OFCO Issues and Recommendations[1]	Zy'Nyia Nobles DOD: May 27, 2000 Age: 3	Rafael Gomez DOD: September 9, 2003 Age: 2	Justice & Raiden Robinson DOD: November 14, 2004 Ages: 16 Months and 6 Weeks	Sirita Sotelo DOD: January 22, 2005 Age: 4
Alternative Response Systems			CA Policy should be amended to provide that in addition to providing ARS services, CPS may conduct investigations into allegations of child abuse or neglect.	
			CA policy should require CPS to review ARS exit summaries and determine whether ARS intervention adequately addressed issues described in the CPS referral.	
			CA should improve oversight and quality assurance of contractors providing ARS services.	
			A parent's participation with ARS alone, should not be used as a sufficient basis to reduce the risk tag or change a CPS intake screening decision on a subsequent referral.	
Assessment/ Evaluation (Lack of)		The severity and chronicity of Rafael's injuries alone suggested the strong possibility of physical abuse. However, the CWS worker did not assess his parents' risk for physical abuse.		Require greater assessment of non-parent adult caregivers in the home who will likely be providing care for a dependent child on a regular basis.

[1] OFCO completed an independent fatality report of *Robinson* in which specific recommendations were made. In *Nobles* and *Gomez*, OFCO identified issues and areas of concern for the fatality review teams to consider.

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Assessment/ Evaluation (Lack of) Cont'd	Case records showed that the DCFS caseworker had returned the children to their mother without obtaining a psychiatric/psychological evaluation or parenting assessment despite documented concerns about the mother's mental health and parenting capacity. OFCO asked the Community Fatality Team to consider this issue (**See** Mandated Reporting section).	The caseworker did obtain a "psycho-social" evaluation of both parents, but, this assessment was inadequate as assessment tools designed to measure the risk for physical abuse were not used and the worker failed to provide sufficient background information on the parents to the psycho-social evaluator.	Require CPS to attempt to obtain an evaluation when it is determined that mental health issues are a contributing factor to the alleged child abuse or neglect.	Current home studies should specifically address in detail, the extent and nature of care provided by other adults in the home, examine bonding/ attachment issues between the child and such adults, and explore whether further evaluation/ assessments of an adult caregiver is warranted.
Caseload			CPS workers' caseloads should allow them to meet department policy and "best practices" standards.	
			Area and Regional Administrators should be required to monitor caseloads of line workers, and develop a response plan when caseloads exceed an acceptable level.	
			CPS supervisors should not carry cases and conduct CPS investigations in addition to their responsibilities as a supervisor.	
			The quality of supervisory reviews suffers when supervisors are also handling case investigations, as it does not allow adequate time for meaningful case reviews and worker support.	

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Caseworker Bias	OFCO asked the Team to consider how the system can better protect against caseworker bias. Bias occurs when a CW develops an initial belief about a person or event and then becomes resistant to altering that belief even with conflicting information.	The case record indicates that the mother experienced ongoing difficulties caring for this child and made frequent complaints to her service providers and DCFS caseworker regarding the child's behavior. The mother described the child as self-injurious, physically aggressive, and possibly developmentally delayed. The mother stated that she was having difficulty understanding his behavior and that she needed more help caring for the child. There is no indication that these complaints caused the department to reassess the parents' ability to care for this child, or obtain additional evaluations of the child.		
		The caseworker provided information to the court and the CPT that tended to accentuate the parents' progress and minimize deficiencies.		
Child Protection Teams (CPT)		OFCO identified CPT membership, the decision making process, and the timing of CPT meetings as issues of concern.		
		The DCFS worker failed to provide complete information to CPT as it was deciding whether to support the worker's plan to return Rafael home.		

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Child Protection Teams (CPT) Cont'd		OFCO was concerned whether the CPT was provided with all medical reports and findings regarding the child's injuries, as well as reports of maltreatment after the child was returned home.		
		Information to the CPT accentuated the parents' progress and minimized deficiencies.		
Definition of Child Abuse/ Neglect			The legislature should consider amending the definition of child neglect, to recognize the harm that may result from an act or omission, or pattern of conduct, that constitutes a substantial danger to the child's health, welfare or safety, and allow earlier CPS intervention.	
			The legislature should consider changes to statutory provisions regarding child abuse and neglect, permitting the court to establish an in-home dependency for the purpose of implementing appropriate service and safety plans. A parent's failure to comply with a service plan or safety plan is a relevant factor which should be considered when determining whether conditions present a substantial threat of harm to the child.	

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Definition of Child Abuse/ Neglect Cont'd			When substance abuse is a contributing factor to alleged child abuse or neglect, state law requires CPS to cause a comprehensive chemical dependency evaluation to be made. Similar statutory requirements should exist to identify and treat mental health issues contributing to the neglect or abuse of a child.	
Guardian Ad Litem	The guardian ad litem did not appear to fulfill his independent investigation and monitoring duties. There was no evidence that supervisory or prognostic staffings occurred after 1998.			
Mandated Reporting	The Team was asked to assess the system for reporting child abuse and neglect. Specifically whether: the categories of service providers required by law to report abuse or neglect should be expanded; mandatory reporters should be required to receive training on their reporting duties; and DCFS should modify its internal system for handling abuse reports made to caseworkers in open cases.			

