Crowley Department of Human Services
Program Review
February 28th – March 3, 2005

The Division of Child Welfare has developed protocols for conducting program reviews. One protocol uses data as a significant outcome indicator of quality performance. The Child Welfare Optimization Allocation model contains a variety of data about a county's performance. Staff conducted a comparative analysis of county departments and found an anomaly with Crowley County. The comparison indicated that Crowley County was performing as an outlier on seven factors. The factors in the model are called drivers. The Department has a policy that when a county has more than four outliers a program review will be conducted to ensure children and families are receiving appropriate services. Listed below are the indicators:

- Changes in the child/adolescent population (ages 0-17)
- Number of families referred, per 1,000 child/adolescent population
- Number of children assessed, as a percent of the number referred
- Number of new involvements, as a percent of assessments
- Number of children in residential care as a percent of open involvements
- Average number of days per year a child spends in residential care
- Average cost per day per child for residential care
- "Program services" costs per open involvement (administration and other direct services related to foster care)
- New adoptions as a percent of the total number of children in residential care
- Average cost per child per day for adoptions

Goals:

The goals of the review were to determine that:

1. Procedures were in place to assure child safety for children who might be victims of abuse and neglect or youth in conflict cases

2. Procedures were in place to receive referrals of abuse and neglect from the community and investigate those referrals

3. Procedures were in place to assure timely court review of children in out of home care as well as children in their own homes

4. Mechanisms were in place for accurate Trails data entry. Case information which should have been recorded in Trails was recorded in Trails and cases which should have been "opened" were opened

5. Children receiving services were eligible for services

6. The process for payment of services was appropriate

7. Operational structures support child safety, permanency and well-being

Review Process:

The Review Team included Art Atwell, Director of Workforce Development Services, Jenise May, Child Welfare Financial Manager, Sharen Ford, Child Welfare Manager and Team Lead for this review that was conducted from February 28th –March 3, 2005, onsite at the Crowley Department of Social Services (CCDSS).

The on-site review consisted of:

- Interviews with staff of CCDSS, School Professionals, District Court Judge, Guardian ad Litem, Sheriff Office personnel, and other community professionals
- Review of all referrals, assessments and cases received from January 1, 2004 through February 28th 2005. Per staff all referrals and assessments are recorded in Trails only, the county does not maintain a hard copy or file to be reviewed.
- The Team reviewed four case files. These files included one open subsidized adoption case, one open out-of-home case, a child protection case involving sexual abuse and a child protection case involving substance abuse with a three-year-old child in the home.

General Information:

Information from staff was as follows:

- The county director has been Director of Crowley County Department of Social Services for 28 years.
- The county has employed Eugene Sena Child Welfare Caseworker for approximately 6 years.
- Kathy Medina provides on-call and Friday intake services for Child Welfare. Kathy was hired primarily for the Colorado Works program and 20% of her time is designated for Child Welfare Intake. She serves as the on-call and Friday Intake worker. She has been with CCDSS for 9 years.
- The structure of CCDSS is that the Director and the caseworker both carry caseloads with the Director supervising the caseworker and the intake caseworker.
- Both CCDSS casework staff are very proficient in utilizing the Trails system.
- The Child Welfare caseworker divides his time among Child Welfare, Child Care Assistance Program, Adult Protections Services, and Adult Services Ombudsman for the county.
- Accounting staff is under the Crowley County Administration.
- The Court had expressed concerns over the lack of filing of dependency actions by CCDSS.

- Staff reported a culture of minimizing the actual home environment or family functioning assessment of children for whom referrals of abuse and neglect had been made.

This review will only cover issues that have been identified as of the writing of this report. A subsequent report will be provided to address any additional financial or other issues and serve as an update to this report.

Findings of the Review:

Strengths of the county were:

- County staff was very committed to using the state automated case management system "Trails".
- The Commissioners were available and receptive and provided the team with information to assist in the review process.
- The community was responsive to the team's requests for information.

Compliance areas noted were as follows:
Note: With the exception of adding referrals to Trails all references to caseworker in the report relate to Gene Sena.

Areas found to be out-of-compliance will be noted according to the goal of the review. Compliance findings were limited to the past year. Due to the numerous rule violations, those will be attached to this report under Summary of Compliance Issues.

1) Goal: Procedures were in place to assure child safety for children who might be victims of abuse and neglect or youth in conflict.

