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**Report of Investigation**

**Death or Serious Injury Following  
A Child Abuse Investigation  
June 2016 - June 2019**

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## INTRODUCTION & EXECUTIVE SUMMARY

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Created in 2012, the Office of Inspector General of Nebraska Child Welfare (OIG) provides independent investigation and performance review of Nebraska's child welfare system. The primary goal of the OIG's investigations and reviews is improving child welfare procedures through identification of systems issues and needed policy changes. The Office of Inspector General of Nebraska Child Welfare Act sets out duties for the OIG, including investigating, "death or serious injury [...] in any case involving an investigation under the Child Protection and Family Safety Act, which case has been open for one year or less [...]." Serious injury is defined as: "an injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition."<sup>1</sup>

The OIG is notified of deaths and serious injuries within the child welfare system via Critical Incident Reports. Between June 2016 and June 2019 the OIG received four reports (one death and three serious injuries) from the Department of Health and Human Services (DHHS) involving children who had been the subject of a child abuse or neglect Initial Assessment (also called an investigation) within the 12 months prior to the critical incident. In each of the four cases<sup>2</sup> the Initial Assessment was DHHS' only recent involvement with the child prior to the death or serious injury.

The following report calls attention to trends the OIG found in these four cases, including shortfalls in the investigation and assessments that took place within 12 months prior to the incident where the child was seriously injured or died and systemic issues that impacted how the Initial Assessments were conducted.

The OIG observed that when analyzing the IA(s) prior to the critical incidents, the cases shared key similarities. These included: a complex family dynamic that was not recognized; CPS history that was not identified; and, protective parenting capacity that was not corroborated outside of the family unit.

Through its investigation of the death and serious injuries of children where there was an IA prior to the critical incident, the OIG found:

1. Child vulnerabilities were identified, but there is no evidence that they were appropriately taken into consideration throughout the IA investigation;
2. Secondary caregivers were not thoroughly investigated preceding the critical incident.
3. Supervision of the investigation and assessment process prior to the critical incident was insufficient.

Based on its findings, the OIG has identified areas where systemic improvements should be made to improve the quality of Initial Assessments. The OIG recommends that DHHS:

1. Enhance policy and tools specific to the examination of secondary caregivers in an investigation.

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<sup>1</sup> Neb. Rev. Stat. §§43-4301 – 43-4331.

<sup>2</sup> The OIG has changed the names of all persons related to the cases to protect their identity.

2. Provide training and tools for workers and supervisors to better evaluate drug/alcohol use to ascertain whether caregiver substance use is affecting the safety of the child.
3. Provide educational and community resource referral material to the family during every Initial Assessment and require documentation of what materials or referrals were provided.
4. Conduct a work study of Child Protective Services (CPS) Supervisors.

## BACKGROUND

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Initial assessment (IA) refers to the process of assessing families after a report of child abuse, neglect, or dependency has been accepted by the Child Abuse and Neglect Hotline (Hotline). The IA encompasses the processes of investigation and assessment, conducted by a Child and Family Service Specialist (worker) from the Department of Health and Human Services – Division of Child and Family Services<sup>3</sup> (also known as CPS), and is generally concluded within a 30-day period. It is intended to ensure child safety, determine whether the alleged maltreatment occurred, and decide if the family should be offered services through ongoing case management (ongoing case). Once a report of abuse or neglect has been accepted by the Hotline, an investigation into the allegations is completed by a worker, a law enforcement officer, or both, depending on the specific situation.

In 2012, DHHS adopted Structured Decision Making® (SDM), a nationally-recognized set of assessment tools used to guide decisions on child safety, risk of future maltreatment, and whether services should be offered. The SDM Safety Assessment and Risk Assessment are the foundational tools of evaluation during IA.

The SDM Safety Assessment policy and procedure document states; “The purpose of the safety assessment is to assess whether a household presents imminent danger of serious harm to any child, and if so, to determine what interventions should be initiated to provide appropriate protection or if protective placement is necessary.” At the completion of the Safety Assessment, the child or children are found to be SAFE, CONDITIONALLY SAFE (with the use of a safety plan), or UNSAFE in the care and custody of their caregiver(s) and placement outside of the home is the only protective intervention possible.

The second assessment, the Risk Assessment, is conducted after the Safety Assessment, and within 30 days of the accepted intake. The Risk Assessment measures the likelihood of further maltreatment occurring in the following 12-18 months. Families are scored to be at LOW, MODERATE, HIGH, or VERY HIGH risk. A score of HIGH or VERY HIGH results in the family being offered services from child protective services within DHHS.<sup>4</sup> An ongoing case may be declined by the family except in those situations where the court has become involved and participation in services has been court ordered.

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<sup>3</sup> The Department of Health and Human Services – Division of Child and Family Services staff function in the role commonly known as Child Protective Services (CPS) in this report the division of Child and Family Services will be referred to as CPS and staff associated with CPS work will be referred to as worker(s) or supervisor(s).

<sup>4</sup> Division of Children and Family Services Protection and Safety Procedure Memo #2-2018 – Initial Assessment, effective May 7, 2018.

## CASES INCLUDED IN THE REPORT

All cases included in this report came to the OIG’s attention through DHHS Critical Incident Reports. During the calendar years 2016-2019, the Hotline accepted an average of 13,900 intakes per year alleging the abuse and/or neglect of 19,000 individual child victims.<sup>5</sup> The four cases included in this report make up a very small fraction of one percent of the total assessed cases and individual child victims during that period.

Table I provides basic details for each of those cases. In three of the four cases (Blair, Douglass, Hosta) the children were found to be SAFE from immediate threat and at MODERATE risk of maltreatment in the next 12-18 months. Based on the Safety Assessment and Risk Assessment, the families would not have been offered ongoing services from DHHS. In the fourth case (Frost) the children were found to be SAFE. The Risk Assessment in this case had not been completed prior to the critical incident because the serious injury occurred before the Risk Assessment was due to be complete.

