

K.T.
Initial Critical Incident Response Team (CIRT) Report
September 2, 2009

EXECUTIVE SUMMARY

K.T. was sexually abused by her adoptive father. K.T.'s adoption was coordinated, recommended and approved through the Oregon Department of Human Services (DHS), and the adoptive family was also a DHS-certified foster provider. DHS had received numerous referrals, incident reports, certification reports and pre-adoption reports regarding K.T. and the family prior to receiving the report of sexual abuse.

Abuse of children in foster care is unacceptable and will not be tolerated. In this case, the events that reportedly transpired in K.T.'s foster/adoptive family's home were also unacceptable. This report reflects a pattern of inappropriate physical discipline and intimidation by a DHS-certified foster family – a family that was supposed to be a safe-haven for children who had been hurt or neglected by their biological families. The record shows that DHS was aware of those reports, and did not act appropriately to address them.

The issues identified in this report are significant and cause for serious concern. The recommendations in the Critical Incident Response Team (CIRT) report focus on the issue of multiple reports of abuse/neglect and incident reports -- spread out over several years -- that were never adequately documented or addressed during the department's foster parent certification process. To address those concerns, the CIRT Team is recommending the following immediate actions:

- The creation of a rapid response, Foster Care Safety Team comprised of law enforcement, child advocates, and other experts tasked within the next 90-days to perform a comprehensive review and analysis of foster care abuse data, reports of abuse in foster care – including those involving reports of abuse like several in this case that were “closed at screening”, and a representative sample of foster care certification files involving long-term foster homes to identify what steps the department needs to take to reach its stated goal of becoming one of the best and safest child welfare systems in the country;
- Also within the next 90-days, a comprehensive review of rule, policy and procedure to determine and implement changes to improve communication in the Field between staff who investigate reports of child abuse or neglect

and staff responsible for safety in foster homes when a safety threat has been identified in a DHS-certified foster home; and

- The development of additional, specialized training for Child Protective Services supervisors and staff regarding reports of abuse or neglect in foster care as well as additional training to promote consistent responses to reports of abuse and neglect, including those involving DHS-certified foster parents.

SUMMARY OF REPORTED INCIDENT THAT LED TO THE CIRT

On January 9, 2009 the Department of Human Services (DHS) and law enforcement personnel responded to a report that 15 year old K.T. had been sexually abused by her adoptive father. During the investigation, K.T. disclosed to a Child Protective Services (CPS) worker and to law enforcement personnel that she had been sexually abused by her adoptive father. K.T.'s adoptive father was arrested in February, following an investigation by law enforcement. In July 2009, K.T.'s adoptive father pled guilty to four counts of sodomy and one count of first-degree sexual abuse. He received a 175 month sentence.

At the time the January 2009 report was received, K.T.'s adoptive parents were also DHS-certified foster parents and had foster children in their care. In the years prior to the current report, the family had more than 90 foster children in their care.

Because this was a serious injury to a child known to the agency, on February 26, 2009, DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened.

Because the focus of this report was on the agency's actions regarding certification and approval of K.T.'s adoptive parents, because of the size of the record, as well as the overlay of the law enforcement investigation into the crime against K.T., release of this report was extended beyond the initial 30-day period. This is the first report of the CIRT team.

BACKGROUND

K.T.'s adoptive family had been involved with the Department of Human Services for nearly 20 years. They were a certified foster home for over 13 years, and had also adopted three children who had been placed with them by DHS. For the purposes of this CIRT document K.T.'s adoptive father will be referred to as W.T. Likewise, K.T.'s adoptive mother will be referred to as M.T. K.T. was first placed with this family as a 23 month old foster child on June 24, 1995, shortly after they became a certified foster home. This family subsequently adopted K.T.

There were a total of 9 CPS referrals on the family, including the referral on January 9, 2009. For the purposes of this CIRT document, when an incident is identified as a CPS referral it means that a CPS worker was assigned to assess the family. For the purposes of this CIRT document the CPS referrals will be referred to as Referral 001, Referral 002, Referral 003, etc. The first two referrals outlined in this section are regarding K.T.'s adoptive family before they were ever certified by DHS or had any children placed in their home. The referrals are regarding the family's biological children.

