



**IN THE MATTER**

**of**

**T.J.**

**REPORT OF CHILD FATALITY PANEL**

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CHILD ADVOCATE**

**October 31, 2005**

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### ***PREFACE***

It is never easy to discuss, view and analyze the facts of how and why a child died. The process requires hard work, diligence, dedication, time, cooperation and finally, courage. Without the assistance of the following Child Fatality Panel Members and Staff, the Office of the Child Advocate could not have attempted to complete this process in a timely fashion. It is with sincere appreciation that the Child Advocate expresses her gratitude to the following people who made it possible to complete this report in a timely fashion.

Ms. Marianna Almeida

Senator Leo R. Blais

Ms. Gretchen Bushy

Patricia Byrnes, Esq.

Ms. Terese Curtin, MSW

Ms. Jan Dion Fontes, LIC SW

Major John J. Leydon, Jr.

Dr. Terrie Mailhot

Dr. Diane Martell

Sharon O'Keefe, Esq.

Ms. Catherine B. Walsh, MPH

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## **INTRODUCTION**

The Child Fatality Panel (hereinafter "CFP") is cognizant of the tireless efforts of the state social caseworkers in Department of Children, Youth and Families (hereinafter "DCYF") and challenges these workers face in performing their arduous work in complex society with many competing social ills. Neither this report nor its recommendations is intended to denigrate the skills, dedication and experience of those on the frontline of child welfare. Instead, it seeks to improve our child welfare system so as to insure the safety and prevent the death of any child in the State's custody. It should be noted that in the daily struggle to provide for children and families who are involved with the State, DCYF provides immeasurable assistance and care.

The Rhode Island General Laws §47-42-1 et seq. grants statutory authority to the Child Advocate to impanel a team of experts to conduct an independent and objective investigation into the fatality of a child held in the care of the State. Such a team was impaneled to examine the facts surrounding the placement of T.J. into his aunt's home and his subsequent death.

CFP reviewed hundreds of pages of documents and listened to hours of testimony. This report is a culmination of the hours of investigation, review and discussion of the facts surrounding this matter. The CFP reached consensus on the recommendations found in this report, and the methods to ensure compliance with the recommendations.

The report constitutes a public record under Rhode Island General Laws §30-2-(d) (16). Names of the persons involved are omitted in conformity with both the Office's confidentiality obligation under Rhode Island General Laws §42-73-1 et seq., and due to the panel's intent to focus on issues regarding the system of placement and supervision of the child.

Determination of any civil and/or criminal liability is not within the jurisdiction of the Office of the Child Advocate or the CFP. Such determination, if any, is left to the jurisdictions of the proper authorities, namely, the judicial system. Instead, the CFP seeks to establish the systematic changes that need to occur to ensure the safety of all children in DCYF care.

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## *SUMMARY OF THE CASE*

On September 11, 2001, T.J. was born weighing seven pounds and one ounce. The delivery was normal, although T.J. needed oxygen for the first twenty-four hours. Sixteen months later, it was apparent that T.J. was suffering severe delays in speech development. He had high lead levels and was referred to the Rhode Island Department of Health's Early Intervention Program at a neighborhood service provider in January 2003.

Early Intervention reports describe T.J. as a "clown" and that his smile and laughter made his mother proud. It was clear that he attempted to assert himself with his older brothers and sister. Although T.J.'s verbal skills were underdeveloped, his mother reported that he was forceful in his dealings with his siblings. T. J. was described as a boy who enjoyed running and being active. He was a motor driven child with good strength. T.J. was a curious little boy and he loved to vigorously throw things. He also enjoyed rough and tumble play with his brothers and sister. It was noted that T.J. had a good appetite and he was able to eat a wide variety of table foods. Although T.J. was not a neat eater at sixteen months, nonetheless, he was an enthusiastic eater.

While initially pleased to receive Early Intervention services, the mother discontinued services when the visiting nurse from the Early Intervention program reported her to DCYF after viewing signs of neglect. During a home visit in March 2003, the visiting nurse discovered the key to the apartment in the door. When the visiting nurse knocked, the door was answered by the school age child on a school day. The visiting nurse requested that the children wake their mother. When T.J.'s mother appeared, she explained that she had been out late the previous night and failed to wake-up in time to get the child ready for school. The visiting nurse noted the chaos in the home and in consultation with her supervisor reported matter to DCYF. While DCYF conducted a child protective investigation on this incident a finding of child neglect was not substantiated.

