports he gave this information verbally to the Morenos. These documents were written in English and the Morenos were Spanish speaking. It is not known whether or not there was a plan in place to get this information to the Morenos or how much information the family had actually received.

Analysis:

- Upon review, it is clear that although the Morenos were given verbal reports from the caseworker about Keyana and her half-

sister and their needs, they were not given written information from the case file that documented the children's medical needs and issues. It is likely the Morenos were not given written information from the case file since the Morenos were Spanish speaking and the documents would have required translation into Spanish. It also seems that DHS policy should require that adoptive parents be given full disclosure in writing of the children and their needs that they are adopting.

Action Steps:

- The state program office will review child welfare policy, procedure and forms and confirm that caseworkers have adequate direction in assuring that adoptive parents are given required disclosure regarding the children they are adopting.
 - **Timeline:** February 1, 2007
 - **Responsible Party:** Staff from the Children, Adults and Families Division's Office of Safety and Permanency
- An information memo will be sent to child welfare staff throughout the state. This memo will instruct staff to provide disclosure items listed on the CF963 (Required Information for Adoption Workers and Adoptive Parents) to selected adoptive parents prior to the placement of the child into their home. The signed CF963 form will be submitted to the state program office, adoptions unit, which will track the forms receipt.
 - **Timeline:** February 1, 2007
 - **Responsible Party:** Staff from the Children, Adults and Families Division's Office of Safety and Permanency

6. Finding: The case review indicated that the Beaverton Branch child welfare office received information that there was a need for medical follow-up for Keyana. The case review indicated there was no follow-up regarding the concerns.

Analysis:

- The review found the caseworker had received information about the need for medical follow-up for Keyana, as the letter was found in a file on his desk. However, despite this fact, the caseworker reports he had not seen the letter and that he was not aware of the concerns. It appears the lack of follow through was due to a system problem at the Beaverton Branch which did not ensure that critical information was processed timely.

Action Steps:

- In November 2006, the Beaverton Branch child welfare program manager examined the Branch's practice regarding mail and faxes. Management subsequently developed and communicated a new procedure and process to ensure that critical case information is delivered and addressed in a timely manner. This includes, but is not limited to, mail, fax and file correspondence.
 - **Timeline:** Completed in November 2006
 - **Responsible Party:** Beaverton Branch child welfare program manager

7. Finding: The information Ms. Moreno provided about herself and her childhood for the adoption home study contained information that needed further assessment and which was not documented and fully assessed in the adoption home study.

Analysis:

- The review found that Ms. Moreno did report information concerning her childhood that should have been assessed more fully by the certification/adoption worker and subsequently noted in the adoption home study. It was found the information was not assessed largely because Ms. Moreno was a relative to the children and the certification/adoption caseworker incorrectly believed that DHS policy did not require as thorough an assessment for relatives as compared with general applicants and non-relatives. While this issue did not rise to the level of disciplinary action, it did indicate the need for additional training on certification and adoption standards.

Action Steps:

- Permanency consultants from the state program office will develop and present a practice forum for certification and adoption workers at the Beaverton Branch child welfare office to enhance their ability to assess and document information from the applicant's personal history. This training will also be provided at the Certification and Adoption Quarterly Meeting.
 - **Timeline:** March 1, 2007
 - **Responsible Party:** Staff from the Children, Adults and Families Division's Office of Safety and Permanency

8. Finding: A review of this case should have occurred by the Citizen Review Board in January 2006. However, this review was not scheduled.

Analysis:

- The review team found that on July 6, 2005, the court combined the Permanency Hearing of Jasmine and her older half-sister, since the children were on different court schedules. After the cases were combined, it appears there was a mistake on the Court and Citizen Review Board's tracking list as this system noted that a Permanency Hearing should have taken place in January 2006. This was inaccurate, as the Permanency Hearing should have taken place 12 months from July 2005, or in July 2006, and a Citizen Review Board Hearing should have taken place in January 2006. This error appears to be specific to this case and it does not appear there is a larger system issue.

Action Steps:

- In November 2006, Beaverton Branch's child welfare program manager met with the local CRB coordinator to discuss the county's CRB scheduling practices and notification of upcoming reviews from CRB to the Beaverton Branch child welfare office. It was determined that Keyana and her half sibling were not on the CRB tracking document, which pulled data from both the Court and DHS computer information systems. Beaverton Branch's child welfare program manager and the local CRB coordinator will continue to work together in determining exactly why Keyana was not on the CRB tracking document.
 - **Timeline:** January 1, 2007
 - **Responsible Party:** Beaverton Branch child welfare program manager

9. Finding: The case review indicated that some hand written case notes were not translated from Spanish to English and were not entered into the child welfare information system so that the information was available and accessible for supervisor review. The review team also found that there were some hand written case notes written in English that were not entered into the child welfare information system in a timely manner so that the information was accessible for supervisor review.

Analysis:

- In this particular case, there were written case notes both in English and Spanish that were not also documented in FACIS. The review team found the primary reasons the notes were not entered in FACIS were: 1) the caseworker had been employed as a Social Service Specialist for less than a year; and 2) DHS policy does not have clear guidelines for a caseworker regarding

timeliness of case note entry as the current policy only states “Face-to-Face contact and unannounced visits must be documented in the electronic case file (FACIS) in the ‘Case Notes’ section.” The current policy also does not address whether written case notes must be documented in English. The review team also found that due to the lack of clarity in DHS policy regarding the timeliness of case note entry into FACIS, the above-noted finding may not be specific to only this case, but may be an issue in other child welfare cases.

Action Steps:

- Beaverton Branch’s child welfare program manager and supervisory staff will discuss and clarify with all casework staff the need to document case information in a timely manner into the state computer system (Family and Child Information System) and that all written case notes must be documented in English. Casework performance in this area will be reviewed in the yearly employee performance reviews.
 - **Timeline:** December 13, 2006
 - **Responsible Party:** Beaverton Branch child welfare program manager and supervisory staff
- Children Adults and Families field administration will review current guidelines for narrative recording and case note entry with all staff by January 31, 2006. Feedback and recommendations will be reviewed by March 20, 2007.
 - **Timeline:** March 20, 2007
 - **Responsible Party:** Staff from the Children, Adults and Families Division’s Field Administration