In addition, there were a total of 7 reports received by DHS about K.T.'s family which were closed at screening. When a report is closed at screening it means that a CPS worker was not assigned to assess the family and no further follow up was done. Reports that were Closed at Screening will be identified as Closed at Screening 001, Closed at Screening 002, etc.

Finally, there is information in this CIRT document from the family's certification file. The information is put into headings which include the following: certification and recertification information, foster parent incident reports, miscellaneous notes, and information about the adoption process including Current Caretaker Committee.

REFERRAL 001: Allegation of Sex Abuse; Disposition - Unable to Determine

On November 23, 1990, a child, D.H., M.T.'s biological daughter, disclosed she was sexually abused by her biological father (M.T.'s ex-husband.) The referral disposition was Unable to Determine based on "inconsistencies" in the child's report. Law enforcement suspended their investigation, and the father was not believed to be in the home. During subsequent interviews and evaluations conducted as part of the assessment, the child continued to disclose abuse that the evaluators determined was consistent with a history of sexual abuse.

CLOSED AT SCREENING 001

In January 1991, D.H. reported she was hit by her mother, M.T.; however, there were no injuries and the report was closed at screening. This was an appropriate disposition for this report.

REFERRAL 002: Allegation of Sex Abuse; Disposition – Unable to Determine

On August 18, 1993, DHS again received a report that D.H. disclosed sexual abuse by her father (M.T.'s ex-husband.) DHS did not make contact with D.H. until October 1993 and did not interview her. Documentation in the file indicates DHS

believed that these were not disclosures of new incidents of abuse, but were the same disclosures that were referred to in Referral 001. It is unclear how this disposition was reached since no interviews were conducted.

CERTIFICATION

In 1995, K.T.'s adoptive parents were certified for the first time as foster parents for DHS. Paperwork was completed as required, and both M.T. and W.T.'s criminal background checks showed no criminal record. Four positive references were received, including one from a certified foster parent. An exception was required due to M.T. providing in-home daycare. The appropriate paperwork was completed for the exception and was placed in the file.

A child abuse background check was completed as per policy. The certification home study contained the information about Closed at Screening 001. In the study, the family's child welfare history regarding the child D.H. was explained as this child having difficult behaviors.

The home study does not address D.H.'s disclosures in 1990 and 1993 of sex abuse by her father (M.T.'s ex-husband).

The home study includes information from W.T. that he used to have a bad temper, but that now he seldom loses his temper. When he gets angry now, he "rants and raves." It is unclear how this information was assessed in the certification process. At the time of certification, D.H. was living with M.T. and W.T. W.T. is D.H.'s stepfather.

ORIGINAL PLACEMENT

On April 21, 1995, M.T. and W.T. had their first foster child placed in their care.

On June 24, 1995, K.T. and her sibling were placed in the M.T. and W.T.'s care.

INCIDENT REPORT 001

On January 29, 1996, M.T. became frustrated with a four year old foster child for throwing a tantrum. She threw a phone book in the air hitting the child in the head. The action taken was that a DHS worker spoke with M.T. about her frustration level. There were no reported injuries. The incident was documented as a Foster Parent Incident Report. The certifier spoke with M.T. about managing her frustration in a different manner. There was insufficient information to determine whether a referral should have been generated.

RECERTIFICATION

March of 1996, K.T.'s family was recertified, and the recertification was positive. There was no reference to Incident Report 001.

INCIDENT REPORT 002

On April 1, 1996, M.T. reported to her certifier that D.H. "flipped out" because she did not like the babysitter her mother had left the children with. LEA was called to the house. D.H. left the home on April 10, 1996 to live with relatives. There was documentation that the matter "appeared to be resolved." It is unclear if this child leaving the home resolved the issues. It should be noted that at the time LEA was called, D.H. was a minor. The incident was documented as a Foster Parent Incident Report.

CERTIFICATION CONCERN

On April 30, 1996, DHS learned for the first time that M.T. had a significant personal issue which she had not disclosed previously to her certifier. This issue was addressed with the family and family supports.