T.J. came to the attention of DCYF again, when he fell out of a second story window in March 2003. He fell out of the window again in August of 2003. It was not until he fell out of the second story window the third time on January 2, 2004 that DCYF "indicated" that the mother has failed to supervise the child. Thereafter, a "Straight Petition" is filed on behalf of T.J. to assess the mother's ability to care for four young children. The matter is assigned to a Family Services Unit social caseworker (hereinafter "FSU") on January 20, 2004.

On January 23, 2004, the mother is stopped for drug trafficking in Illinois and is arrested. It is later learned that the mother's sister and her baby nieces were with her at the time of the arrest. The mother asked the sister to take T.J. and his siblings, who had been staying with the maternal grandmother. The mother contacts the biological father. Upon the sister's return to Rhode Island, the three brothers remain with their maternal grandmother and the mother's sister gives the daughter to the biological father.

Although there is initial confusion, the FSU worker relying upon paperwork provided by the maternal aunt verifies that the mother has sole custody of the children. The mother requests that the children be given to her sister, until she can return to Rhode Island. The father of the children refuses to return his daughter to Rhode Island to go

into DCYF custody. Accordingly, T.J. and his brothers are placed with the maternal aunt in in January 2004.

The maternal aunt of the children resided with her boyfriend and had two children of her own prior to DCYF's validation of the placement of the three boys with her. The Aunt, twenty years old at the time, now had five children ranging in age from ages 2 years old to 8 years old, three of which were under the age of 4 years old. Neither the aunt of the children nor her boyfriend was employed. The two adults and five children lived in a one-bedroom apartment prior to DCYF accessing subsidized housing for the family on or about March 25, 2004 in order to eliminate the overcrowded situation.

The first recorded visit to the aunt's home by a FSU worker was March 15, 2004, more than a month and a half after the placement. Eight (8) additional notes were added to the case notes of T.J.'s file by the FSU worker after T.J.'s death. One such note was dated October 28, 2004, just two days before the fatal beating of T.J. These post-mortem case notes disclose that the FSU worker rarely spoke with T.J. or any of the other children placed in the Aunt's household. In fact, one visit documented that T.J. was asleep, so that no interaction could occur with the child at this time. An interesting fact noted from the interviews and documents provided by DCYF is that the Child Protection Unit worker noted indicators of child abuse in his interviews with the neighbors after the final beating of T.J. on October 30, 2004. The FSU caseworker, who had greater contact with the foster home, and apparently visited often, never indicated such information in her case notes.

On the evening of October 29, 2004, T.J., his two brothers and two young cousins were left in the care of a babysitter while T.J.'s foster parents went out for the evening. In the early morning hours of October 30, 2004, T.J.'s foster parents returned home. They found a mess in the home, which was blamed on T.J. Allegedly, the foster parents took turns beating T.J. to the point that he suffered severe trauma to his body and head. An emergency rescue unit was summoned to the home and T.J. was transported to Landmark Medical Center. Due to severe trauma, T.J. was then transported to Hasbro Children's Hospital. At 12:30 PM on October 31, 2004, T.J. was declared brain dead. T.J. died at 1:50 PM on October 31, 2004.

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## ***I. PLACEMENT***

### ***A. Foster Care Regulations***

The Foster Care Regulations 1998 require under Section IV (Criteria for Holding a Foster Care License/Certification) that prospective foster parents meet certain criteria regarding: age, health, income and fiscal management, family composition and personal characteristics, fostering ability, health and safety, comfort and privacy, and training approved by DCYF. T.J.'s aunt and her boyfriend failed several of the aforementioned criterion set forth in the Foster Care Regulations. Indicators existed that should have prevented DCYF from placing the children in the care of the aunt

and her boyfriend.

Although one must be twenty-one (21) years old to be a foster parent, an exception may be made if the proposed caretaker is a relative.. DCYF is allowed to consider relative placement if the person is eighteen (18) to twenty (20) years old. Yet, DCYF is also supposed to consider family composition. The FSU worker did not express concern during the placement interview about the capability of a twenty-year-old with two children under the age of two to be responsible for three additional children. There is nothing to suggest that this was even considered by the FSU caseworker. Next, it is also interesting to note that the FSU worker felt it appropriate to place the three children into a family where the two adults were not working and did not have adequate housing. Although more adequate housing was arranged for them, it is apparent that neither the aunt nor her boyfriend became gainfully employed during the nine months the three children lived with them. Accordingly, it is unclear how DCYF determined the pair to be financially responsible for five children receiving only state support.

