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Office of the Child Advocate

Tom C. Rawlings, Child Advocate

October 27, 2009

Mr. Mark Washington
DHS/DFCS
Two Peachtree Street, NW
19th Floor, Suite 490
Atlanta, GA 30303

Dear Mark:

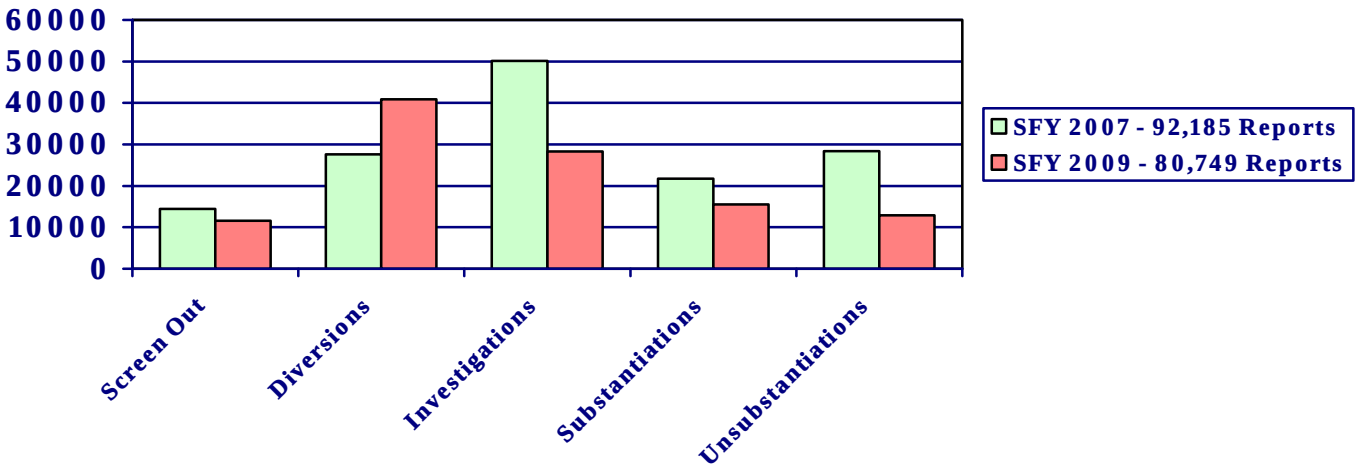
In the agency's response to our analysis stemming from the Bryan Moreno death, you rightly defended the agency's low rate for recurrence of maltreatment as measured by the official federal standard. I want you to know that we appreciate the work DFCS is doing to reduce the recurrence of maltreatment while maintaining children safely in their homes.

Perhaps due to my inartful wording of our concerns, however, your letter went on to defend against something we have not suggested: that is, that the Division should somehow stop using data to measure and guide its practice. That was not our intent, and I hope through this letter to clarify that we do not desire that you stop collecting data. On the contrary, we believe we would be able to better measure the safety of our children if the agency were to collect and report on more data.

The Division responded to our observations in part by highlighting the low rate of recurrence of maltreatment as measured by the federal standard. Our state currently does well on this standard with a recurrence rate of less than 3%, and that should rightly be a point of pride for the agency. That particular recurrence rate is calculated by identifying all children who suffer a substantiated incident of maltreatment during the first six months of the year; determining which of those children have a second incident within six months of the first incident; and then dividing that numerator by the total number of children who are substantiated victims of maltreatment during the first six months of the year.

In other words, the federal recurrence rate measures the safety of the victims whose cases DFCS has investigated and substantiated; however, we substantiate only about 20% of all reports of maltreatment. The number of reports that are investigated has declined by over 50% in the past three years, and 65% of maltreatment reports do not receive an investigation response. Of the 50,000 reports of child maltreatment made to DFCS last fiscal year that were not investigated, around 78% were diverted and 22% were screened out. The chart on the following page gives a visual of the changes between SFY2007 and SFY2009.[1]

[1] Please note that these percentages are based on SFY 2007 and 2009 data supplied by DFCS. Later in this report, OCA reports results based on Calendar Year 2007 data.



Given those large numbers of reports that are not investigated, our office would like to help you develop data measures to determine the ongoing safety of those children whose cases are not investigated, especially those whose cases receive a Diversion response. In the discussion below, we make suggestions as to how those outcomes could be properly tracked. Below, we will share with you some examples of cases that, to us, indicate the need to track broader measures of "recurrence." First, let me try to explain the principles behind our advocacy.