**Table I. Reviewed Case Data**

	AGE	CRITICAL INCIDENT	PREVIOUS IA CLOSURE DATE	CRITICAL INCIDENT DATE	SERVICE AREA
<b>Addy Blair</b>	4 years	Death due to neglect  Blunt Force Trauma	January 17, 2017	July 11, 2017	Southeast
<b>Camila Douglass</b>	5 years	Serious Injury due to abuse  Abusive Head Trauma	August 7, 2015	June 16, 2016	Southeast
<b>Evelyn Frost</b>	9 months	Serious Injury due to neglect  Near Drowning	IA still open at time of Critical Incident	July 20, 2017	Eastern
<b>Gabby Hosta</b>	6 weeks	Serious Injury due to abuse  Abusive Head Trauma	May 21, 2019	May 23, 2019	Northern

<sup>5</sup> Data provided to OIG by DHHS. The OIG used the numbers provided to calculate the average number of accepted intakes per year from 2016 through 2019 and the average number of involved individuals.

The investigation into these four cases included the IA occurring within the prior 12 months of the death or serious injury. In the course of its investigation, the OIG gathered information from the following sources:

1. DHHS records for all cases and children included in the review;
2. Law Enforcement records of death and serious injury investigations;
3. Law enforcement records of prior child abuse and neglect investigations related to the children named in the critical incidents;
4. Interviews with DHHS administrators, supervisors and workers;
5. Interviews with trainers and supervisors from Center for Children, Families and the Law;
6. Interviews with representatives from the National Council on Crime & Delinquency Children's Research Center – Child Welfare Division;
7. Review of relevant statutes, rules and regulations, and administrative memos; and
8. Review of literature and social work best practices.

## CASE SUMMARIES

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### **Death of Addy Blair**

**Age:** 4 years

**Location of Incident:** Southeast Service Area

### **Summary of the Critical Incident:**

Irma Blair and Kurt Blair lived together with their blended family consisting of nine children—eight children and one grandchild.

On July 11, 2017, Addy Blair was taken to a local emergency room by her caregiver, Kurt Blair, with complaints of stomach pain, nausea and diarrhea. Kurt stated that Addy had become ill on July 10, but he and her mother had thought it was a stomach virus. When she did not improve and began complaining of stomach pain, he brought her to the emergency room. Addy was conscious and alert when first seen by medical staff at approximately 8:00 p.m. Within an hour, while still at the emergency room, Addy started complaining of shortness of breath. Her condition quickly declined, and she was pronounced dead at 9:54 p.m. Medical staff reported that Addy had bruising on the left side of her face, lower right leg and on her abdomen which was distended.

The resulting autopsy identified evidence of blunt force trauma to the abdomen as well as secondary complications of the trauma. The cause of death was identified as a combination of septic shock<sup>6</sup> and abdominal hemorrhage which were secondary to blunt force trauma to the abdomen, with the exact cause of the blunt force injury undetermined.

No criminal charges were filed in the death of Addy Blair.

### **DHHS Involvement Prior to the Critical Incident:**

Irma Blair, Addy's mother, has a CPS history in both Tennessee and Nebraska. Her Nebraska history dates back to 2008. Based on information available on N-FOCUS at the time of Addy's death, Irma had 14 intakes in Nebraska and four in Tennessee.

Information on the Tennessee history was limited to allegations and outcomes with one intake dated 2011. While in Tennessee, Irma had two physical neglect intakes, one physical abuse intake, and one intake for educational neglect. Of the four intakes one was unfounded, two were not completed due to being unable to locate the family, and the intake for educational neglect was court substantiated.

Addy was directly involved, being specifically identified as a victim and/or a member of the household, in 8 intakes while in the home of her mother or two different maternal aunts.

Six months prior to Addy's death, on December 7, 2016, the Hotline accepted a report of alleged physical abuse of Addy by Irma for Initial Assessment. The reporter stated that Addy had four linear marks on her left shin and calf moving down to the ankle and three linear red marks on the outer

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<sup>6</sup> The Mayo Clinic explains septic shock to be the progressed result of the body's response to infection which causes a dramatic drop in blood pressure. Retrieved on 02/21/20 <https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214>.

right leg progressing from the shin to the ankle with an additional two or three linear red marks on the inside of the leg and a horseshoe shaped red mark on the inside of the knee. When questioned about the marks, Addy stated that her mother had hit her with a hanger.

The intake was assigned a priority level of two and local law enforcement was notified of the report. An officer made contact with Addy on the same day the intake was accepted. He reported Addy gave an explanation for the marks consistent with the intake.

As part of the screening process, the Hotline made a collateral call to the worker currently working with the Emily Pacer family (sister to Irma Blair) who was living in the Blair home. The worker informed the Hotline that she was working only with Emily and her child and had not made any contact with Addy while in the home.

The Safety Assessment completed five days after the intake was accepted, found Addy and her siblings SAFE as the worker did not identify any active safety threats to the children.

The Risk Assessment did not identify Kurt Blair as a caregiver, indicating that there was no secondary caregiver in the home. A final risk score of MODERATE recommended case closure. The worker agreed with the recommended case closure and a finding of an unfounded allegation. She provided the following statements in the conclusion narrative as support for both the recommendation and finding:

- Addy had been inconsistent in telling her account of what had happened to the worker;
- Law enforcement had not cited the caretakers at the time of their contact;
- Irma had provided a logical explanation for the injuries;
- None of the children in the home reported abuse by Irma;
- Irma and Kurt are able to provide for all the children; and,
- Irma's home is shared with her sister Emily Pacer who is currently court involved with an ongoing case, thus "there are many people in the home on a regular basis, none of whom has ever expressed any concern."

## **Serious Injury of Camila Douglass**

**Age:** 5 years

**Location of Incident:** Southeast Service Area

### **Summary of the Critical Incident:**

On June 16, 2016, emergency crew and law enforcement responded to a 911 call to the home of Camila Douglass's father, Lance Douglass, and his girlfriend, Madison Noel. Madison, the only adult in the home at the time of the incident, reported that Camila accidentally fell down the stairs. Camila was transported to the hospital.

