# 60-DAY CIRT REVIEW REPORT
## January 09, 2008 [1]
## Stephanie Kuntupis

## I. Introduction:

The primary purpose of the Critical Incident Review Team (CIRT) review process is to improve the Department's ability to keep children in its care safe by identifying gaps and improvements needed in practice, policy and training on a timely basis.

The 60-Day CIRT Report provides the following:

- A case status update
- A comprehensive review and analysis of the identified issues and pending questions from the 30 Day CIRT Report; and
- Action steps with specific tasks and time lines to address policy, practice and training needs identified in the CIRT Review Process.

## II. CIRT REASON:

Stephanie Kuntupis (DOB 4/13/05) collapsed at her foster home and was transported by ambulance to Legacy Emmanuel Hospital on June 22, 2007. Stephanie had critical head injuries that have been diagnosed as non-accidental injuries. Stephanie's injuries occurred while she was in foster care, in the care and custody of the State of Oregon.

## III. CIRT RESPONSE AND CASE STATUS UPDATE

The detectives from the Child Abuse Team in Multnomah County have completed their investigation surrounding the injuries to Stephanie and their reports have been forwarded to the District Attorney's office. The Grand Jury was held on 11/20/07 and the foster father was indicted on Assault 1 charges.

[1] Finalization of this written report was delayed but the case review process was conducted pursuant to the protocol timelines.

Local child welfare staff has completed the child protective services (CPS) assessment and there is a founded disposition.

Stephanie was released from Legacy Emmanuel Hospital on 9/14/07 and placed in a medical foster home. The agency is working to balance Stephanie's many physical therapy appointments with her need to spend time with her parents and her brother. She has frequent visits and efforts are being made to incorporate her parents' visit time with some of her appointments.

Stephanie continues as a ward of the court in the care and custody of the State of Oregon. Case plan decisions have been reviewed frequently with the court.

## IV. CIRT REVIEW PROCESS

### A. Case Review Process

Child welfare program staff with expertise in CPS, foster home certification and policy administration conducted a file review and evaluation of all case record information pertaining to Stephanie and her family. This file review was conducted over a 3-day period and was completed on 7/18/07.

Case documentation reviewed included:

1. Monique Peals' case file:
    - 307's (protective services reports)
    - Case notes
    - Medical documentation
    - 147a (narrative recording of case plan
    - 333 (narrative recording of case plan)
    - Evaluations for Stephanie prior to her injury (audio, speech, occupational therapy mental health records).
2. Foster Parent Certification file
    - 1011f's (consent for LEDS criminal history background checks)
    - Foster Home Study
    - Criminal records exception form
    - 11-11-05 Foster Home Study

- 7-7-06 Foster Home Study renewal
- 7-06 Plan for foster parent to complete initial 10 hours of training
- Results of FBI criminal records check

3. Other documentation
   - Face to Face contact notes
   - Caseworker notes
   - Social Services Assistant (SSA) visitation notes
   - Special Rate/Personal Care assessment

These records were also reviewed for screening and assessment referrals regarding Stephanie while she was in foster care. No referrals were made to the Child Abuse Hot Line during the time she was in foster care.

The review of these files resulted in the Identified Issues and Pending Questions outlined in the 30-Day CIRT report.

The area of focus for the case file review was compliance with statute, policy and practice focused on child safety.

**B. Staff Interview Process**

CAF Administration and Human Resources staff interviewed staff from Rockwood and Alberta branches. Interviews focused on issues and questions identified in the case file review related to specific incidents, documentation, procedure, training and supervision.

- Staff members were interviewed individually.
- Seventeen staff were interviewed, including two staff (Staff A and B) who have left DHS for other employment.
- Staff interviewed includes three (3) certifiers, four (4) supervisors, the CPS worker and supervisor, the permanency worker and supervisor, and the Child Abuse Hot Line supervisor and Program Manager. Also interviewed were the permanency worker and supervisor of a case of another foster child placed in the same foster home at the same time Stephanie was in the home.

- Second interviews were conducted with the three certifiers and one certification supervisor.

The number of staff involved in this single case warrants further assessment and is addressed in the analysis portion of this report.

The Human Resources interviews revealed a lack of case documentation in the automated Family and Child Information System (FACIS) on a collateral case with the foster home by Staff A and B. Information gathered during the file review process and interviews with Staff A and B suggest that staff communicated verbally. Correct procedure requires all incidents to be documented in FACIS.