Two Principles

In encouraging your agency to expand its outcome reporting, we rely on two principles. The first is that we need to be responsive to the public. If an individual takes the time to call DFCS about a child, we should track how we are responding to those reports. Responding appropriately is especially important when you consider that in excess of 65% of all child abuse reports are made by mandated reporters -- professionals in a position to know, including the physicians, psychologists, law enforcement officers who work with these cases every day. The second principle is that we need to address a family's problems appropriately in our first contact with it. Repeated DFCS involvement with a family, whether or not we find repeat maltreatment, is disruptive to the family and possibly indicative of an inadequate agency response system.

OCA's Review of CDSI Reports

To gauge some broader indications of outcomes for children who were reported, we looked at "repeat" reports to DFCS involving a family. A good source for such reports is the Child Death and Serious Injury (CDSI) report. As you are aware, those reports are filed whenever DFCS receives word that a serious injury or death has occurred to a child in a family that has had prior involvement with the agency. We reviewed CDSI reports that were filed between late June and mid-October, 2009 and culled from those reports incidents involving injuries to foster children, incidents that involved accidents or harm by third parties, and matters that did not, in fact, appear to involve "subsequent" incidents of abuse or neglect. We then evaluated 35 reports that appeared to us to involve both a prior incident of abuse or neglect and a subsequent report of serious injury caused by abuse or neglect.

Reports Within the Federal Recurrence Measure

Of the 35 CDSI reports we reviewed, we found only six cases that would possibly contribute to the "numerator" in the federal measure for recurrence of maltreatment. Those cases were as follows:

- [redacted]: Two incidents involving this seven month-old occurred two weeks apart, 6/18 and 7/4/09.
- [redacted]: The first incident occurred when this baby was born 2/20/09 after mother had lost 7 other children to termination of parental rights. The baby was left with the mother and then suffered an abusive spiral fracture on 7/13/09.
- [redacted]: This family's first case was opened on 8/15/08 due to domestic violence and the boyfriend's bizarre actions toward these young children that involved giving them alcohol and cigarettes. The second case was substantiated for domestic violence and neglect of children's needs on 5/18/09, but it was closed without any services being offered because the mother agreed to move in with her own mother. She quickly moved out of her mother's home with the children, and on 8/30/09, the infant drowned in the bathtub.
- [redacted]: This case was substantiated for neglect due to drugs and the mother's going to jail on 3/17/09. On 8/6/09, the three year-old child sustained a broken arm due to inadequate supervision.
- [redacted]: Based on a 6/3/09 report, DFCS substantiated domestic violence when the mother left child alone in house because she was fleeing her paramour, who was trying to attack her. DFCS offered no services, however, and on 8/23/09 the same man punched one of the children – the six month old -- so hard he put him in the Pediatric Intensive Care Unit.
- [redacted]: This child was born on 8/17/09 to a mother whose rights to other children had been terminated, but the agency decided to leave the baby in the home. The infant's leg was then broken during an argument between the parents on 8/30/09.

Reports that meet a broader definition of "recurrence."

In reviewing all the cases, however, we found numerous other repeat incidents of likely abuse or neglect resulting in serious injury that we should consider as we determine how well we are doing at protecting children from repeat maltreatment. These cases would not be counted in the federal recurrence measure, which does not take into account (1) cases in which an incident involving maltreatment is diverted (or referred to "family support," as it is now called); (2) cases in which the subsequent incident occurs to a different child in the same family; or (3) cases in which the second incident of maltreatment occurs outside the six month window from the first matter, even if DFCS has remained involved with the family the entire time. Still, these cases all involved prior incidents that, to our staff, appeared to constitute child abuse or neglect under our state's laws. Some of these incidents involved prior diversions that, I believe, you would acknowledge were highly inappropriate and that should have been handled as investigations and likely substantiated.

