Report of The Child Advocate to Governor Deval Patrick
Concerning the Disappearance of Jeremiah Oliver
January 23, 2014

The Office of the Child Advocate (OCA) received a Critical Incident Report on December 13, 2013, regarding the disappearance of five-year-old Jeremiah Oliver of Fitchburg, Massachusetts. The Oliver family had been involved with the Department of Children and Families (DCF) for over two years when social workers learned in December that Jeremiah was missing and could not be located with family members in another state. Law enforcement officers advised DCF employees on December 13, 2013, that they would treat Jeremiah's disappearance as a homicide investigation. On December 17, 2013, Jeremiah's mother Elsa Oliver was arraigned in Fitchburg District Court on two counts of reckless endangerment of a child, two counts of accessory after the fact, and one count of assault and battery with a dangerous weapon. She is being held in contempt of court for failure to produce Jeremiah at a care and protection proceeding in the juvenile court. Ms. Oliver is also detained for a mental competency evaluation and, should she resolve these matters, her bail is set at $100,000 with conditions of release. Ms. Oliver's boyfriend, Alberto Sierra, was arraigned in Fitchburg District Court on December 16, 2013, on three counts of assault and battery with a dangerous weapon and two counts of assault and battery on a child causing bodily injury. He is being held without bail after a judge found him to be a danger to the public. The Office of the Worcester County District Attorney, in collaboration with the Massachusetts State Police Detective Unit and the Fitchburg Police Department, continues to investigate crimes related to Jeremiah's disappearance and possible death.

In response to Jeremiah's disappearance, Governor Deval Patrick ordered the Commissioner of DCF to investigate and report to him concerning DCF's efforts on behalf of the Oliver family. "The Department of Children and Families' Investigation Report, December 30, 2013," (the DCF report) was released to the public on that date and is available on the OCA Website. The DCF report disclosed information about the social work services received by the Oliver family and informed the Governor and the public that DCF had fired three employees and disciplined another employee after reviewing their job performance. In addition to these employment decisions, the DCF report identified actions the agency has

taken related to home visits, screening decisions, case reviews, and collaboration with other state agencies and providers.

Governor Patrick requested that The Child Advocate conduct an independent investigation into DCF's work with the Oliver family. The OCA investigation included document review and interviews with agency, union, and law enforcement personnel. The OCA is prohibited by law from disseminating any confidential information obtained during the investigation of critical incidents. For this reason, we will present only information related to the Oliver family that is already known to the public through media reports or through the DCF report.

During the OCA's investigation of this matter, the Patrick administration contracted with the Child Welfare League of America (CWLA) to conduct an immediate quality improvement review of DCF practices identified in the DCF report. The CWLA review will examine DCF policies and practices regarding screening of reports of abuse or neglect, assessment and service planning, identification of risk factors, home visits, removal of children from the home, and case management. In addition, CWLA will review recent recommendations made by DCF and the Executive Office of Health and Human Services and assess how DCF policies, practices, and recommendations align with best practices. The contract requires that CWLA submit a final report by March 14, 2014.

DCF Casework with the Oliver Family

According to the DCF report, the Oliver family became involved with the agency in September 2011 after a 51A report was filed alleging neglect of the three children, then ages two, five, and seven. The initial social worker assigned to the Oliver family met monthly with family members and helped them connect with services over the next 15 months. After the family relocated to Fitchburg, the Oliver family's case was transferred from the original DCF area office to the North Central Area Office (NCAO) in January 2013. The next social worker assigned to the Oliver family did not make monthly home visits as expected and did not refer the family for any services. The worker visited the Oliver home and saw the children in February and April of 2013. In May 2013 a 51A report of abuse or neglect was filed, investigated, and supported concerning Elsa Oliver's physical abuse of her oldest child. In June three 51A reports regarding a single incident were filed raising concerns about the

Oliver children and their mother; however, because an investigation had just been completed, these reports were not assigned for investigation. Although managers believed that the social worker assigned to the family would follow up on these new concerns, the social worker did not do so. Elsa Oliver moved with her children to a different apartment in Fitchburg and refused to give the social worker her new address when they spoke on the telephone in late June.

When the social worker visited the two older children at their elementary school on November 5, 2013, the children talked about their mother's boyfriend and gave different information about Jeremiah's whereabouts. The worker attempted an unannounced visit at the children's home later that day but there was no answer at the door. On December 3, 2013, a mandated reporter filed a report of abuse or neglect and the ensuing investigation led to the discovery that Jeremiah had not been seen by anyone outside the immediate family since mid-September.