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### ***B. Kinship Placement of T.J.***

Federal and State Law favor kinship placement for children coming into the care of DCYF\*. The FSU worker determines the initial placement of a child into a kinship home. There does not appear to be any formalized training for FSU workers regarding the safety and capability of the foster parents before assessing multiple factors to consider placing a child into a kinship foster home. Instead, an Application for Boarding Children (#036) and Preliminary Assessment of Family and Home are completed by the FSU worker and forwarded to two supervisors for their review and approval. Based upon testimony, this process can take many weeks, thus a child could be placed in a kinship foster home, which, may later be found to be inappropriate. Once the application is approved by the FSU department, it is forwarded to Licensing so a determination can be made regarding whether the kinship placement can be licensed by the department.

The procedure for kinship placement requires the FSU to call into Master File to check the chosen relatives' background to determine if they have had **any** contact with DCYF. This action is mandatory before the children are left with the family. In the case of T.J., it is clear that no one at DCYF (Master File, FSU or Licensing) actually read the DCYF case files prior to T.J.'s and his brothers' placement with the aunt and her boyfriend. A careful check of RICHIST or Master Files would have revealed that indicators existed that should have prevented the placement pursuant to the Foster Care Regulations. This is the first missed opportunity, which led to the death of T.J.

Although other DCYF witnesses were cognizant of the requirements of checking both juvenile and adult records of the potential kinship care providers, it was apparent that the Director of the Licensing Unit was unaware of the necessity of this requirement. A thorough review of the Master File system and RICHIST would have revealed that both the aunt and boyfriend had juvenile records with DCYF. Both of the records indicated substance abuse and/or violence, thus, making both the aunt and boyfriend ineligible to become foster care parents.

As a juvenile, the aunt had been referred to DCYF because CANTS indicated a Drug/Alcohol Abuse charge against her father for giving her marijuana to smoke and Lack of Supervision/Caretaker charge against the mother because the father gave her the drugs with the knowledge of her mother. A complete review of the aunt's records would have disclosed that five years prior to T.J.'s death, the aunt was known to use drugs. Within a one-year period prior to the placement of the three boys into her care, on two separate occasions, she was present in a car that was stopped for drug trafficking. She had been diagnosed with Oppositional Defiant Disorder and discontinued counseling, which has some bearing on whether she could successfully parent children.

The boyfriend was charged with possession of Marijuana with intent to deliver, which was later amended to simple possession. The boyfriend received one year probation and mandatory drug counseling. The boyfriend never complied with the mandatory drug counseling for drug use before the Family Court disposed of the case on or about his eighteenth (18th) birthday.\*\* Clearly less than four years prior to the placement of T.J. and his brothers into this home, the boyfriend had exhibited issues with substance abuse -- a factor which should have precluded placing any foster children into this family.

The licensing application indicated that the boyfriend stated that he had not been arrested. Yet, on May 24, 2004, the FSU caseworker determined that the boyfriend had not been truthful on this issue and conferred with the aunt regarding the news. According to DCYF policy, the boyfriend should have been required to move out of the premises. Based upon the protestations of the boyfriend that he was innocent and that he had not been arrested, only held, and that the record was supposed to be expunged, the Foster Care Regulations were not adhered to by the FSU caseworker. Although the FSU caseworker attempted to verify the boyfriend's assertions, hearsay information from out of state authorities does not provide the documentation necessary to assure the safety of children. The FSU caseworker justified leaving the children in the home on the supposition that "I just feel that sometimes people can be in the wrong place at the wrong time and arrests can occur..." in considering the criminality of a foster parent. Failure to appreciate the gravity of the situation and failure to follow the Foster Care Regulations constituted a second missed opportunity to protect T.J.

\* See 42 U.S.C. § 5113, R.I.G.L. §14-1-27.

\*\* The boyfriend's brother was also known to DCYF and the Juvenile Criminal System. He served time in the RI Training School for Felony Assault and Assault with a Deadly Weapon. In addition, the boyfriend's brother had been involved in a Termination of Parental Rights Action. These family issues should have been reviewed and addressed by DCYF.

