Memorandum

To: Charles Flanagan

CC: Chad Campbell

From: Gregory McKay

Date: 11/15/2014

Re: Inactive Case Process

The following is the memorandum you requested regarding my assertions that the process employed to address inactive (backlog) reports is unsafe and contrary to the mission of protecting children. As instructed, I will confine this writing to facts gathered and analyzed to support my position. It is not my intention to simply undermine good faith efforts to confront a daunting task. If the spirit and intent behind eliminating the backlog was numbers driven(statistical reductions sought), I apologize for condemning the process but would still disagree with that methodology. However, if the spirit and intent was to address and ensure child safety, I offer you this analysis and hope you share my concerns. If that is the case, I look forward to engaging a team of dedicated professionals in creating a better option.

On a date and time unknown to me or any other OCWI personnel, a process was developed to address the inactive reports (backlog). I also do not know who was engaged in the workgroup to develop and implement this process. It appears the reviews began on or about June 2, 2014.

On Wednesday, November 5th, 2014, this process was brought into question by the case I emailed you, [redacted] and [redacted] at 1306 hours. Two reports involving this toddler were part of the backlog and received a level one review on August 28th, 2014. The reviewer cited enough information existed to ensure child safety therefore no response was required. The only information in existence was an email stating the child was seen and was safe nearly eight months prior in January, 2014. Without any documentation, nor hand written notes, nor probative questions, the department said this report merited no response. The child was found three days after this review and was described as, "a skeleton with skin draped over him." Two days after that, case notes and a Comprehensive Safety and Risk Assessment (CSRA) were entered documenting a halfhearted investigation that occurred in January, 2014. My concerns are as follows:

- From 2011 to the present date, the Department has received reports and communications involving the following concerns: substance abuse, food deprivation, mental health issues,

domestic violence, poor living conditions, the child's hunger and poor appearance, concealing the child to avoid abuse detection, confining the child by wrapping him so tightly in a blanket as to not move, the child's developmental delays (couldn't speak) and more.

- Reports involved criminal conduct but police were never called by the Department.
- A status communication was received by the hotline in December, 2013, involving the similar allegations.
- In January, 2014, two interviews were done with other children and both stated the victim child wasn't permitted to eat unless he spoke. No action was taken and the child was not appropriately physically assessed. He was observed sleeping in a crib.
- Additional allegations within the report were never investigated.
- No documentation was completed therefore it became inactive.
- In March, 2014, a second source communication was received and attached to the open January report. The report alleged the child was, "skin and bones," and was not fed for three days because he couldn't say the word, "eat." Despite this information, no one responded to assess safety.
- On August 28, 2014, the level one review assured safety was assessed in January and they left out the second source information from March, 2014.
- Upon my inquiry about this case, neither you nor [redacted] replied.
- [redacted] did respond and said safety was assessed during the level one review and added, *"In essence, the investigation had been completed and was awaiting the entering of the documentation into the CSRA."* He also did not mention the second source information from March, 2014.
- A high profile staffing (CIC) was conducted by the DCS team and also failed to address the totality of the case or the second source report in March, 2014. This second source report should have sparked an immediate response.
- On September 4th, 2014, (two days after discovery), DCS documentation was entered into the CHILDS database and the two prior reports were unsubstantiated.
- Although the child was near death from starvation, hospitalized for weeks, and both caregivers were arrested and charged criminally, the Department did not post this case on the Fatality/Near Fatality website per Arizona law.

Note: The first attached document above is an in depth analysis of all investigations involving this child. It provides more detailed facts and expresses the OCWI's concerns for its handling.

Below are two photos of the child in question. I blocked out necessary areas for confidentiality purposes. I am in the process of consulting with physicians to determine (if possible) details as to the length of time to achieve this level of failure to thrive and malnourishment. Considering food deprivation and malnutrition reports began in April, 2013, and continued until September, 2014, I believe we can safely say this child was not safe in January, 2014. For these reasons, I question the efficacy of the implemented plan.

On November 5th, 2014, at 1306 hours, I requested information on the backlog process that was employed by the Department. On November 5th, 2014, at 1425 hours, the document was modified by . On November 6th, 2014, sent me a document titled, "Inactive Cases Work Plan." It is attached above. The first nine pages of the attachment is the plan provided me. The next twelve pages of information I obtained through my own means from people conducting the assessments. What I received from seems to be a high level overview when at least two other work plans with instructions exist. May I inquire as to the existence of more documentation so I could more accurately understand the process?