The following injuries were observed or detected after a medical evaluation: subdural hematoma, basal skull fracture, retinal hemorrhages, extreme deep bruising under, inside and behind both ears, including bruising on the ear lobes that were almost black, large bruises on her left shoulder blade,

multiple bruises on her buttocks with linear lines consistent with a solid straight object, bruises on both arms toward the wrist area, bruises on her shins, scrapes and contusions on both knees, contusions on her left shoulder, and bruises on her chest area, as well as a large knot on her left forehead above her right eye, and a small bruise on her forehead above her right eye. Medical staff also noted concern for Camila's weight, stating that it was well below the expected weight for her age and stature.

Two independent medical specialists in child abuse reviewed Camila's injuries and determined they were not consistent with Madison's description of events and were not accidental but abusive in nature including, but not limited to, abusive head trauma.

Lance Douglass and Madison Noel lived together with their five children. The Noel children's biological fathers were not involved with their children, while Camila was having sporadic visits with her mother (Opal Peterson), she remained predominantly in the Douglass-Noel home.

In October 2016, both Madison Noel and Lance Douglass were arrested and charged with two counts of felony child abuse each. In March 2017, Madison was sentenced to a six year prison term. Lance was sentenced to a prison term of two years in July 2017. Madison Noel, Lance Douglass, and Opal Peterson voluntarily relinquished parental rights to the children in 2017.

#### **DHHS Involvement Prior to the Critical Incident:**

In June 2015, Lance Douglass and Madison Noel moved in together along with their children. Madison was not employed outside of the home and provided full-time care for all of the Douglass/Noel children. The Hotline accepted an intake for the Noel/Douglass household a month later on July 9, 2015. The priority one intake alleged that Camila had disclosed sexual abuse by her father. A Safety Assessment of the Douglass/Noel home found Camila to be SAFE. Documentation noted Camila's mother [Opal] agreed to keep Camila with her and not allow Lance contact with Camila during the CPS and law enforcement investigations. Camila was interviewed at the child advocacy center, underwent a physical examination, and continued to disclose details of sexual abuse by her father. Throughout the investigation, both Lance and Madison agreed to meet with law enforcement officers and the worker, but refused to answer their questions citing the advice of Lance's attorney.

Concern for the Noel children, who remained in the home, grew when Madison denied potential risk to her children during an interview with law enforcement. A Circumstances Surrounding Maltreatment narrative dated August, 6, 2015 stated that a safety threat had been identified and a safety plan put into place for the Noel children. Madison agreed to not allow Lance to be alone with her children while the investigation continued.

Madison was utilized as the sole safety plan monitor despite denying a safety issue and having a juvenile history of both being an alleged victim of sexual abuse and perpetrator.

The Risk Assessment initiated on July 9, 2015, found the family at MODERATE risk of further abuse and/or neglect and recommended case closure. The worker documented that at the time of the assessment no arrests had been made, but the criminal investigation continued. She went on to state that should no arrests be made, it was her recommendation to "agency substantiate" the allegations

due to the extent of Camila's disclosures in her interview at the child advocacy center and again with medical professionals. The worker advocated for the use of a discretionary override to keep the case open and provide on-going case management due to the continuing criminal investigation, a potential request to file, and the current safety plan.

The Risk Assessment conclusion narrative was updated on August 7, 2015, with a change in opinion from the worker as to whether the evidence could meet the requirements for a finding of "agency substantiated", stating the findings for the allegation of sexual abuse of Camila by her father would instead be "unfounded". The Risk narrative documented that there had not been any arrests made as a result of the law enforcement investigation to date and "it seemed possible that Camila may have been exposed to incidents that led to her exploration of herself and her disclosure." The narrative concluded that due to Camila recanting her statements about her father sexually abusing her, and Lance not admitting to anything "there is not enough evidence to state that Lance is the perpetrator or that more likely than not these incidents happened as reported." The family's CPS case closed on August 10, 2015, with the allegations listed as unfounded.

Requiring a higher burden of proof and evidence beyond a reasonable doubt, the law enforcement case was closed due to lack of evidence on August 31, 2015.

In December, Camila again discussed the sexual abuse by her father with a therapist. The therapist called the Hotline to report the disclosure, however the intake was screened out as Does Not Meet Definition due to the disclosure only containing allegations that had been previously investigated.

In January 2016, Opal Peterson was granted temporary custody of her daughter with Lance being allowed weekly visitation. By the time of the June 2016 critical incident, Camila had resumed living with Lance and Madison full-time, and contact with her mother was once again sporadic.

### **Serious Injury of Evelyn Frost**

**Age:** 9 months

**Location of Incident:** Eastern Service Area

#### **Summary of the Critical Incident:**

On July 20, 2017, law enforcement and emergency medical personnel responded to a 911 call for the possible drowning of nine-month-old Evelyn Frost. Medical staff estimated that she had been hypoxic (experiencing inadequate levels of oxygen in the body) for approximately two to five minutes.

Evelyn's mother, Robin Smyth, reported to officers that she had placed Evelyn and her two-year-old brother, Trevor Frost, into the bath tub together and then left the room for an undetermined amount of time. When Robin returned to the bathroom, she found Evelyn face down in the water and Trevor still sitting in the tub where she had left him. During an interview with law enforcement, Robin admitted to officers that she had used methamphetamine within the previous seven days of the incident.

In November 2017 Robin plead guilty to the charge of misdemeanor negligent minor care and was sentenced to six months' probation.

### **DHHS Involvement Prior to the Critical Incident:**

Robin's first contact with CPS prior to the critical incident occurred on June 28, 2017. An intake was accepted by the Hotline alleging that Robin Smyth was using methamphetamine and neglecting her two young children.

A CPS supervisor made contact with Robin on July 5, 2017, and noted that the mother was co-sleeping with her children, there was minimal food and formula in the house and that Robin had a history of court ordered substance treatment. Robin denied methamphetamine use and refused drug testing. At the conclusion of the contact, Robin agreed to have a pack & play brought to the home by the worker. Robin was provided the opportunity to obtain groceries and formula. After leaving the home to pick up the pack & play for the mother, the worker went to meet Robin at the agreed on location and discovered that she and the children had left the area. A Safety Assessment completed on July 6, found the children to be safe. The supervisor noted in the assessment that despite strong concern, there was no evidence to support a safety threat or to support that drug use was in fact occurring due to the parent refusing a voluntary drug test, no physical evidence found in the home or behavioral evidence observed at the time of contact. The worker continued her attempts to contact and/or locate Robin following the initial contact with her. A Risk Assessment was not due for the intake at the time of the critical incident.