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## ***II LICENSING***

Once the Preliminary Assessment and Application were approved by FSU and transferred to Licensing, it appeared additional opportunities to assess the family did not occur. First, the Supervisor responsible for reviewing the application before assigning it to a Licensing Worker did not do and independent Master File check for prior DCYF involvement. In his opinion, he felt that since three people from FSU approved the placement; and FSU had requested a background check from Master File; he was not responsible to review the application beyond checking to see if the correct documents had been forwarded to him. This is the third missed opportunity to

ascertain the true safety of the kinship placement.

Once the case had been assigned to the Licensing Worker (hereinafter "LW), the LW was responsible to review the paperwork and determine what, if any, impediments existed to prevent the home from being licensed. Upon the receipt of the "Physician's Reference for Foster Parents", on or about March 18, 2004, the form noted that the doctor refused to recommend the aunt for foster care. His exact written comment was, "Would recommend further evaluation". He later changed his position after a telephone call from DCYF.

When questioned as to why he changed his position by the CFP, he stated that a DCYF employee pressured him. She told him that the children would be separated from each other and dispersed to different homes and it would be his fault. Based upon the documents provided by DCYF, and testimony, it is the opinion of the CFP that the FSU had the most to gain if the children remained in the care of the Aunt. This led the CFP to believe that the FSU caseworker convinced the doctor to revise his opinion. Again, this fourth opportunity to protect T.J. by closely questioning the doctor was missed. Unbelievable, the FSU and the LW caseworker ignored the doctor's concern and pressured the doctor to change his recommendation for the "best interest of the children"\*

The next opportunity to protect T.J. and his siblings came on May 21, 2004. An email from LW to her supervisor states that disqualifying information was known about the boyfriend. In the email she requests guidance from her Supervisor as to whether she should discontinue the process to license the home. No documented response was forthcoming from the Supervisor.

On July 29, 2004, the same LW sent a handwritten note to the same Supervisor, yet again; there was no written documentation to discern what the response was from the Supervisor. The LW sent an email on August 23, 2004 to both her Supervisor and the Director of the Unit. There was no response. Again on August 30, 2004 an email was sent to both the same Supervisor and Director of the Unit and again, there was no written response.

When confronted with the documentation of the attempts to obtain guidance, the Director stated that her receipt of too many emails resulted in her not opening them and although the Supervisor noted he spoke with the LW at one point, he had no clear documentation to support his assertion. Clearly, LW's unanswered emails constituted a fifth and final missed opportunity to protect T.J.

At the insistence of the Director of Licensing, the LW completed the licensing process on November 3, 2004, three days after the death of T.J.

*\*The LW told the aunt of the doctor's statement. The aunt contacted the doctor to demand that he revise his opinion.*

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## RECOMMENDATIONS

### A. POLICY CHANGES

1. Directors of Licensing and/or Family Support Unit should make the decision to place children into kinship foster placements.

The final decision to place children in a kinship foster home should be made by an Administrator based on a careful review of the DCYF background and initial home assessment. This is especially critical in kinship placement since the children are placed in the home before the licensing process is completed.

2. Caseloads need to be reduced to no more than 14 families per social caseworker and an active supervision plan instituted by DCYF Administration.

The caseloads of the social caseworkers are untenable. It is clear from this matter that social caseworkers are unable to visit the very children they pledge to protect. Further, the social caseworker is required to not only provide services for the child, yet also for the parents in hopes of fulfilling the reunification goal. Accordingly, the caseloads need to be no more than 14 cases per social caseworker, or in the alternative, a clear policy decision made to limit the amount of high-intensity cases carried by any one social case worker. The Child Welfare League of America recommends no more than twelve (12) cases per caseworker.

It was apparent during the interviews that Supervisors and Administrators do not actively supervise their subordinates. There were no weekly or monthly meetings held to routinely review the caseload of the social caseworkers. It was stated by the Administrators and Supervisors that cases were only reviewed officially once or twice a year with their subordinates. The number of cases held by a social caseworker requires a more proactive supervision than is currently provided by the Administrators or Supervisors.

3. The failure of DCYF Licensing Unit to recognize the difference between licensing and assisting a prospective foster parent through the system.

There appears to be a lack of understanding regarding the regulatory role of the Licensing Unit. The directive of the Licensing Unit appears to be that it assists people through the process until they are successful or they withdraw. This assistance by the licensing Unit continues for as long as necessary. This is in contravention to the rules and policy that limit such reviews to six months. It is clear that a cultural change must occur within DCYF. It must be established that if a kinship provider has not successfully completed the process within a specific time frame that family shall not be licensed and the children, if any are present, be removed.

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4. The unsafe distinctions and practices made between generic foster placements and kinship placement during the licensing process.

