Department of Children and Families'
Investigation Report

December 30, 2013

The Department of Children and Families (the Department) has been working with the Oliver family since September 8, 2011. On December 13, 2013, the Department learned of the disappearance of the family's youngest child, and was advised by law enforcement authorities that they are treating the investigation as a homicide. As a result, the Department's Case Investigation Unit (CIU) conducted a comprehensive review of DCF's involvement with this family. The CIU is responsible for the internal review of all child fatalities and other critical incidents as mandated by the Commissioner. This report is based on a review of the case record and interviews conducted with area office staff and individuals familiar with the case. These are the Department's summarized findings.

Findings

The Department first became involved with the Oliver family on September 8, 2011 when a 51A report[1] was filed with the Department by a non-mandated reporter alleging the neglect of the family's three children (at the time, ages 7, 5 and 2.5 years old) by their parents. This report was screened in as a 15-day investigation.[2] The case was opened for services and assigned to a social worker. According to the case records, the social worker met regularly with the family, and made referrals for services for the family, including childcare for the youngest child. The social worker accompanied the mother to meetings at her children's school, assisted her in making appointments for her children and obtained clothing, furniture and toys for the family.

The social worker followed up on issues identified in a subsequent report of neglect in March 2012. The social worker made all of the requisite regular and consistent home visits through summer and fall 2012. In September 2012, the mother indicated she had

[1] Throughout the report, there are references to terms that are specific to case practice and Department policy and protocol that are defined in footnotes where necessary for ease of review and understanding. A 51A report is the report filed on behalf of children alleging abuse and/or neglect of a child or children in a household. Mass. General Laws chapter 119, section 51A mandates that certain individuals (generally, staff of a medical institution or school) file reports with the Department when they have reasonable cause to believe that a child is a victim of abuse or neglect.

[2] The Department "screens" based on suspicion of abuse and/or neglect. The Department's screening process gathers sufficient information to determine whether the allegations contained in a 51A report meet the Department's criteria for suspected abuse and/or neglect, whether there is immediate danger to the safety of a child, whether DCF involvement is warranted and how best to target the Department's initial response. The report is "screened out" when there is reasonable cause to believe that the alleged neglect and/or abuse did not occur or it is a known condition to the Department which is being addressed, The report may also be "screened out" if the alleged perpetrator is identified as a non-caretaker of the child (these are referred to law enforcement). If the report is "screened in," it is assigned for investigation (emergency or non-emergency, depending upon the circumstances). The Department "supports" a 51A report if it has reasonable cause to believe that the abuse and/or neglect occurred. The Department then takes action to investigate and provide services to the family. Reports that are "screened in" may also be referred to law enforcement.

found an apartment in Fitchburg and needed assistance with the transition. On December 15, 2012, the social worker completed a comprehensive transfer summary that identified the issues that were currently being addressed and the services being provided to the family, including contact information for the family's providers. This social worker had a final home visit with the mother and children on December 24, 2012. The social worker addressed the service plan tasks and the Department's expectations.

On January 15, 2013, the case was transferred to the North Central Area Office and a new social worker was assigned to the family. During the CIU's interview with the social worker assigned to the case in January 2013, she stated that when she received the case record, she read the transfer summary, but not the rest of the case file. The social worker's supervisor stated in her interview with the CIU investigator that she also did not read the complete case record, but did read the transfer summary and some of the 51A reports and 51B written assessments.[3] During this interview, the supervisor also reported that she had told the social worker to visit the home in January 2013. Furthermore, the supervisor told the CIU investigator that the social worker did not make the home visit and did not discuss with her supervisor her inability to meet this requirement. According to the case record, the social worker conducted two home visits in February 2013, and during one of those visits, the mother requested that her case be closed and the social worker agreed to speak to her supervisor about closing the case. The case record does not reflect a home visit taking place in March 2013, and the social worker acknowledged to the CIU investigator that she did not visit the home in March 2013.