   Finding: Procedures were not in place to assure child safety as evidenced by record reviews and interviews with community members. For both child protection and youth in conflict cases procedures were not in place that assure children were assessed and, if appropriate, services provided to keep both the child and the community safe.

   a) CCDSS did not record or investigate all referrals made by the Sheriff's Office. The Sheriff's Office (911) is the referral coverage for evenings and weekends. This was confirmed by the review team cross checking the Sheriff's Office "Critical Reports" that are logged by the dispatcher. The team reviewed all Critical Reports for January 2004 through February 2005. This process identified a number of cases that were referred to CCDSS, however the Trails system did not record a referral was received nor was there any other information that indicated the county investigated the referrals.

b) CCDSS does not function as a child and family-serving agency. The Sheriff's Office responds to community concerns and provides follow-ups on families in the community because CCDSS director and lead worker have not performed these functions.

c) It is reported by professionals in the community that CCDSS does not involve its office in cases where children are suicidal or in need of mental health services. Rather the community has been instructed to call Southeast Mental Health to access services for children and their families.

d) CCDSS failed to protect children who were at imminent risk of harm. The children were re-victimized due to the lack of appropriate response by county staff to ensure their safety. (See 18-6-401 (1) (a) and 18.1-501 (3) C.R.S.). This was evidenced by two children being left in the home where they were sexually abused because the perpetrator had continual access to them.

e) CCDSS does not make a positive finding of abuse based on the evidence. Several cases documented that there were bruises present on the victims and that the alleged perpetrator acknowledged leaving the bruise. However the finding was ruled as 'inconclusive'.

f) The County Board of Commissioners required that the Child Protection Team (CPT) review all child protection referrals. The Child Protection Team met twice during 2004. Upon review of the CPT minutes/files the members were not provided sufficient notice to attend CPT meetings. Notice would occur at 4pm the day prior to the CPT meeting with the meeting occurring at 9:00 a.m. the next day. Due to the number of referrals that were not entered into the state's automated case management system it is unclear whether CCDSS would have been required to conduct a CPT review based on Volume 7 (7.202.61) and 19-3-308.

g) CCDSS did not develop safety plans when children were left in their homes after investigating a referral of abuse or neglect. Some cases indicate that follow up was needed, however none was provided, rather cases were closed.

h) CCDSS does not send a copy of the report of known suspected child abuse and neglect cases immediately to the county's district attorney's office or to the court. This process is required by statute.

i) CCDSS failed to provide services in cases where the cases were founded for abuse/neglect. These cases were closed shortly after opening.

j) CCDSS failed to provide services in cases where it had a finding of at risk/need for services. The cases were closed shortly after opening.

k) CCDSS often 'facilitated' children living with kin without conducting a safety assessment. Staff stated that they did not place the child(ren) with kin as the county had not taken custody of the child.

l) CCDSS failed to provide appropriate referral information to the reporting party.

m) CCDSS failed to provide appropriate services to meet child specific needs consistent with 19-3-208 C.R.S.

n) CCDSS failed to examine the child who was the report of a third party physical abuse.

2) Goal: Procedures were in place to receive referrals of abuse and neglect or concerning youth in conflict from the community and provide timely investigation of those referrals.

Finding: CCDSS did not follow its own procedure for receiving referrals or for conducting timely investigations of those referrals. The County needs to follow its prescribed standardized process.

a) CCDSS failed to meet the required response time based on risk as prescribed in Volume 7 in four cases. Failure to meet the investigation timeframe placed the child at risk of additional abuse or neglect.

b) CCDSS failed to respond to after hour calls (as required in 19-3-308 (4)(a) C.R.S) thus placing children at risk.

c) CCDSS failed to conduct investigations on at least 17 cases that were referred by the Sheriff's Office. None of these referrals were open to Trails nor was there any other documentation of investigation by the county.

d) CCDSS does not obtain a copy of the report summarizing the investigation that was conducted by law enforcement before closing the investigation and case. In particular a case involving sexual abuse of two children was closed without obtaining additional information about the perpetrator and doing appropriate notice to the new county of residence.

e) CCDSS failed to conduct a complete investigation of its cases. Staff routinely failed to contact collateral agencies and individuals involved with the family.

f) CCDSS failed to follow the guidance of the county attorney, which informed them in writing that their policy for receiving referrals from the school and the sheriff's office was contrary to the state statute. Upon review of the county's current policy the Director failed to modify the policy based on feedback received from the county attorney.

g) Professionals from the educational community have stopped reporting child abuse or neglect due to an incident that occurred between a reporting party and the CCDSS. It was alleged that the county director shared the name of the reporting party with a parent of a child. While the CCDSS denies this occurred, the County Director contacted the family of the child to request a letter stating that they had not released the name of the reporting party. It is because of this incident that the educational community report feeling unsafe and will not make referrals.

h) Another factor that caused the educational community to stop making referrals was the lack of follow up (i.e. not opening cases for services). This led them to make statements like "the doors or social services are closed to us" or "it's a waste of time to contact them".

i) Due to the lack of response by the CCDSS the Sheriff's Office has initiated a procedure about taking the referrals and hand delivering them to the CCDSS to document that the staff did indeed receive them. Even with this level of action, the CCDSS continued to not investigate referrals submitted to them by the Sheriff's Office.