The major problem that exists is that kinship placements are treated totally different from generic foster homes. While it is a priority for DCYF to place children with fit

and willing kin, safety must be a priority.

a. Licensing.

Children are placed into kinship placements without full background checks of the relatives. In the instant matter, as months went by information was discoverable that would have indicated that the placement of T.J. and his brothers was inappropriate. Before any child is placed in a home thorough background checks by both FSU and Licensing should be done.

b. Training for Foster Parents

The training for generic foster homes is 10 weeks. The training for kinship placement is one weekend. The purpose of extending the foster training is to gather information about prospective foster parents and to discern who will make successful foster parents. One weekend training for kinship placements does not establish the suitability of the relatives for foster placement.

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5. Convening of New Panel to Investigate the Licensing Unit.

The Office of the Child Advocate will convene a panel of experts to review the practices and protocols of the Licensing Unit. Based upon information gathered in this investigation, it is necessary to delve deeper into the serious problems that are exhibited in the management and direction of the Licensing Unit.

6. Disclosure of Professional Opinion.

In order to guarantee honest assessments of foster parents, it is imperative that a policy be created and upheld that will prevent FSU and LW from ignoring concerns or negative information received from a physician or licensed health care provider. In addition, the policy should state that if a doctor recommends that a prospective foster parent is not eligible to be a foster parent, the licensing process stops until the matter is resolved to the satisfaction of the Director of the Licensing Unit.

7. Removal of Children from Unsafe Foster Homes

It was clear from the interviews that no one was certain of who had the authority to remove children from unsafe foster homes. At points FSU felt only Licensing could remove children, while in other interviews, Licensing felt the sole authority rested with FSU or CPS. Clearly, a stated policy needs to be enacted immediately, so that it is clear to all units in DCYF who can remove the children and under what circumstances.

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## ***B. ACCOUNTABILITY***

1. Director of Licensing will be responsible for reviewing criminal records and determining whether the children can remain in the foster home.

Although DCYF believes that the discrepancy that exists between the Foster Care Regulations and the Licensing Policy regarding criminality of prospective foster parents was not at issue in T.J.'s death, the CFP found this to be untrue. In this matter, the boyfriend had a juvenile criminal history. Further, since there was not a clear finding that the adult criminal record had been expunged, he should have been asked to leave the home until the DCYF resolved the matter.

The safety of children should be paramount in all policy considerations. Accordingly, the CFP asserts that the Director of Licensing should review the criminal records and make a determination whether the children should be maintained in the foster home. It is clear that the foster care placement for T.J. was maintained as a kinship placement beyond the point that someone in the DCYF licensing system should have reviewed the Foster Care Regulations and recognized that the placement was improper.

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2. DCYF should have a special Triple I Unit on the premises to prevent delays in background checks.

To avoid delays, DCYF should have the Automatic Fingerprinting Information Systems ("AFIS"), BCI and finger printing capability. This would allow for swift background checks that would prevent months long delays regarding the suitability of foster parents. This may require a statutory enactment by the Legislature.

3. The lack of effective and efficient use of the technology that currently exists at DCYF that would allow tracking of both the licensing process and the interaction of social caseworkers with their caseload families.

DCYF has an excellent tracking system that is not utilized by the supervisors to monitor the work of the social caseworkers. Given the scope of the RICHIST system, it is unacceptable that FSU caseworkers are not mandated to place case notes into the system in a timely manner. In this instant matter, once T.J. died in October, the FSU worker posthumously added eight notes that were more than six months old to his record.

Further, the scope of information found in the system makes it inexcusable for FSU Administrators and the Licensing Administrators to forego checking into the backgrounds of prospective kinship placements and in addition to the reports they may receive from Master Files. This is especially true given that the Master Files are not a computerized system such as RICHIST.

In addition, RICHIST is an excellent tool for Administrators and Supervisors to use for daily reviews of caseworkers cases. It is an easy method to determine whether caseworkers are in compliance with monthly home visits and filling their case notes in a timely fashion. It should also be used to insure that licensing is completed according to the timeline set within DCYF policy.

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4. Notification to the Office of the Child Advocate when children are placed in unlicensed homes whether they are court-ordered or administratively approved.

During the interviews, it came to the attention of the CFP that over fifty unlicensed foster homes existed. These homes were either court-ordered or administratively approved by DCYF. It is clear that such homes require a greater scrutiny for the safety of the children. Accordingly, monthly updates of the unlicensed homes will be forwarded to the Office of the Child Advocate.