REFERRAL 003: Allegation of Mental Injury; Disposition – Unfounded

On December 18, 1996, DHS received a report that two foster children in M.T. and W.T.'s home disclosed inappropriate disciplinary techniques by W.T. The children, who were approximately 5 and 6 years of age at the time, each disclosed that as punishment they were put in a highchair in the garage. W.T. admitted to some of things the children reported. Even though M.T. and W.T. were foster parents, they were offered services similar to those offered to biological parents. The allegation was determined to be unfounded. It is difficult to determine whether this was the appropriate disposition because the record does not indicate what was admitted by the W.T. It is also unclear from the record whether this information was forwarded to the family's certifier.

RECERTIFICATION

On March 25, 1997, the family was recertified as a foster home for DHS. The recertification study stated that M.T. had many positive attributes and was one of the foster parents in the county that could take on the more difficult special-needs children. The certifier reported the family continued to provide excellent physical and emotional care to the foster children in their home. The recertification study did not address Incident Report 002, the Certification Concern or Referral 003.

CLOSED AT SCREENING 002

On September 24, 1997, DHS received a report that a six year old foster child disclosed that her foster father, W.T., “throws her against the wall.” The child had injuries on her back. When contacted, the foster mother, M.T., minimized the action by saying that her husband would put the child firmly against the wall. This information was Closed at Screening. The incident should have been assigned for a CPS Assessment.

REFERRAL 004: Allegation of Threat of Harm; Disposition - Unable to Determine

On February 10, 1998, DHS received a report that M.T. was using marijuana on a daily basis. The referral was assigned as an immediate response, and the four foster children were removed from the home. M.T. denied daily use, but admitted to a single use within two weeks of the report. All tests came back negative, and two of the four foster children were returned to the home. The disposition was unable to determine. The information should have been forwarded to the certifier.

RECERTIFICATION

March 17, 1998, the family was recertified as a foster home. The recertification form refers to the report in the file dated 2/98 (Referral 004).

REFERRAL 005: Allegation of Physical Abuse; Disposition – Unfounded

On September 17, 1998, DHS received a report that a previous foster child in M.T. and W.T.’s home disclosed that he witnessed children being “beaten with sticks and a wooden back scratcher,” called names, and forced to wear a dog collar. M.T. denied striking the children, but admitted to calling the children names and using an “invisible chair” for punishment, which involved making the children sit in a squatting position for a period of time. This report was determined to be unfounded for physical abuse. There was no documentation that this referral was forwarded to the family’s certifier.

INCIDENT REPORT 003

In October 1998, a foster child in M.T. and W.T.’s home was observed to have a small bruise on the arm which appeared to be a grab mark. The child also disclosed that food was being withheld as a form of punishment. The incident was documented as a Foster Parent Incident Report. There was no corresponding child abuse report. The incident should have been assigned for a CPS Assessment.

CLOSED AT SCREENING 003

On November 9, 1998, DHS received a report that a 10 year old foster child in M.T. and W.T.’s home was acting out sexually, asking children to get on top of

him while he was naked. There was no documentation to suggest that this information was forwarded to the certifier or addressed in any way.

RECERTIFICATION

In March of 1999, the family was recertified as a foster home, and the narration in the home study was positive. There was no reference to the CPS referrals in this recertification.

CLOSED AT SCREENING 004

On March 25, 1999, K.T.'s placement out-of-state disrupted, and K.T. and her sibling returned to M.T. and W.T.'s home in Oregon.

Note in File: April 12, 1999, Central Office staff phoned the Child Abuse Hotline with concerns reported by two individuals who had been in M.T. and W.T.'s home. The individuals expressed concern with the condition of the foster home, and the discipline being used by the foster parents. This was not written up as a report of child abuse nor was there any documentation that the screener contacted the individuals to gather more information.

RECERTIFICATION

In March of 2000, the family was recertified as a foster home, and the narration in the home study was positive. No reference to the CPS referrals was made in this recertification.