Diversions

Several CDSI reports we reviewed showed that DFCS had earlier opportunities to intervene in a family's ongoing domestic violence and substance abuse matters but, pursuant to the local protocols your agency has approved, merely referred those families to other services – i.e., "diverted" the reports. We are concerned that these earlier cases should have been classified as maltreatment, and if they had been so classified in the first instance, DFCS might have taken steps that would have prevented the subsequent death or injury. Those cases are as follows:

- [redacted]: On 7/10/09, this young child was mauled by dogs because the mother left her outside, and DFCS already had an ongoing open family preservation case with the mother based on neglect and drug issues identified at the child's birth on 2/9/07. But while that case was open, the agency on

5/22/09 diverted an incident in which the child was left alone on the sidewalk and neighbors complained that children were often unsupervised and mother was drunk or on drugs "all the time." Had the incident of 5/22/09 been considered neglect, this case would have been classified as a recurrence under the federal standard.

- [redacted] On 9/22/09, the heavily intoxicated mother arrived at the hospital with a nonresponsive child, whom she had been breastfeeding. The baby later died. Earlier, on 6/1/09, the mother had to have seven staples in her head after the father came home and hit her because he found her drunk and breastfeeding the baby. Her liver tests indicated heavy alcohol usage. Since she obtained a temporary restraining order against the father which prohibited him from being around the family, DFCS diverted the matter and left the baby and other children with her. Had the first incident been handled as an investigation and substantiated, the child might not have died.
- [redacted]: On 8/20/09, this 18 month-old suffered a broken arm with conflicting explanations. The case was unsubstantiated because no one could tell DFCS how the break occurred, and it was unsubstantiated despite the mother's positive drug screen for marijuana and subsequent knife fight involving mother and father that occurred in the yard during the investigation. The case manager concluded that "The . . . assessment did not reveal any concerns that the substance abuse has deprived the children in anyway." OCA believes this case should have been viewed as a likely case of neglect. A prior complaint dated 6/5/09 alleged that the children were wandering the neighborhood begging for food late at night and early in the morning because the parents were using drugs or drunk. That report was diverted despite the fact that the father tested positive for marijuana and the mother's screen had been diluted; the father was on probation for selling methamphetamines; and the family already had a prior diversion in 11/08 for domestic violence. It is also significant that while the case manager knew the father was on felony probation, she records in SHINES that she was not going to tell the father's probation officer about the positive drug screen. After the 6/5/09 report was diverted, DFCS received and screened out another report made 8/11/09 in which the reporter stated she had seen a new incident in which the older children (ages 6 and 8) were running around the neighborhood unsupervised and that she had recently seen the father hit the mother in the face.
- [redacted]: A report was made that this child was a "shaken baby" victim on 10/13/09. DFCS had diverted a report of domestic violence between the parents on 7/7/09. The parents had denied any problems and, according to the DFCS records, "no services [were] provided."
- [redacted]: This 23 month old child almost drowned in a pool while living in squalid conditions around 7/27/09, and DFCS has substantiated for inadequate supervision. Despite the conditions of the home demonstrated in the photos in DFCS' record, the agency had diverted allegations of inadequate food, clothing and shelter on 4/28/09; allegations of inadequate medical care on 2/3/09; and squalid living conditions and roaches on 11/26/08. At the time of the injury, the child and her mother were living with a grandmother. The family had moved there at the behest of DFCS following substantiated allegations of drug use by the mother in 9/05.

Subsequent incidents involving other children in the same family

In our review, we found two other incidents that would not contribute to the federal recurrence measure because, although they involved the same problems in the same immediate family, the second abusive injury occurred to a different child. They are as follows:

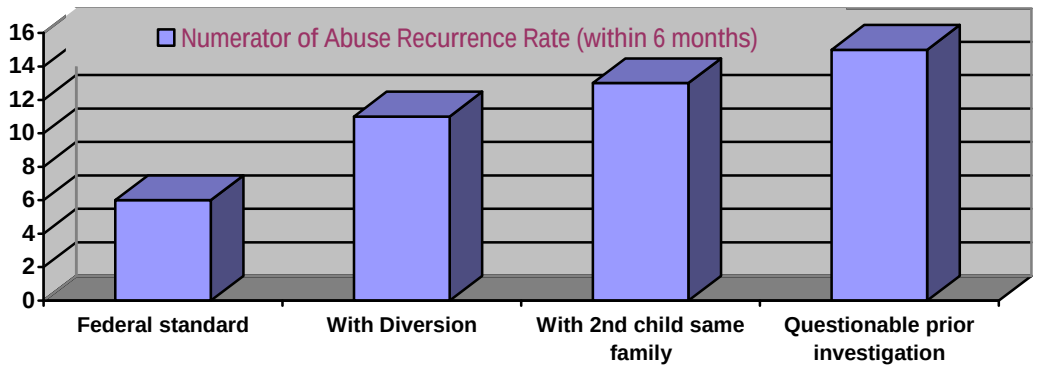
- [redacted]: On 9/2/09, this 18 month old baby was beaten to death. On 4/28/09, the baby's older sibling had told both his preschool teacher and the case manager that his mother had hit him in the stomach very hard. That report received a diversion response. Less than a year before, DFCS had also diverted a report indicating there was domestic violence in the household, possibly against the children, and that the mother had been in a fistfight with another tenant.