### **Serious Injury of Gabby Hosta**

**Age:** 1 month

**Location of Incident:** Northern Service Area

### **Summary of the Critical Incident:**

On May 25, 2019, Van Waterman (maternal grandfather) called 911 in response to his granddaughter having a seizure. Gabby Hosta was transported to a hospital by emergency medical staff where she was assessed for injuries, and then flown to Children's Hospital in Omaha.

Doctors reported that Gabby had sustained significant injuries including a fractured skull with multiple brain bleeds, blood on the spine, fractured left and right collar bones, a fracture of the right humerus, the right femur and both tibias, and five broken ribs all in various stages of healing including some fresh breaks. Initially, Gabby was not expected to survive her injuries.

In an interview with Nebraska State Patrol on June 4, 2019, Gabby's biological father (Allan Hosta) admitted to becoming frustrated with Gabby, throwing her in the air which resulted in her hitting her head on the ceiling of the bedroom, he then shook her violently back and forth.

Allan pleaded no contest to felony child abuse with intentional injury and was sentenced to a 30 to 40-year prison term.

## **DHHS Involvement Prior to the Critical Incident:**

Allan Hosta and Beth Coleman are the biological parents of Gabby Hosta.

The first CPS contact for Gabby Hosta occurred two days after her birth on April 15, 2019. Medical personnel called the Hotline to report concerns that Beth was not able to care for the newborn and was not appropriately bonding with her. The intake was screened as Does Not Meet Definition (DNMD) due to the baby's father being observed by hospital staff appropriately caring for the newborn while in the hospital.

On April 30, 2019, two more reports were made to the Hotline alleging Beth and Allan were neglecting their daughter. The first reporter stated that the parents were not appropriately feeding the baby and that Allan was using methamphetamine. This report was accepted for assessment. The second report, made by medical staff, was screened as a multiple report. The intake alleged that Beth was "doctor hopping" with Gabby to avoid follow up appointments due to the baby losing weight, and that the new mother was refusing pediatrician recommended Home Health Care programming to help her learn to care for the new baby.

Before contacting the family, the worker made a collateral contact with a cousin who had been with the family two weeks prior. The family member told the worker that she was concerned about doctor hopping to avoid having Home Health Care provide services. She also reported that while in the home of Beth and Allan she observed their roommate using methamphetamine, and she believed that Allan was using as well. A second collateral contact was made with the medical clinic where Gabby was last seen for a well-child check. The nurse informed the worker that the couple was generally cooperative, but that it had taken "extra persuasion" to get the parents to comply with scheduling and attending appointments and that they had refused Home Health Care services multiple times despite Gabby's doctor strongly recommending them.

The worker met with Beth, her mother, her aunt, and her brother at the DHHS office on May 8. Contact with Allan was made during the meeting via telephone as the father stated he was too busy to meet with the worker in person. The Safety Assessment of Gabby was completed on May 9 and found the baby to be SAFE due to the family denying drug use and no evidence that Gabby was continuing to lose weight.

A follow up meeting was scheduled for May 16 at the home of Beth's mother and step-father as the couple had moved in with the grandparents several days after the worker made the initial contact with them. The worker completed a walk-through of the home and met with Allan in person.

The Risk Assessment, completed on May 22, indicated MODERATE risk for future neglect/abuse and recommended case closure. The worker agreed with the recommendation, noting that Beth and Allan were living with maternal grandmother [Franny Waterman] so the couple would have a support system in place to assist with caring for Gabby. The case closed 24 hours prior to the serious injury of Gabby.

## INVESTIGATION FINDINGS

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Within the OIG investigations of the four cases, the OIG identified issues which are included in the following findings. Additional issues identified, but not included in these findings, will be monitored and potentially included in future reports.

*Child vulnerabilities were identified, but there is no evidence that they were appropriately taken into consideration throughout the IA investigation.*

Within the 12 months prior to the critical incident, all the children were shown to have a decreased ability to protect themselves from future abuse/neglect due to coexisting vulnerabilities. Two of the cases involved children who were preschool age (Douglass, Blair) and two of the cases involved infants under the age of one year (Hosta, Frost) thus, all four children were vulnerable due to their young age. In addition, all of the children were vulnerable due to diminished visibility to others outside of their immediate family.

It is understood that the majority of abuse/neglect reports concern children who are limited in their ability to remove themselves from the situation; to seek out other protective persons; and, to have contact with others who are able to recognize the danger and take an active role in keeping them safe. And these cases do not subsequently result in a critical incident. The OIG also recognizes that these two coexisting vulnerabilities (young age and diminished visibility) are not unique to only the children included in the critical incidents that are the subjects of this report.

The SDM Safety Assessment tool used by Nebraska workers identifies the following vulnerabilities to safety and risk: age six and under; significant diagnosed medical or mental disorder that significantly impairs ability to protect self; isolated or less visible in the community; extreme allegiance to the alleged perpetrator; diminished developmental/cognitive capacity; diminished physical capacity; and prior history of abuse/neglect as a victim that impacts child's ability to protect self.

SDM guidance informs workers that child vulnerabilities are conditions resulting in a child's inability to protect themselves. Workers are specifically instructed that younger children are to be considered more vulnerable, as they are less verbal, less able to protect themselves from harm, and have less capacity to retain memory of events. In regard to infants, workers are told that they are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protections.<sup>7</sup>

DHHS Policy and Procedure Memo #2-2018 provides ambiguous guidance related to child vulnerabilities, stating that at the initial contact and every subsequent contact with the family, the worker must recognize immediate safety concerns, starting with a review of child vulnerabilities that will be considered throughout the assessment.