5. The Office of the Child Advocate shall start a process that will include the inspection of foster homes.

The Office of the Child Advocate has been instrumental in protecting children who are placed in institutions, group homes or day cares. We have not had a strong role in reviewing foster homes. Based on the facts of this case, it is clear that the office must now turn its focus to the issue of foster homes. Accordingly, the Office of the Child Advocate has a two-fold mission in this area. First, the Office of the Child Advocate must develop a strong relationship with the foster care community service providers; and second, start an inspection program which includes foster homes with an emphasis on kinship placements.

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### ***C. STAFF DEVELOPMENT***

DCYF has a stated policy that mandates twenty (20) hours of staff training. The previous director has not enforced it. Accordingly, we recommend that the Department actively enforces the policy.

#### **1. Supervisory Development**

During the interviews it was apparent that supervisors had not been trained to supervise social caseworkers. All of the supervisors had been social caseworkers at some point in their career with DCYF. The supervisors applied for advancement, successfully completed the hiring process and started as a supervisor without any training. It is imperative that the people supervising the social caseworkers learn how to set expectations for their subordinates and follow through with discipline if necessary.

#### **2. Ongoing Staff Development**

Generally, most of the social caseworkers and supervisors were not trained in the social welfare field and did not have any social work knowledge or class work. One of the most disturbing notes during the interview process was the underlying lack of ongoing training for the staff. The CFP acknowledge that the heavy caseload and court appearances impose overwhelming time constraints on social caseworkers.

Nonetheless, many of the state social workers hired prior to the implementation of the Child Welfare Institute in June 2001 lack formal social welfare training. For this reason, it is imperative to offer and mandate training to guarantee that all state social caseworkers are trained in the current social welfare methods and skills. Training would provide social caseworkers with the skills to recognize child abuse, substance abuse and trauma indicators. In the instant case, had the FSU caseworker been familiar with the indicators that evidence abuse in non-verbal children, this incident may not have occurred.

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#### ***D. EVALUATIONS***

1. Performance evaluation system used to establish whether DCYF staff follows protocols and procedures.

The lack of adequate evaluation and monitoring of staff in the instant case was an astonishing fact. The administrators do not evaluate the supervisors and supervisors do not evaluate their social caseworkers. In the event administrators or supervisors felt work was not handled properly, they did not initiate a formal review process. Further, no staff meetings were held to maintain a daily awareness of cases handled by the social caseworkers. During the interviews, the LW disclosed that she had the responsibility of over 300 cases. These cases had been delegated to her by the Director of Licensing. Yet, at no time had the cases been reviewed by the Supervisor or Director.

It is interesting to note that in talking with the four (4) supervisors who have been employed with DCYF for over twenty years, only one recalled having disciplined an employee. Clearly, an objective tool needs to be developed to review the work performed by supervisors and social caseworkers beyond the initial six-month probation period used by DCYF for the newly hired social caseworkers.

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### ***CONCLUSION***

It is the responsibility of the Office of the Child Advocate to monitor the implementation of the recommendations submitted in this report. Accordingly, the following timeline will be used to assess the implementation of the above-stated recommendations. A monthly report shall be submitted to the Child Advocate addressing the progress of the following changes:

#### **A. Policy Changes**

1. Directors of Licensing and/or Family Support Unit should make the decision to place children into kinship placements.

- **Immediate**

2. Caseloads need to be reduced to no more than 14 families per social caseworker and an active supervision plan instituted by DCYF Administration. - **June 2006**

3. The failure of DCYF Licensing Unit to recognize the difference between licensing and assisting a prospective foster parent through the system. - **Immediate**

4. The unsafe distinctions and practices made between generic foster placements and kinship placement during the licensing process.

A. Licensing. Background checks must be completed before placing children in the home. - **Immediate**

B. Training Curriculum and Incentives revised to resemble generic foster parent training. - **June 2006**

5. Convening of a New Panel to Investigate the Licensing Unit. - **Immediate**

6. Disclosure of professional opinion. - **Immediate**

7. Removal of children from Unsafe Foster Homes. - **Immediate**

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## **B. Accountability**

1. Director of licensing will be responsible for reviewing criminal records and determining whether the children can remain in the foster home. - **Immediate**

2. DCYF should have a special Triple I Unit on the premises to prevent delays in background checks. - **June 2006**

3. The lack of effective and efficient use of the technology that currently exists at DCYF that would allow tracking of both the licensing process and the interaction of social caseworkers with their caseload families. - **Immediate**