The Inactive Case Work Plan provided consists of an introduction, a problem, and a work plan process flow. I don't see any clear objective concerning ensuring child safety. The emphasis is one of activating an inactive case, having level one and level two reviews, case closure, and ensuring the cases remain active by monitoring the sixty day timeline and entering a review case note every 60 days to keep the case active. In fact, I couldn't find the words "ensure child safety, eyes on children", etc. anywhere. Boiler plate language is riddled throughout all of the plans I found. Paper reviews are no substitute for actually seeing children and assessing safety.

<u>Critical Incidents:</u>

In addition to the case that started my inquiries, I found five inactive backlog cases that had a level one review that was followed by a "critical incident." I will describe them briefly as follows but they are all attached for your review above:

- Inactive Case Review Tool (Level One)#1: The level one review tool checks "yes" for open investigation but fails to check a box asking if, "Sufficient information was obtained to assess and ensure safety." Reviewer cites "no immediate response is needed" on August 10th, 2014, in response to two, open inactive reports. The case is reactivated same day. On August 28th, 2014, the child is reported by police running down the middle of a street, naked. On September 10th, 2014, a toddler nearly drowned in a dirty pool, required CPR and was hospitalized. The child survived. A different child was found naked and eating in the family car. Unknown if heat was a factor. The CSRA was not completed until after the near drowning and notes children were seen prior to level one review.

- Inactive Case Review Tool (Level One)#2: The level one review tool checks "yes" for open investigation and that "sufficient information was obtained to assess and ensure safety." The case contained multiple concerning prior reports. On February 27th, 2014, an open report alleges the child is present for a domestic violence incident in which the father threatened to cut the mothers throat. The mother left the home and father wouldn't allow child to leave. The father and mother have a history of sexual trafficking. The father's criminal history is very extensive. The caseworker claims she was directed by police to not interview the children due to an ongoing police investigation. This never excuses our

obligation to ensure safety. Additionally, the caseworker had difficulty locating the family. The case was reactivated on July 15th, 2014. On August 14th, 2014, the child was present when the father and his friend kidnapped and assaulted a female who refused to prostitute for him. The female was hospitalized and the father was arrested. All CSRA documentation was entered after the critical incident involving sexual trafficking, kidnapping, and assault.

- Inactive Case Review Tool (Level One)#3: The level one review tool checks "yes" for open investigation but fails to check a box asking if, "sufficient information was obtained to assess and ensure safety." On December 12th, 2013, a report of physical abuse was made and becomes inactive. There are no reviewer comments but the case is activated on July 14th, 2014. On August 18th, 2014, a toddler died from drowning in the pool. OCWI and police investigated. Per the law enforcement agency, criminal charges were submitted. There were handwritten notes found in the abandon case file that suggests family contact occurred on March 13th, 2014. All documentation/CSRA was completed after the child's death. This death was not reported on the Fatality/Near Fatality website.

- Inactive Case Review Tool (Level One) #4: The level one review tool checks "no" for open investigation and "yes" that "sufficient information was obtained to assess and ensure safety." There is no report date or report number listed. The reviewer notes the child was last seen on March 14th, 2014, says a CSRA was completed and no safety concerns are identified. The case was reactivated on August 5th, 2014. There are three prior reports and one prior substantiated dependency adjudication. On October 31st, 2014, the toddler was found unresponsive and was pronounced deceased. The child had medical issues but no cause of death was known or anticipated based on health issues. The case is pending the autopsy results.

- Inactive Case Review Tool (Level One)#5: The level one review tool checks "yes" for open investigation but fails to check a box asking if, "sufficient information was obtained to assess and ensure safety." The date of the open, inactive case(s) is not listed and nothing is documented on the review tool to assess safety. The case was reactivated on August 27th, 2014. On October 22nd, 2014, the child was present in the home when her mother was violently murdered. Police are still investigating. All documentation/CSRA was completed after the murder.

The level one reviews fail to document how child safety was assured. Additionally, the reviewers are making a safety assessment with no documentation yet available. As seen above, most cases don't have any documentation present until after the critical incident.

<u>Cases Reviewed Requiring an Immediate Response:</u>

- Inactive Case Review Tool (Level One)#1: This inactive report of physical abuse originated on March 12th, 2013. The level one review tool shows "yes" for open investigation and "no" for "sufficient information was obtained to assess and ensure safety." The reviewer lists comments as follows: "Report injury to child's head, substance abuse." The reviewer documents further as follows: "per case manager, child not seen, safety not assessed." This reviewer marked "Immediate Response Required," and reactivated the case on August 18th, 2014. In the Inactive Cases Work Plan provided by [redacted], it says cases requiring an immediate response will be assigned immediately. Based on the information I have, however, an immediate response doesn't occur. The case gets sent to a level two reviewer where more paper review is done instead of going out and seeing a child. Although this case was activated on August 18th, 2014, with clear language that a child was injured and never seen, the level two review was conducted on November 3rd, 2014, with instructions to complete a comprehensive safety and risk assessment. A CSRA has been generated in CHILDS but is blank.