3) Goal: Mechanisms were in place for accurate Trails data entry. Case information, which should have been recorded in Trails, was recorded in Trails, and cases, which should have been "opened", were opened.

Findings: Reviewers did not find adequate information in the Trails system for the cases reviewed. Trails is the State's case system of record, so all information related to a case is required to be included in Trails with the exception of reports generated by other entities and court reports. The worker reported that she had received direction to not enter information into Trails. Cases appeared to have had referrals made and some had services offered that reviewers could not locate in the Trails system.

a) At least 17 cases were found that should have been investigated and documented in the Trails system. The Team discovered these cases by reviewing the Sheriff's Office reports and reports from educational professionals.

4) Goal: Children receiving services who were eligible for services.

Findings: Some of the children reviewed were not receiving services. Adequate documentation did not exist for the county's records as to why appropriate services were not provided to children and their families.

a) CCDSS failed to offer or provide services in cases where there were clear child safety issues identified. 19-3-208 C.R.S.

b) Two children were referred to mental health services. However, CCDSS failed to follow up with mental health to ensure that the children received victim specific treatment. Treatment services did not appear to be appropriate. (19-3-308 (b)). There is no documentation indicating that CCDSS advised mental health of the core issues for providing treatment to the children. Based on the review of the case treatment began and ended in approximately two months. It is difficult to believe that given the severity of the sexual abuse of the girls by both father and step brother that the treatment adequately addressed their issues during this period of time.

5) Goal: The process for payment of services was appropriate.

Findings: Gene Sena inappropriately billed for mileage. (See attached spreadsheet for detail.)

6) Goal: Operational structures support child safety, permanency and well-being.

Findings: It was determined that the operational structures in the county do not support child safety, permanency and well-being. A full-time caseworker, a 20% caseworker and director responsible for the management of the Department as well as carrying a caseload is not adequate to cover the caseload of the Department.

a) The full time caseworker is responsible for dividing his time among four task areas: Child Welfare, Child Care Assistance Program, Adult Protective Services, and Adult Ombudsman Services for the county. While there is only one on-going case open in child welfare, the 1 FTE is not providing adequate services to child welfare. This is documented by the lack of appropriate services being provided to children who are at risk.

b) The Director is responsible for overseeing the county's operations and providing supervision of the staff. Based on interviews the team was unable to document that routine supervision was consistently being provided to staff.

c) The professional community related that with the exception of the on-call worker, the CCDSS child welfare staff were routinely not available on Friday's. Referrals made on Friday's were not responded to until Monday.

d) CCDSS does not follow Volume 7 procedures. If they did there should be several more cases opened for services.

e) CCDSS does not provide services to families and children who are in conflict. Rather the staff's response is to refer all cases to mental health services or to parent education classes at the local head start program. There was no documentation that in-home or Family Preservation services were provided.

f) CCDSS does not document that Southeast Mental Health was contacted when the file indicates that a referral has been made.

g) CCDSS failed to complete a safety assessment within 7 days of contact with the alleged victim.

h) CCDSS failed to maintain a logging system of all incoming calls.

Corrective Action:

The county will be required to submit a single corrective action plan to remedy all identified areas in violation of statute or rule. The plan will need to be submitted to the State for approval within 30 days of receiving the final report.

Changes Since the Review:

Crowley reports the following actions have been taken since the on-site review:

1. The director and lead child welfare staff person have been placed on administrative leave pending the outcome of the review.
2. The director and lead child welfare workers' access to the various state automated systems have been revoked.
3. State Child Welfare has assigned staff to investigate cases that needed follow up and will respond to calls needing investigation and provide on-call services.
4. Negotiations are underway to identify a temporary plan to cover the child protection functions and provide supervision to staff.
5. As of March 21, 2004, Kim West will process CHATS application and approvals.

Current Information:

At the conclusion of the review there were serious concerns with child safety issues. At the exit interview with the Crowley County Board of Commissioners, the State Review Team informed the Board that the State would be placing a Child Welfare Child Protection Specialist in Crowley to investigate four cases to determine if Child Protections Services were required. The Board was informed that Crowley would be responsible for the costs incurred to provide these services. The Board indicated that they were aware of the issues and would take the necessary steps to ensure child safety.