4. Notification to the Office of the Child Advocate when children are placed in unlicensed homes whether they are court-ordered or administratively approved.- **Immediate**

5. The Office of the Child Advocate shall start a process that will include the inspection of foster homes. - **October 2006**

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## C. Staff Development

1. Supervisor Development
  - A. Development of Curriculum. - **January 2006**
  - B. Implementation of Curriculum. - **April 2006**
2. Ongoing Staff Development
  - A. Development of Curriculum - **January 2006**
  - B. Implementation of Curriculum - **April 2006**

## D. Evaluations

1. Evaluation system used to establish whether DCYF staff follows protocol
  - A. Development of evaluation tool.- **January 2006**
  - B. Train Administrators and Supervisors to administer evaluation to
  - C. Implement Evaluation of Social Caseworkers.- **June 2006**

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### **APPENDIX**

### **CHRONOLOGY \*\***

3/10/03	CANTS INVESTIGATION - UNFOUNDED - Reporter (R) - Early Intervention Nurse - mother asleep, kids not in school, house unkempt, mother on antidepressants.
3/10/03	2 early warnings (EW) noted re: T.J. falling out window, 8/12/03 R-ER staff- T.J. fell out window; M left emergency room without exam on 8/18/03 - T.J. fell out window while mother outside usin
8/13/03	Mother files for divorce from Father. Requests custody of 4 child and child support.
10/22/03	Judge orders special notice of unanswered divorce complaint to F (NO SERVICE TO FATHER DOCUMENTED IN DIVORCE FI
12/15/03	Decision pending entry of Final decree in Divorce - sole custody of all 4 children to Mother

- Child support left open  
(NO FINAL DECREE ENTERED)

01/02/04 T.J. falls out 2nd story window at mother's apartment in W. T.J. at hospital - dislocated left elbow, no LOC, no injuries - no injuries on x-rays discharged without admission to hospital, referred to DC Hospital records note that mother says T.J. is very hyperactive and aggressive and 1 or 2 kids in family are ADHD; T.J. discharged home with referral to CPS

01/02/04 CANTS Investigation - CPI  
INDICATED - Lack of supervision  
Dr., Pediatrician vouches for mother's good care of T.J. and other k

01/08/04 Case opened to INTAKE on T.J. only

01/15/04 CANTS - EW - R from housing authority reports 2nd story window open when she entered house to inspect for safety.

01/15/04 DCYF decides to file STRAIGHT petition on T.J.  
-assessment of mother's ability to care for children;  
-mother may be overwhelmed caring for 4 young children.  
**\*\* Researched and drafted by Sharon O'Keefe, Esq.**

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01/20/04 case assigned to FSU SW

01/23/04 Mother arrested out of state.

02/04/04 T.J.'s father calls FSU SW. He tells her that he has moved back W. MA from FL because his wife is in jail in IL.  
-FSU SW called SP who verified arrest; Mother - held on \$25,000 bail  
-Father says his 3 sons are in the care of maternal Grandmother ; daughter is in the care of Maternal Aunt  
-maternal Aunt returns daughter to Father. Maternal Grandmother refuses to give Father his sons.  
-Worker conducts NCIC check on Father and his girlfriend.  
-Father has a charge of possession of Class C Fireworks  
-Girlfriend has no record.  
-Father wants custody of all his children.

02/05/04 FSU SW verified that Mother is in prison.

02/06/04 FSU SW calls Father - tells him clearances are done. She will come to his home Feb. 9, 2004, to inspect. She needs birth certificates

02/09/04 FSU SW cancels home visit with Father due to snowstorm and tells Father to come to court on Feb. 13, 2004.

02/13/04 ARRAIGNMENT on straight petition filed on T.J. Father is present.; referred to RILS. Family Court Judge, -Temporary Custody of T.J. to DCYF - continued to March 11, 2004 for PTC  
Father has birth certificate for son M and daughter M only.  
Father says he and Mother are not divorced.

Telephone call from Maternal Aunt to FSU SW; Father wants his kids; Maternal Aunt tells FSU SW about divorce and sole custody to Mother. She also says family is trying to make bail for mother. She will care for kids in interim.

02/16/04 FSU SW calls Maternal Aunt. Maternal Aunt has divorce paperwork and birth certificate. Father refuses to bring daughter Maternal Aunt.