- [redacted]: This severely handicapped two year old was physically abused on 8/11/09. DFCS has admitted that it inappropriately screened out a report of sexual abuse against this child's older sibling that came to the Department's attention on or about 5/5/09.

Did poor investigation result in lower rate of recurrence?
Finally, we identified three cases in which we believed a better investigation of the prior incident might well have identified the injury to the child as abuse. Those cases are:

- [redacted]: On 8/30/09, this 18 mo child was found abused with a broken leg and healing rib fractures. As recently as 1/09, DFCS had diverted allegations that the child's parent was leaving child alone at night to smoke marijuana. The parents denied the allegation, but it does not appear a drug screen was performed. This child also suffered a broken leg in 3/09, and there was no concerted effort to determine its cause.
- [redacted] This physically handicapped child suffered a severe immersion scalding on 10/13/09. DFCS had an open case on this family from 2/09 to 7/16/09 based on a report from the hospital regarding the mother's "erratic" behavior and indication of mental health issues, but the agency never substantiated neglect or abuse. Additionally, a report came in on 8/10/09 that the child's arm had been broken. There was no explanation for that injury, but the agency found no reason to intervene.
- [redacted] The mother in this case had a history of mental illness, was institutionalized as a child due to abuse by her mother, and was in foster care herself as a child. Back in July 2007, the one child in this family suffered an "unexplained" broken leg, and DFCS was unable to substantiate any neglect. On 7/29/09, the father of this 3-year old reported to law enforcement that the mother had disappeared with the child. Law enforcement reported the matter to DFCS, which took no action despite the fact that they had a prior diversion on this family in August 2008 and never made contact with the family at that time. On 8/11/09, the three year old child suffered an unexplained broken arm, and the case was substantiated for "inadequate medical care" due to the length of time it took to take the child to the doctor. The child was returned home on a family preservation case plan.

A Broader View of "Recurrence of Maltreatment"
The chart below indicates the impact that including these cases might have were we to measure "recurrence" more broadly and emphasizes the source of our concern that, by not classifying diverted cases involving "real" maltreatment, the agency is deprived of the ability to adequately assess its performance. As the chart shows, if all of these cases were included in the recurrence rate, it would almost triple that rate over any given denominator.



Our review of the CDSI reports also reminds us that repeat abuse does not merely occur within a six-month time frame. While a six-month window may represent to the federal government a reasonable standard for comparing performance among the 50 states, it should not necessarily be the capstone of our internal assessment. In four additional cases, we found situations in which DFCS had, within the prior 18 months, had open family preservation cases or foster care cases on families involving troubles that we believe were significant factors in the subsequent injury to or death of the child. One of the cases was closed less than two months before the child died, and in two of those cases, the family preservation case remained open at the time of the child's death or injury. Still, the matters would not have been classified as "recurrence" of maltreatment because they were outside the six-month time frame. Those cases are as follows:

- [redacted]: This 9 month old baby was apparently left in the bathtub around 10/10/09 and drowned. Mother has denied using drugs, but she has had an open family preservation case with DFCS since 1/29/09 when the baby was born and tested positive for marijuana. During that open case, mother has not been cooperative and has said her doctor said smoking marijuana during pregnancy is acceptable.
- [redacted]: This case came back to DFCS' attention on 7/22/09 because the mother gave birth prematurely (at 25 weeks) due to mother's excessive cocaine use, and the baby died. The baby's one year old sibling had been the subject of an open family preservation services case because of mother's drug use from 7/20/08 until 4/29/09, even though DFCS stopped testing mother for drugs in 12/08. That same one year old was born on 10/31/07 but was not removed to foster care even though she had siblings in foster care.
- [redacted]: This 9 year old child died of respiratory problems apparently related to ongoing asthma troubles on 8/27/09. DFCS found no reason to believe child's death was related to parental neglect despite fact that house "smelled of smoke" and DFCS had multiple prior involvements with the family since 2003, the most recent being a "family preservation" case that was open from April 2007 until April 2008 because the mother was not meeting this child's medical needs.
- [redacted]: On 7/9/09, this 1 year old child was placed in foster care after, it appears, the mother slapped him so hard in the head that it broke his eardrum. On 2/4/08, this child was severely physically abused – by his father, it appears – and was in foster care until he was returned home. That case was closed on 12/3/08.