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Mandated Reporting Cont'd	There is no evidence that anyone involved with the family-including the caseworker and other individuals required by law to report child abuse or neglect acted on documented concerns about the children's possible abuse in their mother's care.			
Monitoring/ Health and Safety	The Ombudsman asked the Team to assess **the role of in-home service providers.** DCFS relies heavily upon in-home providers to monitor the safety of children. Yet**, many service providers do not see safety monitoring and reporting as part of their role in working with families.**	It is also **unclear from the record if FPS and Home Support Service providers were sufficiently trained to address child safety issues,** and mental health or personality issues identified in the mother's psycho-social evaluation.		Revise and implement policy requiring regular health and safety checks for children returned to a parent's care.[2] Make requirements for in-home health and safety checks of dependent children returned to a parent's care at least as stringent as the current standards set forth in CA Policy 01-02: CA Policy 01-02 requires in-home contact with the child, twice a month, during the first 120 days of in-home placement, for children age birth to five. After the first 120 days, visits must occur at least monthly.

[2] Children's Administration Practices and Procedures Guide establishes standards requiring caseworkers to conduct health and safety checks of children residing in out-of-home care. However, the current edition of the Practices and Procedures Guide is silent as to whether health and safety checks are required once a child is returned to a parent's care.

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Monitoring/ Health and Safety Cont'd	In-home services **and requirements to support the family and monitor the children's safety either failed or** were never put into place **by the caseworker.**	The parents were not required to utilize therapeutic daycare to help address Rafael's reported behavioral issues.		In addition to requiring regular and consistent, in-home contact between the caseworker and the child and parent, the department should **increase efforts to provide services to a child and family once a child is returned home.** Existing tools, such as safety plans and service contracts should be utilized to assure that families engage in appropriate services (**See** Services (Non-Compliance) section).
	DCFS must monitor the family after return of a child to ensure that in-home services agency indicated would be in place to support family are, in fact, in place.	**The CWS worker did not ensure that critical in-home support services were provided to the family upon the child's return home.** A public health nurse was not assigned to work with this family, as recommended in the parents' psycho-social evaluation.		The case record should specifically document steps taken to provide services.
				Expedite efforts by CA to address policy issues regarding health and safety checks of dependent children in a parent's care, and to revise department manuals.
				Assure that caseworkers and supervisors are aware of existing requirements regarding health and safety visits.

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Screening and Investigation	The **caseworker** and others required by law to report child abuse or neglect **did not act on documented concerns about possible abuse by the mother (see** Mandated Reporting section**).**	Case records indicate that Rafael sustained several severe injuries while living with his parents. Reports about these injuries were either not investigated or determined to be inconclusive or invalid by CPS workers. Moreover, on one occasion, a DCFS Child Welfare Services **(CWS) worker documented a service provider's concern about the suspicious nature of one of Rafael's injuries, but did not forward the concern to CPS for screening and investigation.**	Develop and implement an Investigation Master Checklist, designed to aid workers and supervisors to track investigative tasks and time requirements. Use of a checklist would assist supervisors to complete reviews in an efficient, consistent manner, verify tasks completed, and identify whether any further investigative action is required. Supervisors and workers should sign off on the checklist attesting that tasks have been completed.	
			Institute a standardized process for reviewing and documenting CPS investigations.	
			Strengthen supervisory review of CPS investigations.	
			CA should develop and implement corrective/ disciplinary action if supervisors or workers fail to comply with investigation standards.	
			CA Policy should be amended to provide that in addition to providing ARS services, CPS may conduct investigations into allegations of child abuse or neglect.	

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			CA policy should require CPS to review ARS exit summaries and determine whether ARS intervention adequately addressed issues described in the CPS referral.	
			A parent's participation with ARS alone, should not be used as a sufficient basis to reduce the risk tag or change a CPS intake screening decision on a subsequent referral (**See** Alternative Response Systems section).	
Services (Non-Compliance)	During the three-year period before the family was reunited, case records show the **mother had not completed court-ordered substance abuse services or parenting classes.** In addition, there was no evidence that she had completed or made progress in court-ordered mental health counseling. Yet, the caseworker returned the children to their mother.	The record indicates that the **mother consistently failed to comply with her out-patient treatment.** She also insisted on changing treatment providers whom she perceived as being critical of her progress. There is no evidence that this caused the DCFS worker to reassess his support for returning Rafael to parent's care.	CPS records indicate that mental health issues were a contributing factor to the mother's alcohol abuse and child neglect. **CPS did not assess or address these concerns (See** Assessment/Evaluation section).	Increase efforts to provide services to a child and family once a child is returned home. Existing tools, such as safety plans and service contracts should be utilized to assure that families engage in appropriate services. The case record should specifically document steps taken to provide services (**See** Monitoring / Health and Safety section).
				The department should continuously assess the need for and implement appropriate services, as long as a case remains open for supervision.

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Supervision			CA policy should also require that the substance of supervisory reviews, including the completed checklist, be entered in CAMIS.	
			CPS supervisors should not carry cases and conduct CPS investigations in addition to their responsibilities as a supervisor (**See** Caseload section).	
			The quality of supervisory reviews suffers when supervisors are also handling case investigations, as it does not allow adequate time for meaningful case reviews and worker support.	
System Checks and Balances	The Team was asked to consider how the system's checks and balances were overcome. The Ombudsman noted that inaccurate and incomplete information from the caseworker undermined oversight by the court and Child Protection Team. The guardian ad litem did not appear to fulfill his independent investigation and monitoring duties. There was no evidence that supervisory or prognostic staffings occurred after 1998.			