The importance of identifying child vulnerabilities is that they indicate there are factors within the child's family and their environment that increase the likelihood of harm from abuse and neglect. When these vulnerabilities coexist, the potential for harm may be heightened because the greater the

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<sup>7</sup> "SDM Initial Assessment Policy and Procedure Manual." NDHHS March 2013.

number of coexisting vulnerabilities, the higher the risk of maltreatment.<sup>8</sup> The OIG was unable to locate evidence within the documentation of these cases that indicated workers were taking this into consideration throughout the IA process.

*Secondary caregivers were not thoroughly investigated preceding the critical incident.*

Through the process of case review and personnel interviews, the OIG found that gathering information about secondary caregivers was not pursued with the same tenacity as gathering information about primary caregivers. Superficial consideration was given to the secondary caregivers during the investigation which resulted in the inadequate assessment of safety and risk to the child.

In three of the four reviewed cases (Douglass, Blair, Hosta) the secondary caregiver was involved in the death or serious injury and had been present in the household during the investigation prior to the critical incident. During those investigations, workers were less assertive when:

- Making contact with them,
- Obtaining information about them and their role within the family, and
- Incorporating informal assessment and/or observation of them into case work documentation.

The investigation of the Douglass-Noel home did not note the three intakes occurring from 2011 through 2015 for Madison (secondary caregiver) or relevant information from her juvenile history with CPS. A narrative from the Blair case clearly suggested that Kurt Blair was a secondary caregiver by stating that Irma and Kurt could provide for the children, yet assessments indicated there was not a secondary caregiver in the home. In the Hosta case, the intake identified secondary caregiver Allan Hosta as one of the perpetrators of neglect and alleged his use of methamphetamine. A collateral contact confirmed there was concern that Allan was using methamphetamine. Despite this, brief initial contact was made with him by phone, in person contact was delayed until nine days later, and documentation was absent of information about his prior involvement with CPS as a juvenile or drug use as an adult.

*Supervision of the investigation and assessment process prior to the critical incident was insufficient.*

Through the process of reviewing policy and procedure, case file reviews, and interviews, the OIG found that prior to the critical incident, the supervision of the investigation into alleged child abuse or neglect and assessment of the maltreatment was insufficient. This was evidenced by IA supervisors not detecting or correcting case management and assessment errors and/or practices that were inconsistent with policy.

Unlike the Blair, Douglass and Hosta cases, the Frost investigation was completed in its entirety by an IA supervisor and presented very few of the same type of quality issues noted in the other three cases.

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<sup>8</sup> Rycus, J. S., & Hughes, R. C. (1998). Field guide to child welfare. Washington, DC: CWLA Press.

- The incorrect documentation of blended families in NFOCUS case files;
- Parents declining to answer any questions about the allegations; and,
- SDM errors such as incorrectly entered Safety Assessment findings, undocumented Safety Plans, and contradicting Risk Assessment answers and supporting narratives.

Policy and procedure documents provide detailed guidance as to the expectations and duties of supervisors during Initial Assessment (see Appendix A). Supervisors are directed to assure that the worker has gathered pertinent, relevant and adequate information to arrive at the necessary decisions, review worker documentation to assist with clarifying what information is known about the family and what it means, and to sign off on Safety Assessments, Safety Plans and Risk Assessments as a means of stating that everything that reasonably could be considered has been brought to bear in arriving at the conclusions of the assessment. Supervisors and workers are provided with mandatory points of consultation that are to be documented by the supervisor (see Appendix B), and supervisors are expected to conduct SDM Case Reviews monthly for permanent workers and more frequently for probationary workers (see Appendix C).

While these documents are specific, it is understood that the practical application of these requirements are left to the individual supervisor. Individual supervisor experience, skill level, and disposition could explain why, in contrast to the written expectations of supervisors, workers reported that they frequently don't feel comfortable when managing complex cases asking their supervisor for extra time to discuss the case in general. Workers reported they believe once they complete their probationary period they are expected to work independently with little feedback and/or support, thus as a means of finding support and guidance they most often rely on co-workers and sometimes supervisors other than the one they are assigned. A worker explained to the OIG "the supervisors have so much being put on their plates by administration...they don't have extra time to give us until we screw up."

In response to this issue, DHHS administration shared with the OIG that supervisors are not necessarily doing more work, but instead are being trained to do the work differently and are steering away from "hallway supervision" practices. They went on to state that workers may perceive this as their supervisor having more work when in reality supervisors are being trained to respond to the worker's requests/questions in a more purposeful way, thus they (the worker) assumes the reason their supervisor is responding to them differently than in the past is because they (the supervisor) have more work to do.

It was brought to the OIG's attention that a change in procedure has shifted the oversight of SDM work product. It is no longer necessary for supervisors to review and approve all SDM assessments before they are finalized. Workers can now finalize their own SDM assessments or the assessment will be automatically finalized within the system after a period of 10 days from completion. When asked for clarification of the process, DHHS administration stated that while this is the procedure, supervisors still have access to all completed assessments, the ability to review them, and to require workers to edit/make changes to them as necessary. This change came as a response to feedback from supervisors who indicated that they were spending all their time giving SDM a cursory review instead of focusing on workers that needed more support or those on work improvement plans. Supervisors reported that they were having to take SDM reports home on the weekends to keep up and were spending extraordinary hours at the office reviewing SDM thus not giving 100% of their

attention to any one reviewed document. The goal was that the change in SDM review requirements resulted in supervisors putting their energy where it was most needed and most efficient.

When asked about the requirement for monthly SDM reviews, which is meant to assure quality and identify critical thinking errors; a supervisor acknowledged that in her experience the reviews can “slide down list”, noting that once a worker “hits the one year mark” the expectation is that they are able to do the work without constantly being checked on.

Locating, assimilating, and analyzing the chronology of CPS involvement, formulating a clear understanding of family functioning, assessing the impact of child vulnerabilities, and proper documentation coupled with accurate SDM assessment completion requires critical thinking and job experience that is best supplemented with supervisor guidance.