According to the case record, on April 2, 2013, the social worker attended a meeting at the youngest child's preschool. The case record also provided details about a home visit conducted by the social worker with the mother and her three children on April 30, 2013. The social worker's dictation indicated that she did not speak to the children, but observed them playing and noted they were clean and dressed appropriately. During this visit, the mother first informed the social worker she was considering sending the children to her mother's home in Florida for the summer.

On May 14, 2013, a mandated reporter filed a 51A report alleging the physical abuse of the family's oldest child by his mother. This report was screened in as a 15-day investigation, and ultimately supported. Information learned by the investigator, which was included in the case record, reflected the following: a DCF investigator met with the mother and youngest child at the family's apartment on May 20, 2013, and the mother provided extensive collateral information, including that her children received certain services which had been obtained outside of the Department, and reported that she was in the process of trying to obtain her own apartment. The investigator noted in the case record that he spoke at length with the youngest child during this visit, and the record describes the child as precocious, talkative and articulate. This was the last time any Department staff saw the youngest child.

[3] When a 51A report is filed alleging abuse and/or neglect of a child or children, the Department is required to investigate the allegations and provide a written assessment of the safety of and risk posed to the child or children, which is referred to as a 51B report. See Mass. General Laws chapter 119, section 51B.

The social worker told the CIU investigator during the interview that she cancelled a scheduled home visit with Mrs. Oliver and her children on May 28, 2013. Three subsequent reports of abuse and/or neglect of the Oliver children were filed with the Department in June 2013. All three reports, which related to a single incident, were screened out and the social worker was requested to follow up with the family on the issues identified in the reports. There is no documentation in the case record showing that the social worker followed up on any of these issues.

According to the case record, on June 17, 2013, staff at the youngest child's preschool called the social worker and reported that they had concerns that the youngest child was coming to school hungry and reported their observation that he seemed to not be eating a lot at home. The following day, staff from the preschool called the social worker again and reported that the mother informed them she was considering moving to Florida.

According to the case record, on June 26, 2013, Mrs. Oliver called the social worker and reported that she did not want to work with the Department any longer, and that she was not receiving any services or help from the Department. She refused to provide her new address to the social worker. After speaking to Mrs. Oliver, the social worker contacted the providers working with the family. One provider reported that she saw Mrs. Oliver weekly, but did not know where she was residing and only met with her outside of the house. The staff at the youngest child's school reported to the social worker that the mother informed them the child would no longer be attending school as the children were moving to Florida.

At the CIU interview, the social worker stated that she did not conduct home visits of the Oliver family in either June or July 2013. The Area Program Manager (APM) reported in the CIU interview that she instructed the supervisor to ensure that the social worker visited the families that had not been regularly visited. In the same CIU interview, the APM stated that the supervisor and Mrs. Oliver's social worker needed to improve their compliance with home visits. The APM took no further affirmative action to address the deficiencies.

According to the case record, on August 22, 2013, the social worker learned through a provider that the children did not go to Florida and that the family had moved to a new apartment in Fitchburg. The provider reported that the mother was utilizing their services much less frequently and they were scheduled to close the services in October 2013. The case record does not provide any information about a home visit in August.

The case record reflects that, on September 20, 2013, the supervisor and social worker conducted a specific review of this case as part of a larger agency review of all cases that involved children under the age of 6 who were living at home. The purpose of this agency review was to identify warning signs, take action and elevate cases to managerial review if necessary. During this review, the supervisor entered into dictation that the family's new apartment was clean, without hazards and was adequately furnished; however the case record reflected that there had been no home visit to the new apartment.

The social worker confirmed at her CIU interview that she did not visit the family in their new apartment in September 2013.

According to the case record, on October 9, 2013, the social worker called the youngest child's school and learned that the child had not attended the program since June 26, 2013. The social worker did not conduct a school or home visit in October 2013.[4]

According to the case record, on November 5, 2013, the social worker went to the school attended by the two older children and spoke to the guidance counselor and others at the school. The social worker interviewed both children. The oldest child reported that his youngest sibling resided with their "other family" that he did not know. The middle child reported that the brother of her mother's boyfriend sometimes watched her younger sibling. After interviewing the children at school, the social worker made an unannounced home visit, but no one answered the door. The social worker left a business card in attempts to get in contact with the family to close, according to the case record.