North Central Area Office

The North Central Area Office (NCAO) is one of the busiest DCF offices in the state and consistently has one of the highest ratios of weighted caseloads to worker, averaging 18.53 weighted cases per ongoing social worker for the 12-month period ending October 2013. Since 1986 the contract between DCF and the Service Employees International Union Local 509 (the union) has stipulated that an ongoing worker's weighted caseload will be capped at 18. A weighted caseload assigns a higher value to cases that require more intensive action, such as a new investigation or assessment. The high weighted caseload ratio at NCAO is the result of a large increase in the number of open cases in the office combined with a high number of full-time employees on approved leave (e.g., family medical leave). The efforts by DCF management to increase staffing to help lower weighted caseload ratios appear to have been offset by the steady and significant increase in new cases and staff leaves. In May 2013, then-Acting Commissioner Olga Roche met with staff at NCAO to discuss ongoing concerns, including the issue of high weighted caseloads.

A Memorandum of Agreement (commonly called a Memorandum of Understanding or MOU) between DCF and the union was signed on March 18, 2013, and ratified by the union

in April 2013. The MOU specifically addresses caseload standards for ongoing social workers. Rather than weighting and capping caseloads based on the single measurement of number of families, the MOU provides that caseloads will be based on three measures: no more than 15 families, no more than 28 children, and no more than 10 children in out-of-home placements per worker. Full implementation of the MOU is contingent on the availability of funding for additional social workers. After the Fiscal Year (FY) 2014 budget was passed without an appropriation for implementation of the MOU, DCF and union representatives began meeting in September to discuss actions that would move DCF toward realization of the 15 families, 28 children, 10 children in placement measurements without additional funding. As of early December 2013, DCF and the union were exploring various options to try to equalize caseloads between and within offices.

During the period from May to October 2013, the union filed a grievance on behalf of the social worker assigned to the Oliver family every month due to weighted caseloads over the average of 18 negotiated in the union contract. DCF measures weighted caseloads for social workers on the last day of every month and showed the worker's weighted caseload to be above 18 in June, July, August, and October.

DCF Budget and Staffing

The global recession of 2009 reduced state revenues and resulted in budget cuts throughout state agencies. The DCF budget was reduced drastically from a high of $836.5M in FY09 (later reduced by $20.2M due to 9C cuts) to a low of $737.1M in FY12. While the budget did increase to $759.3M in FY13 and further increased to $779M in FY14, the vast majority of this additional funding was absorbed by increased foster care rates, Chapter 257 human service provider rate reforms, and collective bargaining salary increases for unionized workers, including social workers.

A decision to preserve frontline social worker positions in the face of budget cuts, particularly in FY11, resulted in an overall reduction during the period FY09 to FY14 of 47 managers at the area, regional, and central office levels (17%) and 124 social workers (5%) statewide. These numbers reflect layoffs and attrition with limited ability to hire for positions left open by retirement or resignation. An October 2010 restructuring of the 29

DCF area offices reduced the number of regions from six to four. Half of the Area Director positions were eliminated, so that each Director of Areas oversaw two area offices. The reduction in management created additional demands and pressure on both managerial staff and the supervisors and social workers who look to them for help. Area Program Managers (APMs) are the first level of nonunion management and are responsible for direct clinical and administrative operations of an area office. One top manager remarked that, "APMs are busy 100% of every day." With the reduction in managers, the ability of APMs to monitor the supervisors necessarily diminished, as APMs were less available to discuss concerns, act as resources for clinical management, and manage personnel issues. Quality assurance functions, including case reviews, are led by managers, and the loss of 47 managers compromised those functions as well. Finally, even when DCF can hire a new manager, the hiring and approval process takes months, so each managerial vacancy left the affected area office with ever more demands on the existing staff.

OCA Observations

The DCF report identified the agency's actions and plans to improve processes and systems, and this report will not duplicate that information. The OCA offers the following additional observations:

Child Protective History in Other States:

The Oliver family had a history of serious child protective concerns in another state that did not follow the family to Massachusetts. Although DCF investigators in Massachusetts were aware of this history and requested more information in 2011, the child protective agency in the other state did not respond. After Jeremiah's disappearance in 2013, the sister state agency sent selected records to DCF. It is critical that child protection records be made available to other states in appropriate circumstances, such as during investigations, so that social workers can assess the risk and safety of the child.

Case Transfers between Area Offices:

When a case is transferred between area offices, DCF policy states that "when appropriate, a case conference involving the sending social worker and supervisor and receiving social worker and supervisor should be held. In situations where this is not possible, the newly

assigned supervisor and the sending supervisor should conference the case on the telephone." No transfer meeting or telephone call was held between workers or managers in the original DCF area office and NCAO for the Oliver family. DCF policy also requires the social worker and supervisor to review the case record, but the DCF report states the worker only read the transfer summary and the supervisor did not read the entire case file. These lapses – no record from the other state, no transfer meeting or phone call, and incomplete record review by the social worker and supervisor – compounded one another, so that the social worker and supervisor at NCAO had limited information about a family that had been involved with protective services in two states over six years.