The interviews and case file documentation revealed that a referral was made to the hotline regarding another foster child placed in the same foster home. The referral was closed at screening by a screening employee, and notification was sent to the child's worker, that worker's supervisor and the foster home certifier. However, notification was not sent to workers for other foster children in the home, including Stephanie's worker.

In addition to District 2 management developing and implementing a training plan to address documentation and proper notification procedures, appropriate corrective actions steps will be taken.

## V. IDENTIFIED ISSUES, ANALYSIS, AND ACTION STEPS

**A. Identified Issue:** The case file review raised questions about how information is shared among DHS staff and whether information was correctly documented. The pending questions to be addressed are:

1. Was information regarding suspected self-cutting by Stephanie's brother shared with the appropriate staff? What is the local process for sharing information among staff that have responsibilities in a single case?
2. Stephanie's mother pointed out bruises during the 5/29/07 supervised visit. Was this information shared with appropriate staff according to policy? Should this information have been reported to the Child Abuse Hot Line?

3. Regarding a report to the Child Abuse Hotline on another foster child placed in the same foster home as Stephanie, what is the protocol for sharing information among multiple workers with responsibility for other foster children in the same foster home?

**ANALYSIS:**

Current Policy Regarding Pending Questions 1 & 2

There is no written local or statewide procedure to assure consistent practice in sharing information among the DHS staff who supervise visits and the assigned caseworker. Because there is variance in branch sizes, units and staff assignments, it is difficult to have a single uniform procedure. However, a framework for sharing information and a required timeline for sharing that information is reasonable and could be applied at each branch. Many branches already have such procedures. Policy I.I.2 describes required documentation in the case file in the Case Notes section. This includes a record of the caseworker's observations of behavior, conditions or circumstances of what is seen or heard.

This Case

Separate interviews with staff regarding the possible self cutting by Stephanie's brother and the bruises on Stephanie confirm that staff supervising the visit left a voice message for Stephanie's caseworker and followed up with a personal conversation with that worker. The caseworker assessed the information and in the first incident relayed it to the brother's therapist and to the foster parent. Regarding the bruises, the caseworker determined that the injury was consistent with the foster parent's explanation and did not make a referral to the CPS hotline.

The caseworker did not make an adequate record confirming her conversation on either event. The SSA visitation notes were documented in the case file on both incidents.

Conclusion

The way staff shared information about the possible self cutting by Stephanie's brother and the bruises on Stephanie was an appropriate practice for sharing information. The worker's documentation of information shared and actions taken on both events was not adequate.

Policy in Place at Time of Incident Regarding Pending Question 3
Policy I.-AB.2 and I.-B.2.2.3 directs the "screener" who receives information related to a certified foster home or relative caregiver to notify and document that the screener notified each worker who had children placed in the same foster home, the assigned certifier and their respective supervisors of all information received.

This Case
On 6-12-07 a call was received at the Child Abuse Hot Line regarding another foster child in the same foster home as Stephanie. There is documentation that the worker for the child who was the subject of the referral, that worker's supervisor and the foster home certifier were notified of the report. Other staff interviewed reported no communication among other workers who had children placed in the same foster home.

Conclusion
The protocol in place in the District 2 Child Abuse Hot Line does not follow policy when a referral is "closed at screening." There is documentation that the worker for the child who was subject of the referral, the supervisor and certifier were notified as expected in policy, but the other workers who had children placed in the same foster home and their supervisors were not notified.

**ACTION STEPS:**

- With Central Office assistance, this local office will develop protocol for sharing information among staff that have responsibilities in the same case and documenting the information and that it has been shared among appropriate staff. This will include protocol for sharing information between SSAs, caseworkers, supervisor's certifiers and any other staff who have contact with the child, parents, and providers. This local protocol will be completed by Feb 18, 2008.
- Central Office program staff will share this protocol with other CAF offices across the state. Each local office will develop local protocol to address this practice issue and provide a copy of their local protocol to Central Office field by March 15, 2008.
- District 2 management staff will work with CPS program staff to provide training and direction to screeners, supervisors, caseworkers, and certifiers on policy I.AB.2 regarding sharing

information among staff when there is a CPS report on a child in foster care including those referrals "closed at screening." District 2 will identify a lead manager to coordinate and present the training by March 01, 2008.
- Central program staff will send a clarifying memo regarding policy I.AB.2 to all child welfare staff by Jan 23, 2008.