ADOPTION PROCESS

On March 14, 2000, a Current Caretaker Committee was held to consider whether M.T. and W.T. should be an adoptive placement option for K.T. and her sibling. It was determined that an adoption home study should be done to determine whether M.T. and W.T. could become a permanent adoptive resource for the two children. This type of committee is part of the adoption planning process for foster children who have been in a foster home for at least six months and the foster family is interested in being a permanent resource for the children. The family's DHS certifier was not present at the committee to discuss historical concerns. There was no documentation of the committee discussing the past closed at screenings, referrals or certification incident reports.

RECERTIFICATION

On March 28, 2001, the family was recertified as a foster home, and the narration in the home study was positive.

ADOPTION PROCESS

On May 7, 2001, a second follow-up Current Caretaker Committee was convened and the adoption home study was presented for K.T. and her sibling. The adoption worker discussed multiple concerns about the possible placement, and reported that many of the concerns had been addressed by the family. The adoption worker recommended that K.T. and her sibling needed to stay with the family, and that the strengths of the family as a resource outweighed the concerns. The case record includes psychological evaluations for both children that discussed their strong attachment to M.T. and W.T. and vulnerability if moved to another home. The adoption worker recommended M.T. and W.T. as the adoptive resource for K.T. and her sibling.

REFERRAL 006: Allegation of Physical Abuse; Disposition – No Disposition

On May 9, 2001, DHS received a report that K.T. was disclosing physical abuse, being thrown against a wall, by W.T. Additionally, the caller indicated that K.T. disclosed that other foster children were scared of M.T. and W.T. There was documentation in the certification file that the foster children were interviewed. Some children reported being afraid of W.T. Three of the foster children reported that W.T. would pull their hair. There was nothing in the documentation about K.T.'s disclosure of being thrown against the wall. Although the report was assigned, there was no documentation in the Family and Child Information System (FACIS) that a child abuse assessment was conducted. This incident should have resulted in a CPS assessment.

RECERTIFICATION

In March 2002, the family was recertified as a foster home. There was no mention of the CPS referral in the recertification.

CLOSED AT SCREENING 005

On March 9, 2004, DHS received a report that a 10 year old foster child disclosed that he did not want to go home because W.T. choked him. There was no injury to the child. There is not enough information provided to determine whether this should have been referred for CPS assessment. There was no documentation the certifier was notified of this information.

RECERTIFICATION

On March 13, 2004, the family was recertified as a foster family. The certifier documented that the Closed at Screening 005 regarding the allegation of choking was addressed. The certifier narrated in the study that the foster parents did not

use physical discipline. There was no further documentation as to how this information was addressed.

CLOSED AT SCREENING 006

On December 6, 2005, DHS received a report that police were called by M.T. because one of the children was “out of control.” The child reportedly kicked M.T. and hit another foster child. There is no indication that this was referred to the certifier.

REFERRAL 007: Allegation of Physical Abuse; Disposition – Unfounded

On November 6, 2006, DHS received a report that two foster children disclosed that W.T. would squeeze their heads and grab them by the neck. The referral was assigned and an assessment was completed. M.T. and W.T. admitted to being rough with children, but denied physical abuse. Disposition was unfounded because the children had no injuries. Given the difference in the children’s statements and the M.T. and W.T.’s statements, this referral should have been coded unable to determine and a referral made to the certifier.

RECERTIFICATION

In March of 2006, the family was recertified as a foster home. The certification file refers to Referral 007 the allegation of physical abuse that was Unfounded.

CLOSED AT SCREENING 007

On January 8, 2007, DHS received a report that two girls previously placed in this foster home had been sexually abused by W.T. At the time this report was received, the two girls were both adults and their whereabouts were not immediately known to the caller. The call was reported to the office in Gold Beach, Oregon. Since the family did not live in Gold Beach, the screener contacted a screener in Washington County where the family lived. The Washington County screener staffed the call with a supervisor, and the report was Closed at Screening with the following reason: “During a prior assessment, (child) made no allegations of abuse regarding (W.T.), as caller suggests. She made reference only to abuse by (a relative of W.T.). There is currently no information to support caller's allegations against (W.T).” Because the girls’ whereabouts were unknown and, therefore, additional information could not be gathered, it was appropriate not to assign this report.