On November 15, 2013, the guidance counselor called the social worker and stated she had been unable to get in touch with the mother. There was no successful home visit in November 2013.

According to the case record, on December 2, 2013, a mandated reporter filed a 51A report alleging the neglect of the three children by their mother. The social worker and her supervisor went to the family's home on the day the report was filed, but no one answered the door. That same day, at 8:55 PM, the mother left an incoherent voice mail message for the social worker. The social worker left a message for the mother the next morning, December 3, 2013. Later in the day on December 3, a man who referred to himself as "Luis" called the social worker and indicated he was a family friend and that Mrs. Oliver was depressed. The social worker asked Luis to have Mrs. Oliver contact the Department immediately.

The report was screened in as a 15-day investigation, and assigned to an investigator. According to the investigator's narrative in the case record, on December 5, he made an unannounced home visit and could hear noises from the front door, but no one answered. This investigator made two more unannounced home visits on December 6. At the first visit, the oldest child was on the front porch, but no one answered the door and the investigator did not see anyone else in the family. No one answered the door at the second visit and the investigator did not see anyone from the family. Workers from the Comprehensive Emergency Services (CES) hotline were sent out to the family's home on December 7, 2013 and heard people inside the apartment, but no one answered the door. On December 9, 2013, a message was left for the mother by the supervisor indicating that if she failed to contact the Department on that day by 5:00 PM, then legal action would

[4] In CIU's interview with the Area Program Manager (APM), the APM stated that she directed the supervisor to instruct the social worker to remain in the office and complete all her dictation. She reported having told the supervisor that if there was a removal or an emergency in the unit, the supervisor could not use the social worker, but rather was instructed to talk to the manager directly so she could procure assistance from another unit.

be taken. The mother failed to respond to the urgent message and on Tuesday, December 10, 2013, the Department sought and obtained custody of the three children.

On December 13, the investigator spoke with the maternal grandmother and maternal aunt at their respective homes in Florida, and they denied that the youngest child was in Florida. The local sheriff's office in Florida sent an officer to the maternal grandmother's home and confirmed that the youngest child was not there. On December 13, the mother appeared in court without her youngest child, and did not produce her youngest child, as required by the court, on December 16. The mother has refused to disclose the location of the child and has subsequently been arrested. Currently, the youngest child's whereabouts are unknown and he has not been seen by DCF since May 20, 2013.

Assessments

The social worker assigned to the family for the period of September 2011 – December 2012 engaged with Mrs. Oliver and her family appropriately. The social worker routinely met with Mrs. Oliver, interviewed the children at regular intervals and fostered a supportive relationship with the family. The social worker spoke frequently with collaterals working with the family, facilitated meetings with providers and clinicians and made several referrals for Mrs. Oliver and her family. The social worker was able to address and assess risks faced by the family while at the same time cultivating a strong working relationship with Mrs. Oliver. When it was evident that Mrs. Oliver was not following through on the Service Plan and Safety Plan[5] tasks she had agreed to, the social worker facilitated a meeting with Mrs. Oliver and the family's service providers. The social worker procured furniture and clothing for the Oliver family.

When the case was transferred to the North Central Area Office in January 2013, the new social worker and supervisor failed to review the complete case record. The social worker responsible for the case for the period of January 2013 – December 2013 only visited the family in February 2013 and April 2013 and failed to follow up on risk factors presented in the case.

The supervisor did not review the social worker's dictation and although she indicated that she was aware that the social worker was not seeing the family, she did not raise the concerns to the manager. The social worker acknowledged that she did not conduct any follow up visits with the Oliver family after three 51A reports were filed in June 2013. The supervisor reported that she was surprised that the social worker did not follow up with the family, but took no steps to ensure that she did.