03/09/04 FSU SW calls Mother. Mother says she has sole custody but has given the kids to Maternal Aunt. Mother tells FSU SW that she has spoken to Police Department regarding Father and they were supposed to charge him in August 2003. Mother says Father has paid **no** child support in 2 years and is wanted in two states for child support. FSU SW decides to seek the custody of other 3 kids.

03/10/04 LEGAL CONSULT- FSU SW and DCYF Attorney decide that Neglect Petitions on all 3 kids should be filed.

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3/11/04 COURT DATE - Father - No Show - defaulted as to T.J. Temporary Custody to DCYF; hearing continued for proof to April 15, 2004 . FSU SW reports to Court:

- 1) The mother's allegations regarding father;
- 2) Father's denial of allegations;
- 3) 10 yr Child's confirmation of mother's charges;
- 4) T.J. in relative foster care with Maternal Aunt, who has been part of the children's life since birth

03/15/04 Petitions on children are signed.

03/18/04 First visit to Maternal Aunt's home by FSU SW.

She notes: - 3 boys clean and appropriately dressed and so were Maternal Aunt's girls.  
- Maternal Aunt gave FSU SW copies of birth certificates and social security cards. FSU SW described WIC, foster board, health care and discussed Mother. Maternal Aunt said they were close. Maternal aunt said she had been present at birth of each child; and that Mother had a nervous breakdown when Father left her.

03/30/04 FSU SW called Father's mother and left a message for Father to call to set-up a visit and advise him that the court date was April 14, 2004

04/01/04 Licensing Supervisor calls FSU SW. Maternal Aunt's home pre-approved for foster care.

04/15/04 COURT - proof offered against father. FSU SW testifies to all the hearsay about father that she heard from M and child. Petition is amended to abandonment. Father - no show. T.J. committed to custody, care and control of DCYF.

- petitions on younger children filed.
  - no service on father on summons; hearing continued to May 2004
  - petitions include abandonment
  - petition regarding daughter dismissed
- NO JURISDICTION - Child is out-of-state with father

Telephone call from maternal Aunt with complaints about care father is giving daughter.

- 05/20/04 COURT HEARING - No service on father; continued hearing to June 10, 2004
- 05/24/04 E-Mail from Licensing Supervisor - Aunt's boyfriend has disqualifying information, even as a pending charge. 10:00 am on 05/24/04 ; FSU SW telephones maternal Aunt. Per maternal Aunt, Mother has ovarian cancer? FSU SW told mater Aunt that Aunt's boyfriend has disqualifiers and will have to mo out or she will remove kids.
- Aunt's boyfriend says a State Trooper stopped him with another guy who the stuff belonged to. He paid a fine of \$750. He was told to have police fax information on charges and disposition before 2:00 pm or FSU SW will remove the kids.
- 05/25/04 FSU SW calls Court in state where arrest occurred. FSU SW gave her the name of RB and K found information on RB only and said she would fax it to FSU SW.
- 06/10/04 Court hearing - continued.

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- 07/03/04 FSU SW returned Maternal Aunt's call - Maternal Aunt in scl
- 07/13/04 Mother sentenced and transferred to LCC.; sentenced to 6 years for manufacturing/delivering of cannabis; parole date 1/23/07.
- 07/15/04 "CEDARR does appear any other needs so will close case" Social Worker from B wants FSU SW to call.
- 07/29/04 COURT HEARING - FSU SW cannot get in touch with fathe Father doesn't return her calls. She was told by father's moth he has moved out of her home and PGM refused to give his n address or telephone number. The telephone number FSU SW had was disconnected.
- the three boys in relative care and doing fine.
- 08/17/04 Maternal aunt calls for clothing voucher.
- 09/09/04 COURT DATE - Public Defender wants to discuss guardians
- 09/14/04 Letter sent to father at PGM's address; father needs to contact
- 09/27/04 **TRIAL** - 3 boys committed 11/7/2005

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- 10/30/04 FSU SW notified of T.J. hospitalization due to abuse.
- 10/31/04 12:30 pm - T.J. "brain dead"  
1:50 pm - T.J. Deceased.

## **ADDITIONS TO CASE ACTIVITY NOTES - MADE POST MORTEM**

Notes regarding SCW visits to home of maternal Aunt and Aunt's boyfriend:

Entries Dated:

2/18/04  
2/20/04  
3/18/04  
4/23/04  
6/07/04  
7/23/04  
8/31/04  
10/28/04

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