Thus, if you were to assess our ability to prevent subsequent abuse by including incidents that occurred within six months of DFCS active involvement through an open family preservation case, the numerator for our rate of recurrence of maltreatment would be a full <u>three times the federal measure</u>.

Analyzing the Quality of DFCS' First Contact With the Family

The federal recurrence rate is an excellent measure, and we make these comparisons not to diminish its value but to show that there are other types of cases in which we might question whether our <u>original response</u> to a report of maltreatment was sufficient given that the agency was again called out to address serious harm to a child. Take as examples these additional cases among those reviewed. In the following matters, might more intensive work with the family following the first report have prevented the subsequent injury to the child? What might we learn from a systematic review of such cases?

- [redacted]: Infant co-sleeping death in which the child was possibly smothered by the mother. During the investigation, authorities found evidence of drug use in the home. As recently as 6/30/08, the Department had investigated the family and its other children for drug use and domestic violence. Since the parents refused to take a drug screen, the agency unsubstantiated the case. This report followed an earlier 2/6/08 diversion following a report that the family was living in a condemned home and using drugs. The father tested positive for marijuana and was referred for a drug assessment, although there is no indication that assessment was ever completed.

- [redacted]: On 10/1/08, a report alleging the mother was using Loricet and Valium while pregnant was diverted. She had young children in her home at that time. The baby was born on 11/8/08. On 6/13/09, the baby suffered an abusive skull fracture and the children have been safety resourced to a friend. SHINES notes indicate the mother denies hurting the child, but law enforcement suggests she "knows who did it."

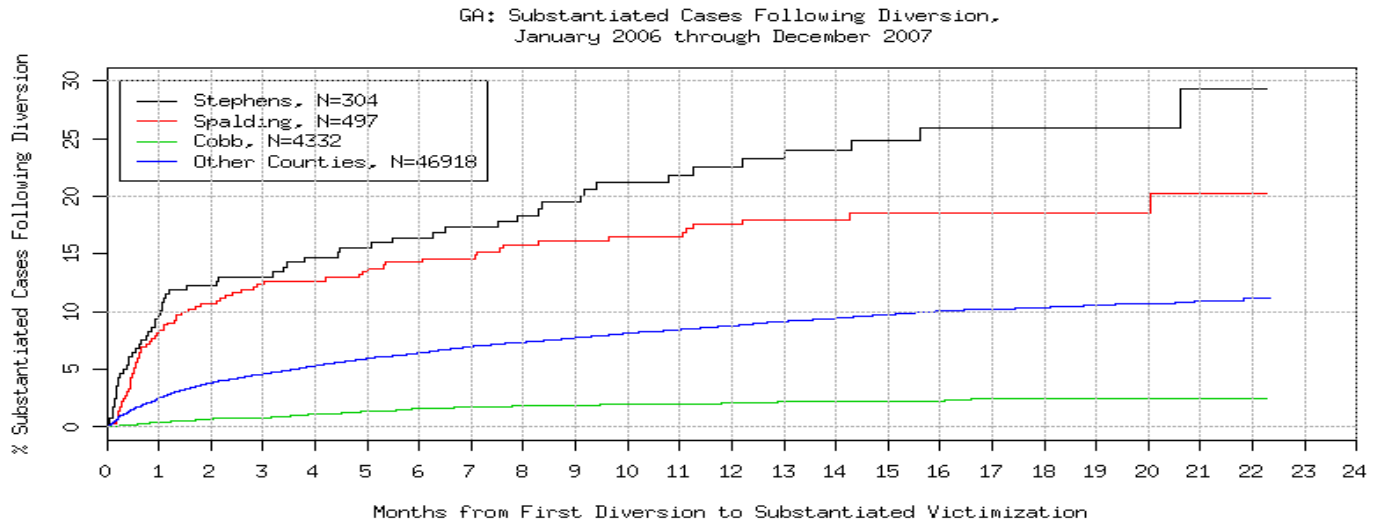
Recommendations:

1. More Targeted Data Collection and Reporting

As we indicated above, OCA would encourage you to adopt broader outcome measures that will give us a more complete picture of how we are doing in responding to all reports of child maltreatment. Better measures are especially needed in measuring outcomes for Diversion cases. Current DFCS practice is to determine what percentage of cases diverted statewide later became CPS cases. We are concerned that this measure is inadequate and misleading.

First, DFCS does not currently distinguish between cases that are diverted and involve maltreatment and cases in which a family truly has issues, such as poverty, that do not involve maltreatment. There is a solution. As you are aware, the National Child Abuse and Neglect Data System encourages states to report "alternative response" cases and classify the children served as "victims" or "non-victims." By distinguishing between the two in our own data collection and reporting, we can do a better job of measuring repeat DFCS involvement on different types of cases that receive a diversion response and adjust our Diversion system so that it lowers repeat cases of maltreatment.

Second, DFCS' current measure does not indicate how long after a first diversion the state has to once again intervene in a family's life, nor does it demonstrate which counties are doing a better or worse job in their "alternative response" efforts. Using your agency's PSDS data, Andy Barclay was able to develop the following survival chart showing the length of time in various counties from a first diversion to a repeat case involving substantiated abuse or neglect. You will note that Cobb County, for example, appears to have a good record. In Stephens and Spalding Counties, however, approximately 13% of families whose cases were diverted had a substantiated case of maltreatment within three months. We would like to conduct similar analyses for the 2008 data.



Third, we need broader measures that analyze the frequency of contacts between DFCS and a given family. The federal measure, as noted earlier, evaluates how we are doing in preventing serious repeat maltreatment among those cases we investigate and substantiate. A Diversion measure such as the one above would give us a better indication of whether our alternative response practice is keeping children safe in the cases we do not investigate: the majority of our cases. And we should develop similar measures to analyze all our "repeat" families, whether the reports on those families are screened out, diverted, investigated, or substantiated. Repeated contacts with the same family should raise concern about the family, about the adequacy of our agency's response, or both.

2. Implement Consistent Statewide Diversion Policy

We would also suggest that the agency move as quickly as possible toward implementing a family assessment tool for use in Diversions and some minimum statewide standards for the types of cases that can receive a diversion response. As you are aware, Georgia's diversion/family support practice does not contain the essential elements that have made "alternative response" a success in other states. We also lack standardized policies regarding necessary contacts to be made with the family, provision of services to the family, or follow-up to ensure the family's needs are met.

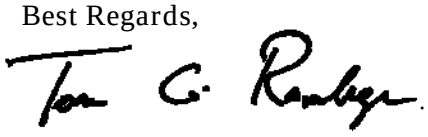
The CDSI reports we reviewed demonstrate that there are problems with the way counties are using Diversion to respond to certain cases. The examples cited above involving young children in circumstances involving substance abuse and domestic violence stand out particularly. Andy's survival chart also suggests that there may be wide variations in Diversion practice across the state. One might question, for example, why Cobb County's diversion practice in 2007 succeeded while Spalding County's did not?

3. Formalize the CDSI Review and Include Stakeholders

Finally, our review convinces us that we need some more formal way of reviewing these CDSI reports to improve policy and practice. As you may be aware, there was at one time a formal committee within DFCS that met to review these reports, but it is my understanding that committee is no longer operating. Part of the criticism of this committee was that it was often used to punish individual caseworkers rather than to improve practice. I believe we need to take a more proactive approach to reviewing these cases collectively, and that approach should be transparent. Each of these reports should be open to public scrutiny, as SB 79 passed last legislative session requires, so community stakeholders can and should be involved in the review process.

Thank you for allowing us to follow up with you on these issues. While we may not always agree on policy or practice, I know we all agree that we have an obligation to protect all of Georgia's abused and neglected children from further harm. Thank you for the work you are doing to fulfill that mission.

Best Regards,



TOM C. RAWLINGS
Director

cc: Tommy Hills, CFO (redacted)
BJ Walker, Commissioner DHS
Mary Eleanor Wickersham (redacted)