After the case was transferred to the North Central Area Office, the Department missed multiple opportunities to engage with the Oliver family, but the absence of home visits to

[5] A service plan is a contract with the family that defines the goal to improve parenting skills. It outlines the services provided by DCF and other partners and the expectations for the family. The safety plan is different from the service plan. It is developed in response to a specific safety concern in order to eliminate that risk factor to the child's safety.

assess the safety of children and to ensure that the family was receiving the appropriate services and the children were safe represented a serious failure.

The agency wide review of cases in September 2013 was meant to catch problems such as these. During this review, the Supervisor should have noted and addressed the lack of home visits throughout the year and should have reviewed actions taken in response to the three 51A reports in June 2013. The Supervisor did not. In addition, the Supervisor claimed that the apartment was clean and suitable even though the social worker had not visited the apartment. Based on the CIU interviews, it is evident that the Supervisor was proven to be untruthful and that the social worker did not conduct a visit in September 2013. Had the facts been properly documented and appropriate action taken by the social worker, the case would have been elevated for further action by senior agency management.

Actions

Employment Decisions

The Department made the decision to terminate both the social worker and supervisor assigned to this case. In addition to these actions, the Department has terminated the Area Program Manager (APM) because she never ensured there was any follow up from the supervisor regarding the screened out 51A reports which presented multiple risk factors to the safety of the children. She was aware of the poor compliance on home visits to families under the supervisor's caseloads, but there was no concrete plan developed with the supervisor to address the missed home visits. During regular supervision with the social worker, the supervisor should have developed a work plan to assist the social worker in her compliance with required regular and consistent home visits. The APM is responsible for insuring that this work plan occurs.

The Area Program Manager of Intake is responsible for making decisions on the disposition of 51A reports. The APM decided to screen out critical reports without ensuring appropriate follow up was done and that the safety of the children had been assessed. For these reasons, the APM was given a 3-day suspension without pay, and immediate removal from the decision making process through intake.

Process Improvements

The Department will use the lessons learned through the case review of the Oliver family to implement systemic changes that will improve the safety net for children in need of protective services. The following actions are being instituted:

- All Directors of Area Offices are been instructed to immediately report back to the Deputy Commissioner of Field Operations to ensure that each family under DCF care is receiving regular and consistent home visits.
- The Commissioner is directing the Department to screen in for investigation and intensive case management any report alleging abuse or neglect about a family with a child five years old or younger which presents any, or a combination, of the following risk factors: young parents; or parents of any age which have a history of substance abuse, domestic violence, mental health issues, or unresolved

childhood trauma. The National Research compiled in the 2013 Child Welfare League special issue on Preventing Severe Maltreatment- Related Injuries and Fatalities indicates that children living with families with the above risk factors are at the highest risk for severe maltreatment[6].

Systemic Improvements

- Institute case reviews of families with children living at home to mirror our foster care review process. Reviews will be conducted every 6 months by area program manager, social workers and supervisors with parents (and children whenever possible) to review services provided and progress toward improving parental capacity. This practice will enable managers to directly assess and verify the workers impression and documentation in their work with their families. Implementation of this action will require a contractual agreement with the Union.
- Ensure collaboration with other state agencies and providers and increase partnership opportunities to improve services to families for the prevention of child abuse. Many families referred to the Department present complex problems which are challenging to social workers. Effective intervention with these families require adequate services in the home (such as home visiting, early intervention, and treatment for substance abuse, domestic violence and trauma) while keeping the children visible in the community, including at childcare providers, Head Start, schools and after-school programs.

Conclusions

Department staff manages multiple, complex, time-sensitive challenges in their day-to-day work. When social workers engage with families in the way the social worker initially assigned to this case did, families get the support and reinforcements required to stabilize their living situations and better ensure a safe and more secure environment for their child(ren). In addition, when caseloads are effectively monitored for signals of distress or concern, families are better served.

[6] Child Welfare 25 Years of Excellence 1922-2013 Special Issue Preventing Severe Maltreatment –Related Injuries and Fatalities: Applying a Public Health Framework and Innovative Approaches to Child Protection. Guest Editors: Zeinab Chahine, Peter J. Pecora, David Sanders and Dee Wilson.