## RECOMMENDATIONS TO DHHS

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The OIG is tasked with making recommendations to improve system performance and efficiency.<sup>9</sup> The OIG's investigation of death and serious injury within the 12 months following Initial Assessments recognized a number of areas in the Initial Assessment process where improvements are needed. Adopting the recommendations in this section will assist in making improvements to the identified systemic issues, and result in better safeguards for children through more thorough investigations, appropriate connections to services, and consistent quality monitoring by IA supervisors.

### **I. Enhance policy and tools specific to the examination of secondary caregivers in an investigation.**

Over time, the OIG has noted the role of secondary caregivers in critical incidents of abuse in multiple reports, including in the 2016 Report of Investigation: Death and Serious Injury Following Child Abuse Investigations<sup>10</sup>, which detailed the death or serious injury of 10 children occurring after a child abuse investigations. The OIG finds that secondary caregivers are not subject to a sufficient level of scrutiny.

Current policy and practice related to the inclusion of secondary caregivers in the IA process is found in Protection and Safety Procedure Memo #2-2018. The memo narrowly covers the identification of a legal parent who provides 49% of the care to the child or another unrelated adult in the home who provides the most care for the child, for the purpose of accurately completing the SDM Risk Assessment. Protection and Safety Procedure Memo #2-2018 regarding Initial Assessment is void of any other direct language related to a secondary caregiver.

Strictly defining a secondary caregiver for the purpose of completing the SDM Risk Assessment is understood, however, there exists a gap between the SDM definition of a secondary caregiver and the reality that there could be multiple caregivers relevant to the investigation who truly function as a secondary caregiver. Examples of this type of secondary caregiver could include a boyfriend/girlfriend living in the home who interacts with the child, other family members providing care for the child, or other unrelated persons identified by the family as significant to the care of the child on a routine basis.

Providing workers with a tool to assist them in more broadly considering actual secondary caregivers will assist with obtaining critical information when evaluating the alleged maltreatment of a child or children within the household. Explicit examination of secondary caregivers should also be conducted by workers during the investigation process. The addition of more specific policy relating to secondary caregivers and tools to assist workers in gathering information from secondary caregivers would acknowledge the significant role they play within the functioning of the family. It is

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<sup>9</sup> Neb. Rev. Stat §43-4327.

<sup>10</sup> "Office of Inspector General of Nebraska Child Welfare Report of Investigation: Death and Serious Injury Following Child Abuse Investigations October 2013-June2015." OIG: March 15, 2016.

important to ensure that all caregivers in the household are being included in the assessment of safety and risk, and that pertinent information about them is being documented within the case file.

## **II. Provide training and tools for workers and supervisors to better evaluate drug/alcohol use to ascertain whether caregiver substance use is affecting the safety of the child.**

In Protection and Safety Memo #3-2018, DHHS states that alcohol and drug use can be a contributing factor in child abuse and neglect, but drug testing is not an effective gauge of use, abuse, or dependence, nor do drug tests provide sufficient information for substantiating allegations of abuse and neglect. The memo quotes the National Center for Substance Abuse and Child Welfare's position that a drug test alone cannot determine the existence or absence of a substance use disorder.

In order to ascertain whether a caregiver's substance use is affecting the safety of a child, a worker must first identify whether substance use is occurring; if it is occurring, whether it is a problem; and if it is problem, whether the caregiver's substance use detrimentally affects the safety of the child. In the absence of a drug test, workers routinely stated and/or documented that they were unable to determine if drug use was a factor in the investigation and in determining safety and risk. Workers lack the knowledge and tools to evaluate drug/alcohol use in these situations.

Research tells us that the relationship between substance abuse disorders and child maltreatment is undeniable. Parents with substance use disorders are three times more likely to abuse their children and four times more likely to neglect them.<sup>11</sup> It is critical that workers and supervisors be provided with the training and support necessary to evaluate and document the affect caregiver drug use is or is not having on children as part of the Initial Assessment process. Workers in the field state that there is little they can do to identify drug use, unless there is tangible evidence at the time of contact or the parents admit to use. If workers are unable to confidently identify drug use and connect it to child safety issues, interventions, like a referral for a substance use assessment, will be unlikely.

In the Frost case, the mother declined a voluntary drug test. Despite having serious concern for the very young children, the Safety Assessment indicated there wasn't enough evidence to prove drug use to the extent of an active safety threat. In the Hosta case, policy prohibited the use of a drug test. The intake included concerns for methamphetamine use, and a collateral contact reiterated the concern. Again the worker was unable to ascertain whether the drug use, if any, presented a threat to the infant's safety or risk. In both cases, the caregivers denied methamphetamine use during the IA prior to the critical incident and then admitted to using after the serious injuries of the children. The length of time between the prior IA and the critical incident for both the Frost case and the Hosta case was less than 30 days.

Workers and supervisors identified the issue of drug testing/substance abuse to be the area they feel most uncomfortable with and an area where there is need for better training and guidance. The

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<sup>11</sup> Kelleher, K., Chaffin, M., Hollenberg, J., & Fischer, E. (1994). Alcohol and drug disorders among physically abusive and neglectful parents in a community-based sample. *American Journal of Public Health, 84*(10), 1586–1590.

absence of being able to drug test parents has reportedly increased worker stress levels when assessing for the safety of children.

**III. Provide educational and community resource referral material to the family during every Initial Assessment and require documentation of what materials or referrals were provided.**

IA workers responding to intakes alleging child maltreatment through the traditional response model have an opportunity to connect families with information about beneficial services to help keep children safe and to avoid further system involvement. This is currently not happening to the full extent it can or should be.

As an illustration, research indicates that educational campaigns designed to prevent abusive head trauma are most likely to reach mothers, despite the fact that most perpetrators of abusive head trauma are secondary male caregivers. By providing abusive head trauma prevention material to secondary caregivers at the time of the required contact with the family, the opportunity to promote child abuse prevention efforts has been broadened.

An example brought to the OIG's attention at the local office level is the distribution of community resource booklets to all families at the time of an investigation. The resource booklets contain information about local food pantries, women's shelters, public transportation etc., and were provided to the particular office for distribution by a local community group. The office receives updated copies of the booklet and are only responsible for the cost of printing additional copies. This should occur in every part of the state.