Previous Critical Incident from NCAO:

The OCA received a critical incident report in 2012 concerning the Jones family (a pseudonym) documenting serious injuries inflicted on a two-year-old child by the mother's boyfriend. When OCA staff visited NCAO to discuss the Jones family and case practice with DCF managers, the managers identified a number of missed opportunities in the casework. The same social worker from NCAO assigned to the Jones family was later assigned to the Oliver family. In this context, one would have expected the manager to construct a concrete plan for the social worker outlining heightened supervision requirements, monitoring, and training until she demonstrated that she had incorporated the lessons learned by the area office after the Jones child was injured. However, this did not occur.

The Social Worker's Responsibility:

Frontline social workers are fundamental to the effectiveness of DCF. The children and families, the supervisors and managers, all depend on the social worker's investment in the family and the worker's ability to continually assess and effectively evaluate risks and protective factors. The worker assigned to the Oliver family was focused on those cases she believed were in crisis, including the cases of other workers in her unit. From her perspective, she was in the trenches with her co-workers, making sure that she was available to help them manage crises in their cases and knowing that they would be available to her if she needed them. In this way, her professional gaze drifted from the children within her own caseload and she lost touch with the truth that she was the person responsible for

visiting those children, knowing them, and ensuring their safety. A professional must find a way to meet basic obligations even when the workload is difficult. Everyone at DCF agrees that the most basic obligation is to "visit your children." This is the cornerstone of protective work and the worker's consistent failure to visit the Oliver children cannot be excused. The social worker was fired as a result of Jeremiah's disappearance and the resulting review of her work.

The Supervisor's Responsibility:

Supervisors are critical to DCF. They are responsible for the direct oversight of social workers and share responsibility for understanding and responding to a family's needs. In this instance, the supervisor did not help the worker set priorities within her own caseload to ensure that she got the basics done. The supervisor was aware that the worker had not visited the Oliver family for months but did not insist or ensure that the visits happened. When the Area Program Manager inquired about the visits, the supervisor made excuses for the social worker. As a result, DCF's supervisory structure failed Jeremiah Oliver. The supervisor was fired as a result of Jeremiah's disappearance and the resulting review of her work.

The Area Program Manager's Responsibility:

Supervisors are in turn supervised by Area Program Managers. APMs are responsible for direct clinical and administrative operations of an area office, including the quality of casework services and personnel management. APMs are nonunion employees, while both social workers and supervisors belong to the Service Employees International Union Local 509. The relationship between the supervisor and the APM in this instance was strained, and this led to ineffective supervision. The APM was aware that the social worker needed to visit the Oliver children and she directed the supervisor to make sure the worker visited the children in September and October. The supervisor told the APM that the worker had visited the children and needed to catch up on her dictation in the case record, while in turn directing the social worker to visit the Oliver children. It is achingly frustrating to look back and see that the APM directed the supervisor who directed the worker to perform her most fundamental responsibility – yet it still didn't happen. In this instance, DCF's supervisory structure failed to identify the problems with casework that supervision is intended to

highlight. The APM was fired as a result of Jeremiah's disappearance and the resulting review of her work.

Home Visiting Reports:

DCF uses a statewide data report to ensure that children and families are visited on a monthly basis. Home visit reports measure social worker compliance in completing home visits and provide the date of the last documented home visit. These reports are generated by DCF twice monthly and are provided to all DCF Area Office managers and supervisors. At NCAO, home visit reports are used at all levels of management and NCAO has demonstrated a compliance rate close to the state average (NCAO 81.4% vs. state 82.5% for 12 months ending November 20, 2013) with the expectation of monthly home visits for all children on a worker's caseload. The home visit reports list the date of the social worker's last home visit and the names of the parents and children. The Oliver family was last visited in their home by the social worker on April 30, 2013. This date and the names of the family members appeared on the June 15, 2013, home visit report and on every home visit report thereafter through December 1, 2013. The worker's lack of compliance was evident to managers through the home visit report and was regularly brought to the attention of both the supervisor and the social worker. The DCF system of generating and utilizing home visit data reports can be a useful tool to monitor compliance regarding home visits. In the case of the Oliver family, the home visit reports accurately reflected the date of the worker's last home visit and alerted the APM and supervisor to the need for an immediate home visit. However, the social worker failed to visit the family despite this additional layer of oversight. Managing by data is invaluable – and yet only as valuable as the ability of the workforce to use the information constructively and to provide direction effectively.