**B. Identified Issue:** The case file review raised questions regarding the role of foster parents in the foster home certification process, assessment of the applicants who have multiple aliases and the assessment of applicants who may not be able to perform the duties of a foster parent. The pending questions to be addressed were:

1. What is the local process for interviewing applicants for foster home certification? Was there a discussion with the foster father about his failure to complete required training?
2. How were the foster father's aliases and additional criminal history considered and assessed? Did DHS perform CPS background checks using the aliases?
3. What assessment was made regarding the foster father's ability to perform duties for young children with special needs?

**ANALYSIS:**

Current Policy Regarding Pending Question 1

Certification rules require a review of training at the end of each certification period. Policy II-B.1.1 outlines the responsibilities regarding the renewal of the foster home certificate including the confirmation of the completion of required hours of training and the development of a training plan for the new certification period. The same policy also outlines the steps the certifier must take with all applicants to complete the certification.

This Case

In July 2005 an initial special (emergency) certification was completed for the foster parents to care for their nephew. During this process the foster mother indicated that she wanted to be a regular foster parent. This is noted in the home study. Each certifier met with the foster father face to face as part of the interview process, but all stated the foster mother was the primary caregiver due to the foster father's out-of-town work schedule.

All required paperwork for the initial certification was completed. The consents for LEDS criminal history background checks were completed. The foster mother indicated no arrests or convictions and none were found. A Portland Police report indicated a charge of "Larceny/shoplifting" in 1992. This incident did not require an exception according to administrative rule.

The foster father self-disclosed a conviction for a 1992 misdemeanor of providing false information to police and careless driving. The certifier obtained an exception for this criminal history and noted on the exception forms that: 13 years had passed since the incident that resulted in the misdemeanor conviction; there were no subsequent convictions; the crimes did not involve children; and the foster father had a valid driver's license and insurance.

During re-certification in May 2007, the certifier noted that the foster father had not completed the required core 10 hours of training. The certifier arranged for the foster father to complete training via on-line training with "Foster Parent College." The foster father completed the following: Positive Parenting I, II, III; ADHD/ADD/ODD; Running Away; and initial orientation.

Conclusion

The foster father was a co-applicant in the certification process and was a full participant in the certification process. He was interviewed at the time of the initial certification and later by the ongoing certifier. He was not interviewed at the first recertification. The file does include one form with the box checked "other" referring to the foster father. According to staff interviews, this box was marked in error. The self-disclosure on the 1100f (criminal records consent) as well as information in the home study would confirm this error.

Allowing on-line training for foster parents who are unable to attend classroom training due to work schedules is within accepted practice.

Current Policy Regarding Pending Question 2

Policy I-G.1.4 requires reconsideration of a foster home approval upon receipt of any additional criminal history information not available at the time of the previous approval. This policy provides that DHS will review additional criminal history information not available at the time of the previous approval and reconsider the foster home approval to assess the

home for suitability. Any information that reflects on the decision making criteria must be documented and filed in the foster home records.

This Case

According to the criminal history unit data base, results of the fingerprint inquiry were completed on 8/31/05 - four weeks after the initial foster home approval. Additional criminal history information was identified on that report. The file has documentation that this additional criminal history information was received after the foster home was initially approved. The certifier and worker did not remember seeing this additional information. Branch practice would indicate that the certification clerk filed the additional information. There is no documentation in the certification file that the foster home approval was reconsidered after the agency learned additional criminal history information.

A CPS record check was not completed using the foster father's aliases nor after the additional criminal history information was received. During the CIRT process a CPS record check was completed using the additional criminal history information and no records were found.

There were three (3) different certifiers involved in this case at various times. The foster home was originally certified as a relative provider. The original branch uses a process in which an immediate Intake Certifier does the certification for relatives and child specific emergency placements. Once that certification is in place, an ongoing certifier is assigned. The practice of having one certifier assigned to do emergency or child specific certification and then transferring the certification case to another certifier is common practice in larger branches. This practice leads to expedited placement for children, but may also raise concern about the transfer of information that is critical to the certification process. The case was transferred later to the branch where all Indian Child Welfare Act (ICWA) cases are managed because the first child placed in this home was subject to ICWA.

Conclusion

The previous foster home approval was not reconsidered after receipt of additional criminal history information. Because of the local practice of having one certifier assigned to do emergency or child specific certification and then transferring the certification case to another certifier, this case had a number of transfers, which meant a number of different certifiers performed

different tasks. When cases are transferred, workers do not generally verify the accuracy of work that was done previously. This may have contributed to the initial foster home approval not being reconsidered after receipt of additional criminal history information. The practice of having multiple foster home certifiers for a single foster home warrants further assessment.