Purposefully providing educational material and community referrals into the traditional response model during the IA process, especially to those who will not engage further in CPS services, brings IA into line with the practice of the Hotline making and documenting community referrals in cases that do not meet definition. The Alternative Response model also requires documentation of such efforts at the time of case closure. By expanding the use of educational material and community referrals to traditional response cases, DHHS can increase efforts to avoid future maltreatment.

**IV. Conduct a work study of Child Protective Services (CPS) Supervisors.**

A commitment by DHHS should be made to develop and implement a systematic work study of CPS supervisors. The study should be conducted as soon as is feasibly possible and be inclusive of all service areas. The purpose of the study should include identifying strengths and weaknesses of the current supervisor structure, assessing supervisor workload in relationship to the quality of supervision being provided to workers, and to determine if the need for further supervisor training/development exists. Results of the study should be shared, in good faith, with stakeholders and partners.

Research indicates that it is in the supervision of front line workers that latent conditions for error are the most overlooked and can be the most difficult to detect (for example, whether child vulnerabilities are appropriately integrated throughout the IA process). Lack of training and development of supervisors in conjunction with administrative burdens and a lack of support and guidance can lead to supervisors who have a tendency to lean towards heuristics- shortcuts that ease the cognitive load in decision making. The results of such practices on the team they supervise is workers who describe

themselves as undervalued, in need of more support to fulfil their job duties, and ill-equipped to manage complex cases.

DHHS has made an effort to improve supervisor caseload numbers, increase worker satisfaction and decrease turnover rates, while also initiating research based practices and tools such as those included in Safety Organized Practice to assist supervisors in their duties. However, it is imperative that the role and needs of the CFSS supervisor be thoughtfully and systematically considered and addressed in an effort to maintain quality and stability in the process of Initial Assessment of children and families.

**APPENDIX**

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## Appendix A: Protection & Safety Procedure Update #1-2013



### Division of Children and Family Services

State of Nebraska  
Dave Heineman, Governor

<b>Division of Children and Family Services</b>	
<b>Protection and Safety Procedure Update #1-2013</b>	
<b>Regarding:</b>	<b>Supervision of Initial Assessment Process</b>
<b>Rescinds:</b>	#1-08, #13-2011 Sections on Supervision
<b>Date Effective:</b>	January 8, 2013
<b>Contact:</b>	Suzanne Schied at 402-471-9245 or Suzanne.schied@nebraska.gov
<b>Issued by:</b>	Thomas D. Ristow

#### **Philosophy:**

The Division of Children and Family Services believes that supervisors are the key to successful case practice, and staff support, utilizing their knowledge and experience serving children and families.

#### **Procedure:**

Consultation is important to assure the consistent application of Department policy and to assure that as many factors and ramifications as possible are considered when critical decisions are made. The CFS Supervisor has the responsibility to call to the attention of and redirect the worker regarding any decision made on any case which is not consistent with the following criteria:

1. The safety AND best interest of the child;
2. State or Federal statutes;
3. DHHS policy and practice;
4. Current court orders or established protocol;
5. The case plan; and
6. For DHHS OJS wards, the safety of the community.

#### **During Safety and Risk Assessment:**

CFS Supervisors must provide consultation and support related to the initial contact with the family to begin the assessment:

1. Assure adequate CFS Specialist preparation so that the CFS Specialist understands the nature and family circumstances that represent a threat to child safety; that the CFS Specialist has a strategy for making the initial contact, for collecting information, and for evaluating safety threats. The CFS Supervisor will assist the CFS Specialist in considering possible action if the child is determined to be conditionally safe or unsafe.
2. Consider additional preparation for the safety assessment involving issues around law enforcement participation for purposes of joint investigation/assessment, CFS Specialist safety, legal response to criminal acts, and to assist with child protection. The CFS Supervisor will also discuss other resources the worker may need for the intervention to be successful.
3. Discuss agency response if there is a need for immediate action to protect the child(ren), determine if the CFS Supervisor agrees with the worker's assessment of safety threats, and discuss the worker's planned course of action, verifying that the planned response is the least intrusive necessary to provide adequate protection.

The most essential product of the assessment is information. The CFS Supervisor must assure that the worker has gathered pertinent, relevant and adequate information to arrive at the necessary decisions. Decisions include determining if maltreatment occurred, if there are safety threats present, if the family has any unmet emergency needs, risk or prevention level determinations and if the family is in need of continuing services. The quality of these decisions is directly related to the quality and sufficiency of information gathered. CFS Supervisor consultation early in the assessment process may consider:

1. What the focus of the information gathering should be. The CFS Supervisor should understand all that he/she can about the family functioning which includes the extent of maltreatment, the nature or circumstances surrounding any maltreatment, child functioning, parenting practices and adult/caregiver functioning.
2. How to overcome barriers in information gathering such as caregiver resistance, communication difficulties, access to family members, location and circumstances that must be managed, avoiding premature judgment and conclusions, worker bias, and reasoning vs. rationalization issues.
3. Determining from whom to get information. Who would be the best source of information, discuss the order in which people should be interviewed, and how to use the information to confirm and corroborate.
4. Determining recommendations during the process and completion of an Assessment of Placement Safety and Suitability regarding continued child placement or removal of a child in a foster home and/or care concerns and next steps.

#### **Criteria for reviewing the CFS Specialists documentation**

When reading assessments or discussing family situations with the CFS Specialist, the CFS Supervisor must consider the following characteristics about the information provided:

1. Breadth: Is the CFS Specialist's understanding and analysis of the family based on information that covers the critical points (maltreatment, surrounding circumstances, child functioning, parenting, and adult functioning.) The information gathered about the family is comprehensive;
2. Depth: Is the CFS Specialist's understanding of the situation based on more than superficial information? Is the information pertinent and detailed?
3. Reliable: Is the information trustworthy and dependable, reasonable, believable, and can be justified?
4. Pertinent: Is the information relevant, significant and useful in determining the presence of safety threats?
5. Objective: Is the information factual, actual, and unbiased? Information exists without interpretation or value judgment;
6. Clear: Is the information easily understood and unambiguous?
7. Association: Does the CFS Specialist understand how the information is connected and inter-related? How the information is linked?
8. Reconcile: Has the CFS Specialist resolved differing perspectives so that discrepancies are reconciled?
9. Supported: Is the information confirmed or corroborated by reliable sources outside the immediate family?