- Inactive Case Review Tool (Level One)#2: This review involves two open, inactive reports originating in March, 2013, and April, 2014. The level one review tool shows "yes" for open investigation and no for "sufficient information was obtained to assess and ensure safety." The reviewer lists comments as follows: "Two reports regarding child under 5, unsafe living conditions, reported drug use by source who is relative, reported domestic violence, police activity." The reviewer documents further as follows: "per case manager, child not seen, safety not assessed." This reviewer marked "Immediate Response Required," and reactivated the case on August 18th, 2014. Again, it does not appear to be assigned for a physical response to assess safety and goes to the level two review process. Again, the level two review was conducted on October 30th, 2014, with instructions to complete a comprehensive safety and risk assessment. The level two reviewer created a CSRA and enters the initial documentation. The rest of the document is blank.

- Inactive Case Review Tool (Level One)#3: This review involves an inactive report originating in February, 2013. The level one review tool shows "yes" for open investigation and no for "sufficient information was obtained to assess and ensure safety." The reviewer lists comments as follows: "Criminal conduct allegations called in from [redacted] sex abuse allegations." The reviewer documents further as follows: "per case manager, child not seen, safety not assessed." This reviewer marked "Immediate Response Required," and reactivated the case on August 18th, 2014. Again, it does not appear to be assigned for a physical response to assess safety and goes to the level two review process. The level two review was conducted on November 3rd, 2014, with instructions to complete a comprehensive safety and risk assessment. The level two reviewer created a CSRA that is blank. Upon review of the original report, the allegation is child molestation committed on a young child six years ago. The child moved to [redacted] mailed a report to the

hotline reporting the sexual abuse. It does not appear law enforcement has been notified. It is unclear as to where this child currently resides (in) or with the alleged perpetrator). There appears to be two other children currently living in the home with the alleged perpetrator.

Conclusions:

As I hope has been demonstrated in this memorandum, the processes employed does not serve the mission of child safety and protection. Below I will propose some initial solutions that may be more appropriate. I need to collaborate with additional people to verify if they will work and be effective considering the challenges the departments is experiencing:

- I would ask( )(Reports and Statistics) to pull data to prioritize reports more efficiently. Using people to determine if a case is an open investigation or an ongoing investigation is time wasted. The data can eliminate the first step of the level one review process.

- Data can separate cases and make an immediate determination as to the immediate need. Open cases, cases involving removals, legal status, etc. If we know a case is in ongoing, it is likely the child has been assessed and the case manager is simply behind on case notes regarding the legal processes or service provision.

- Immediately send out all inactive, ongoing cases (kids in care) to the involved region (APM's or Program Specialists) and instruct them to get case notes updated. We should conduct weekly data runs to see if they are complying which would safety lessen the backlog.

- Identify all abandon cases and assign them to new units with no current assignment or zip code responsibility.

- Identify all resources in the department (this has been challenging).

- Utilize Law Enforcement and other service providers to assist. Facilitate agreements with law enforcement off duty work coordinators and structure a plan to pay officers to respond to select inactive reports.

- Once we have parted out ongoing from investigations I would suggest triaging in this possible manner. The clear objective must be eyes on children and physically assessing safety unless we have legitimate documentation to support the work has been adequately done:

First Round: Substance exposed newborns (SEN's). There is a correlation between SEN's and future serious abuse, neglect, and fatality. Consider the immediate dispatch of police to check welfare on these children.

Second Round: Children five and under. This is the most vulnerable population and the least likely to be seen at schools where abuse or neglect is better detected. Consider the immediate dispatching of police to check welfare on these children.

Third round: Children six and older with 3+ Priors

Fourth round: All remaining

In additional to attempting to remedy the inactive case/backlog issue, I would highly recommend changing the Department's stance to have four different priority codes for incoming reports. Hotline personnel, nor any prudent person can determine when danger is imminent. The OCWI finds some of the most egregious reports as priorities three and four. Historically, and as witnessed in the current constructs, priority three and four reports are the ones deemed eligible for a subdued response or potentially no response at all (although not intentionally). I have suggestions on prioritizing incoming reports as well.

As always, I am prepared and remain committed to protecting children and supporting the long term health and success of this Department.