RECERTIFICATION

On March 13, 2008, the family was recertified as a foster family. The certifier had face-to-face contact with all members of the household. The certifier also contacted caseworkers who had worked with the family in the past year. The comments were positive, but it was noted that most of the contact information was related to M.T., the foster mother. The certifier discussed the concern with W.T., the foster father about his yelling. During the conversation, the W.T. admitted to occasionally losing his patience.

INCIDENT REPORT 004

On March 25, 2008, a community member reported that the W.T. was observed yelling obscenities at his foster child.

REFERRAL 008: Allegations of Physical Abuse and Threat of Harm; Disposition –Unfounded

On July 16, 2008, DHS received a report that two children previously placed in this foster home were disclosing abuse by W.T. In the report it was stated that one of the children was eating dinner and dropped a plate. The child reacted by hiding under the table and crying. The other child stated that when they lived in the M.T. and W.T.'s home, they would be yelled at and physically abused for doing such a thing. One of the children described W.T. holding the other child down by the throat because the child dropped something.

Per policy, a staffing was completed with all the necessary DHS employees. The certification supervisor wrote a memo expressing concern with the fact that the issues in the foster home have remained constant over such an extended period of time. It was the same allegation throughout the years from different children, all with individualized explanations as to why those specific incidents were not substantiated. M.T. and W.T. denied the allegations, and the disposition was determined to be Unfounded.

REFERRAL 009: Allegations of Sexual Abuse and Threat of Harm; Disposition - Founded

January 9, 2009, DHS received the current referral in which K.T. disclosed she was sexually abused by W.T. The referral was founded for Sex Abuse to K.T. and Threat of Harm Sex Abuse for the other children in the home.

SYSTEMIC ISSUES

- Members of this CIRT team are extremely concerned about the multiple incidents in which information was documented in the certification file but

never reported to the Child Abuse Hotline. There were multiple incidents that, according to DHS policy, should have been documented as a Closed at Screening or referred to CPS for assessment. There were also multiple instances in which information received and sometimes even assessed by Child Protective Services staff should have been referred to the certifier.

- Also of critical concern were the numerous instances where M.T. and W.T. were certified and recertified a short time before and after abuse allegations had been made. To be certified, the Department requires all foster parents to agree not to use physical discipline against a foster child. In this case, even if the disposition of a CPS report of physical abuse was properly determined to be “unfounded”, M.T. and W.T.’s use of physical discipline with foster children was inappropriate and never adequately addressed by the department. Additionally, there were multiple reports of abuse/neglect and incident reports spread out over several years which also were not adequately addressed in either the re-certification or adoption processes.
- The CIRT team identified a significant systemic issue related to how information pertaining to foster families and prospective adoptive families is stored and shared between program areas, namely, Child Protective Services and Foster Care Certification.
- It is often difficult when reviewing a single case to determine whether the issues presented in that case are widespread throughout the system, or unique to a particular case. However, The CIRT team also identified a potential systemic issue with respect to how reports of abuse concerning DHS-certified foster parents were handled. The CIRT team would like more information to determine whether systemically, the fact that alleged perpetrators of abuse and neglect are foster parents, has any impact on the Child Protective Services response to those referrals.

RECOMMENDATIONS

The Department has made and implemented significant changes over the past several years that address many issues and concerns raised in this review. Most notably, these include:

- Implementation of the Oregon Safety Model which focused the Department’s effort on insuring safety throughout the life of a case including when a child is in foster care;

- A new, more thorough home study process for foster home certification and re-certification;
- Increased requirements for home visits by certifiers (now, in addition to every-other-month visits in a foster home by each caseworker assigned to each child in a foster home, certifiers must visit foster homes every 180 days);
- DHS is currently implementing a new statewide database, OR-Kids, to replace its existing database, FACIS. The new system will change the way child abuse reports about DHS Certified Foster Homes are recorded. This will make them easier to track and more accessible to certifiers and CPS workers. The new database is expected to be fully operational in July, 2010.