#### **CFS Supervisory Assistance During Legal Action**

CFS Supervisor activity related to helping with legal intervention can include:

1. Processing the decision to invoke court authority, including helping the CFS Specialist explore less intrusive options;
2. Approving the decision to remove a child or seek court oversight;

3. Providing step by step guidance to the CFS Specialist regarding necessary documentation and processes required to involve the court, and assisting with preparation of the CFS Specialist to provide testimony;
4. Assistance to the CFS Specialist to produce documentation and take responsibility to expedite the process;
5. Consultation with attorneys representing DHHS' interest;
6. Advocacy for the child and DHHS's interests; and
7. Attendance with the CFS Specialist in various proceedings.

Although the CFS Specialist is responsible for doing the analysis of child safety, the CFS Supervisor may assist the CFS Specialist in clarifying what information is known about the family and deciding what it means. CFS Supervisor questions may clarify what actions are necessary to protect the child and help determine an appropriate safety plan, by identifying family strengths and resources that may be mobilized.

#### **Review and Approval of Initial Assessment**

CFS Supervisory sign off of the safety, risk assessment and safety plan means the CFS Supervisor is taking responsibility for the outcomes that may result from the actions and decisions made. CFS Supervisory approval is a statement that everything that reasonably could be considered has been brought to bear in arriving at the conclusion that the child is safe, conditionally safe, or unsafe; that any necessary safety plan will work as intended; and that the risk level determination had sufficient supportive information.

The CFS Supervisor will complete the Supervisory review of each assessment to assure that:

1. The Initial Assessment was completed correctly and completely;
2. The safety of the child was assured during the assessment process;
3. The safety plan was appropriately completed and implemented to assure child safety, and documented in accordance with required practice (if applicable);
4. The family network and others were appropriately involved in developing safety plans if such plans were necessary;
5. The safety plan is sufficient to protect the child from threats of severe harm (if applicable);
6. The family network and others were appropriately involved in the gathering of information;
7. Information was obtained about non-custodial parent, relatives, and other family supports;
8. Sufficient information was gathered and documented in the Family Functioning narratives in N-FOCUS that supports the safety and risk/prevention assessment decisions;
9. Available written documentation was obtained from law enforcement, medical providers, school personnel, and others as appropriate;
10. ICWA information was documented and active efforts were made to prevent removal from the home;
11. The SDM Assessments were completed and documented in accordance with required practice;
12. The documentation for safety plans, assessments, worker contact and other required narratives are on N-FOCUS, including all mandatory consultation points; and
13. Required SDM and Court time frames were met.

For cases involving allegations of maltreatment:

1. Efforts to coordinate with law enforcement were documented;

2. Interview protocols were followed or reasons for deviation were documented;
3. The appropriate definition was used in making the case status determination;
4. The finding was correctly documented on N-FOCUS system;
5. Factual information supports the selected finding; and
6. Proof of certified notice to the alleged perpetrator is located in the file.

If information is not sufficient or there are other areas of the assessment needing improvement, it may be necessary for the assessment to be returned to the CFS Specialist for additional work.

**References:**

None

## Appendix B: IA Related Mandatory Consultation Points

Adapted from DHHS Protection & Safety Procedures Update #22-2017 as provided in New Worker Training (2019) by the Center on Children, Families and the Law (CCFL).

<b>Supervisor Consultation</b>	<b>Documented by Supervisor in:</b>
1. When a safety threat is identified	SDM Safety Assessment-Supervisor Consultation Narrative
2. When considering any out-of-home placement of a child 3. When evaluating “good cause” to not follow ICWA placement. 4. When a person living in a potential relative or kinship home has been convicted of a crime not listed in the Placement of Relative and Kinship Memo Approval or Denial of Placement Based on Background check section. 5. When considering recommending court action. 6. When a CFSS suspects or receives new allegations of abuse or neglect in the family home or in a foster home.	Program Case Consultation Point
7. When the Initial Risk Assessment risk level is High or Very High and the case involves: <ul style="list-style-type: none"> <li>a. domestic violence;</li> <li>b. methamphetamine use by parent/caretaker;</li> <li>c. previous termination of parental rights;</li> <li>d. serious physical abuse; or</li> <li>e. sexual abuse by parent.</li> </ul>	SDM Risk Assessment-Supervisor Narrative
8. When parent declines to be interviewed or chooses not to allow access to the child during the Initial Assessment. 9. When a response time exception for an intake is needed for families that cannot be located, cannot be identified or the parent declines to be interviewed. 10. When entering a finding of “Unable to Locate” or determining if additional efforts to locate family are necessary.	Intake Consultation Point
11. When no risk assessment will be completed.	SDM Intake Consultation Point
12. In non-court cases where there are no identified safety threats, the risk level is High or Very High and the family declines to work with DCFS.	SDM Risk Assessment-Supervisor Consultation Narrative

## **Appendix C: Protection & Safety Memo #2-2018 [Case Reviews]**

### XXI. SDM Case Reviews;

- A. At a minimum, the CFS Supervisor will conduct the following reviews of SDM Assessments. The CFS Supervisor will utilize discretion and the work performance of individual CFS Specialist to determine the frequency of additional SDM Reviews.
- B. The CFS Supervisor will review every SDM Assessment in which an Override is utilized.
- C. The CFS Supervisor will review every SDM Assessment for New Workers for the first 6 months from training completion.
- D. CFS Supervisors will conduct a random Douglass of SDM Assessments for CFS Specialist who have been fully trained for more than 6 months. One SDM Assessment will be selected each month for each CFS Specialist. The CFS Supervisor will conduct an in-depth review of one SDM Assessment for each CFS Specialist.