Current Policy Regarding Pending Question 3

DHS Policy II.B.1 requires that foster parents possess certain abilities and capacities to perform the duties of a foster parent. OAR 413-200-0308.

This Case

The certifier gathered information about the foster father's ability to perform the day-to-day duties of a foster parent. And the certifier documented that the foster father had clearance to perform those duties. As previously noted, each certifier met with the foster father face to face as part of the interview process, but all stated the foster mother was the primary caregiver due to the foster father's out-of-town work schedule.

Conclusion

While the certifier confirmed that the foster father could perform the duties of a foster parent, the primary basis of the certification for this family was the foster mother's abilities as a primary caregiver and the fact that the foster parents' biological children appeared to be well adjusted and exhibited no problems. Both foster parents are to be assessed equally and separately and that did not occur in this situation.

**ACTION STEPS:**

- Central Office will provide training and consultation to all District 2 certifiers on conducting a home study assessment that considers both foster parents equally and does not focus on the primary caregiver. This will be completed by Feb 15, 2008.
- Central Office will provide a practice forum at the next Certifier Quarterly meetings scheduled in February and April to provide training regarding the requirement to consider both foster parents equally in the certification process.
- District 2 management staff will provide direction to certification staff and their supervisors regarding current policy and subsequent criminal records information received after the initial certification. A process will be developed that insures that information is not filed without the worker having reviewed the information. The Rockwood child

welfare manager will be the lead on this action. This will be completed by Feb. 15, 2008.

**C. Identified Issue:** Stephanie had significant medical evaluations and medical procedures performed on two occasions and had emergency room visits. There is no documentation that DHS was aware of these evaluations, procedures or visits.

The pending questions to be addressed were:

1. Who signed the approval for medical procedures?
2. Was DHS staff aware of the medical issues and the visits to the emergency room?
3. What is the process used for foster parents to notify DHS staff about medical issues and needed or planned treatment?

**ANALYSIS:**

Current Policy Regarding Pending Questions 1, 2 & 3

DHS policy in place at the time of Stephanie's injury, required foster parents to notify the agency immediately of any circumstances in their home which reasonably could affect the safety or well-being of a child in foster care, including, but not limited to, any injury, illness, emotional or mental health issue, communicable diseases, accidents, or arrests. For example, policy II.B.1 requires foster parents obtain prior consent from DHS before a child receives medical care or undergoes a procedure other than routine medical care. In an emergency, the foster family must notify the child's work as soon as possible and no later than 24 hours after an injury requiring medical treatment.

This Case

Neither the caseworker nor any other DHS staff signed permission for any of the medical procedures performed during the emergency room visits. The caseworker received verbal reports from the foster parent regarding some, but not all, visits for medical treatment.

Conclusion

The current policy depends on the foster parent to convey the information to the caseworker, which was not done consistently in this case. The policy also provides that the caseworker clearly instruct the foster parent on how

and when information is shared. There is no documentation that this occurred.

**ACTION STEPS:**

- Effective in June 2007, Chapter IV, Section 21 of the CAF procedure manual clearly outlines consents and procedures for health care and medical emergencies. Supervisors in each district will review this chapter with all casework staff by Feb 28, 2008.
- Central office staff will explore the possibility of a method to alert caseworkers when a medical card is used in specific ways. Initial concepts include: alerting a caseworker if a child's medical card is used more than 3 times per month; the use of the card with multiple providers; or the failure to use the card over a period of months. A workgroup representing the DHS medical unit, the CAF field staff, and foster parents will make recommendations to Central office by March 15, 2008.

## IV. NEXT STEPS

Program and field administration staff will review the action steps monthly to ensure timely completion and to achieve necessary practice improvements.

A goal of the CIRT Review Process is to identify potential statewide systems issues. Program and field administration staff will assess the following list of potential statewide issues, identify which have policy and training implications and develop a plan to address those issues.

1) The potential misinterpretation of I. A. B.2 regarding notifying ALL workers and supervisors of children placed in a foster home when a referral of abuse and neglect is received at screening, including referrals that are closed at screening.
2) Assess the statewide practice of treating and assessing the potential foster father and potential foster mother equally in the certification process.
3) Assess the practice of foster parents notifying workers of medical emergencies and treatment of children in their home and the practice of workers instructing foster parent regarding when and how to notify DHS of medical emergencies and treatment of children in the foster home.

4) Identify and evaluate the practice regarding the use of intake and ongoing certifiers which results in multiple certifiers and multiple certification transfers. Is this a statewide issue? A large branch issue? Or an isolated practice?

The initial plan will be completed by March 15, 2008.

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