Nevertheless, the State, when responsible for the care and safety of children who have been the victims of abuse or neglect, should take all reasonable steps to insure their safety. Accordingly, it is imperative that the State act upon the issues identified in this case to protect children in its foster care system.

The CIRT team recommendations are as follows:

- The CAF Assistant Director should immediately convene a Foster Care Safety Team, comprised of law enforcement, child advocates and other experts, to do the following:
 - 1) Review and analyze the data surrounding the incidents of abuse or neglect in foster care in 2008 including, but not limited to, a review of the types of abuse and factors that cases involving abuse may have in common, in an effort to identify issues or factors contributing to the abuse or neglect and any changes in practice or policy that may be warranted;
 - 2) Review a sufficient number of foster home certification files involving foster parents who have been serving children for at least 5 years or longer to determine whether the issues presented in this case also are identified in cases in different parts of the state with different foster parents (i.e. are systemic in nature);
 - 3) Review a representative sample of child abuse reports relating to DHS-certified foster homes that were “closed at screening” and identify whether there are trends or practices that are inconsistent with statute, rule or policy and to determine whether a systemic issue (or issues) exist regarding the Department’s response to allegations of abuse against foster parents; and

- 4) Review all efforts for the last 10 years, including those currently in process, by the Department to ensure the safety of children in foster care.

ACTION – Based on the data and case reviews, the Foster Care Safety Team should make recommendations of any additional improvements (including resources, changes in policy or practice, etc.) that may be needed. The Foster Care Safety Team has been asked to complete its review and analysis, as well as develop preliminary recommendations, within the next 90-days, with a final report and recommendations to the department no later than January 30, 2010. *(See also T. Sensitive Case Review, also published 9/2/09, which also references the work of the Foster Care Safety Team.)*

In addition, the following are steps DHS should take immediately that will begin to address the systemic issues that were clearly identified:

- The CPS Program, in conjunction with the Foster Care Certification Program and in consultation with Field staff, should immediately undertake a comprehensive review of rule, policy and procedure to determine what changes are necessary to improve communication in the Field between the two program areas when a safety threat has been identified in a DHS Certified Foster Home.

ACTION – This review should be completed by October, 2009 and identified changes implemented within 90-days of this report.

- To promote consistent responses to reports of abuse and neglect, all Screeners and those DHS employees whose job duties include determining whether information they receive is child abuse and who decide whether a report should be assigned to a CPS worker or closed at screening, should receive quarterly trainings specifically around these issues. The training should include, but not be limited to: screening guidelines, child abuse statutes (419B.005 and 419B.020) and practice discussions.

ACTION – Quarterly training opportunities specific to these issues should begin at the next Supervisor “Quarterly” held in January, 2010.

- DHS should develop a specialized training curriculum which addresses assessing child abuse allegations that occur in department certified foster homes.

ACTION – This training curriculum should be completed by October, 2009.

AUDIT POINTS

None

CONCLUSION:

In its strategic planning efforts, as well as in its Program Improvement Plan in response to the 2007 Federal Review of Oregon's child welfare program, the Department has set a goal of becoming one of the safest foster care systems in the country by drastically reducing the rate of abuse in foster care in Oregon. Any abuse by an out-of-home caregiver of a child who already has suffered abuse or neglect at the hands of his or her parents cannot be tolerated. As a state, we must expect that our children in foster care are safe and, in turn, we must support our child welfare system and our foster parents in such a way as to ensure that that expectation is met.

PURPOSE OF CRITICAL INCIDENT RESPONSE TEAM REPORTS

Critical incident reports are to be used as tools for identifying systemic issues when there are incidents of serious injury or death involving a child who has had contact with DHS. The reviews are launched by the Department Director to quickly analyze DHS actions in relation to each child. Results of the reviews are posted on the DHS Web Site. Actions are implemented based on the recommendations of the CIRT Review Team.

The ultimate purpose is to review department practices and recommend improvements. Therefore, information contained in these incident reports includes information specific only to the Department's interaction with the child and family that are the subject of the CIRT Review.

In addition, when a serious injury or death involving a child who has had contact with the Department occurs, the Department separately addresses any necessary personnel actions involving individual employees and/or their supervisors.