Agency-Wide Review of Children under Six:

During the months of August through October 2013, DCF conducted an agency-wide review of cases with children under age six who remained in the care of their parents. The purpose of this review was to ensure the safety of young children. Accordingly, the supervisor and social worker met on September 20, 2013, to review the safety of the Oliver children. As specified in the DCF report, the supervisor entered a misleading note in the case record that did not reflect the current status of the casework. This undermined a crucial

opportunity to identify the Oliver children as needing immediate attention. The supervisor and social worker appeared to view the agency-wide review as one more task from management that they could not satisfy, rather than viewing it as a tool for ensuring the safety of children.

Screening Decisions in Ongoing Cases:

The DCF report documents that three 51A reports of abuse or neglect (two by mandated reporters) pertaining to the same incident were filed in June 2013 but were screened out. The Intake APM who made the screening decision was disciplined through a 3-day suspension without pay and a change in job responsibilities. In addition, before the case with the Oliver family was transferred from the original area office to NCAO, a report of abuse or neglect by a mandated reporter was filed in January 2013 and was screened out by an APM in the original area office.

When a new report of abuse or neglect is filed concerning a caretaker who has an open case with DCF, it is the responsibility of the Intake APM to decide whether the report will be screened in for assessment or investigation. An investigation is performed by a different social worker with additional training who re-evaluates the protective concerns within the family. Screening out reports of abuse or neglect filed by mandated reporters discourages these professionals who work with children from reporting concerns to DCF. These four instances of screened-out reports represent missed opportunities for re-evaluation and intervention with the Oliver family in contravention to DCF policy. We can appreciate the desire to use the existing resource of the ongoing social worker as a follow-up to reports of protective concerns, but we also recognize the value of the intake unit and the specialized protective lens they bring. In both January and June 2013, the allegations in the reports merited an investigation and should have been screened in.

The DCF report lists as a process improvement the following: "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." This action would require additional social workers, supervisors, and managers to implement and should be examined during the CWLA review of DCF policies.

Discussion

How can a social worker not notice when a five-year-old boy on her caseload disappears? One of the top managers from NCAO said, "I didn't think something like this could happen in our office with our systems." The same manager also said, "We have ridiculously high caseloads, but that's not what this is about." The high weighted caseloads at NCAO provide a context rather than an explanation or excuse for repeated failures. When we expect more of everyone in a system, we may see increased performance for a period of time – but eventually everyone will have contributed the extra effort they have to give, and continued expectations for ever-increasing performance may not be met.

The weighted caseloads of all social workers at NCAO deserve consideration. In a busy office with high caseloads all around, each worker is scrambling to keep up. Workers are called on to help one another; supervisors have responsibility for more workers with more cases; APMs supervise a cascading number of clinical cases through the supervisors and workers. In the ever-increasing push for workers to handle more cases, the system becomes more crowded, the pressure builds, and the opportunities for clinical social work and thoughtful supervision diminish. Families with complex problems receive less attention and their children, already identified as having been abused or neglected, suffer.

A good child welfare system needs it all – a skilled workforce with manageable caseloads, staff committed to meeting their professional obligations, knowledgeable and supportive supervisors, seasoned managers, plus support, training, and quality assurance. There is no shortcut to creating this system but DCF has already charted a course to reduce caseloads through its MOU with the union. This is the first step to rebuilding the resources that would be required by any system that delivers complex services every day of the year to families in crisis. And of course, to their children.

Recommendations

1. The weighted caseloads at NCAO in 2013 were among the highest in the state. These high caseloads created highly stressful conditions at NCAO and were a contributing factor in the failure of the social worker and her supervisors to carry out fundamental protective casework and supervisory responsibilities. **Governor Patrick's FY15 budget provides the necessary resources to permit the assignment to each social worker of no more than 15 families, no more than 28 children, and no more than 10 children in out-of-home placements. It is vital that this level of funding be supported by the Legislature.**

2. Excessive caseloads do not excuse the specific failures that prevented DCF from discovering Jeremiah Oliver's disappearance. DCF supervisors and managers failed to prioritize their limited resources in a manner calculated to do the least harm to children and families. Precisely because of concerns about high caseloads, DCF should have had a plan in place for triaging its services. Indeed, such a plan should always be in place. It is not enough to request additional funding; even an inadequate budget must be spent in a manner that does the most good and the least harm. **We urge DCF to develop a protocol to establish priorities when caseloads exceed acceptable levels.**

3. CWLA has been engaged by the Patrick administration to conduct an immediate quality improvement review of DCF policies, practices, and recommendations identified in the DCF report and how these align with best practices. **During the course of its investigation, the OCA identified specific existing DCF policies and practices that warrant further review by CWLA. These include case transfers between offices, case reviews, ongoing casework, case closing criteria, and information sharing between DCF and child protection agencies in other states.**

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Let's end by remembering Jeremiah – a bright, articulate little boy who loved strawberries and cornbread and who loved to sing.