Amariana Crenshaw Review

Finding #1- Amariana was not thriving in foster care. Her medical and mental health care were not adequately monitored.

Throughout Amariana's time in care, no one person, other than her foster parent, had a complete picture of her health status and injuries. CPS workers relied primarily on information from the foster parent, rather than direct consultation with medical providers. The absence of direct communication between health providers, Child Protective Services (CPS) and the Foster Family Agency (FFA), contributed to an incomplete picture of Amariana's circumstances, including a lack of understanding of her frequent injuries and poor tracking of her growth and development. Specific contributing factors include:

- CPS and FFA social workers relied primarily upon reports from the foster parent for the ongoing assessment and monitoring of Amariana's health and well being, and did not regularly update her Health and Education Passport (HEP), the designated section of the CWS/CMS that documents health and education information for each child.
- Numerous injury-related medical visits were not reported or known to CPS.
    - In a two year span, Amariana had a total of 17 medical visits, 12 of which were for injuries. Despite mandates for foster parents to report all incidents of injury and health information to the FFA social worker and for the FFA social worker to in turn, report to CPS, only ½ of these visits were reported by the foster parent as required.
    - When injuries were reported by the foster parent as required, explanations given by the foster parent were often taken at face value without further verification of reports with physicians and medical professionals who had seen Amariana.
    - Additionally, presentations of injury and abnormal requests for medical tests and treatment by the foster parent did not appear to trigger mandated reporter response to CPS or the FFA.

***Finding #2 – Once in foster care, no one* social worker had a sustained relationship with Amariana.**

During her time in foster care, Amariana was seen by seven different CPS social workers and numerous FFA social workers and was approved for social worker quarterly rather than monthly contact based upon perceived stability of the placement.

- The lack of continuity in relationship and perception of stability in the placement contributed to a lack of depth in contact reports which often described Amariana as "healthy" or "happy." Various workers provided contradictory assessments of her language skills and development.
- Amariana's mental health care was stalled and eventually discontinued as a result of the foster parent's failure to keep appointments. Had CPS and the FFA ensured foster parent compliance with mental health appointments, it is likely that a fuller picture of her behaviors and well being would have emerged.

Finding #3 – Case management was not anchored in Amariana's well being.

In addition to the lack of continuity in relationship and communication among multiple care providers referenced above, communication more often than not ran through the foster parent rather than between agencies and child welfare professionals. This was an important contributing factor to creating a lack of child focused casework.

- Addressing Amariana's needs was left almost entirely to the discretion of the caretaker.
- Amariana's court approved case plan stressed the goal of adoption with her sibling and the generic service objective of receiving age-appropriate services without addressing significant manifestations of distress and her specific individual needs.
- Frequent "rolling" from one FFA to another initiated by the foster parent likely contributed to a lack of depth in case management by the FFA.

Finding #4 – Opportunities to fully inquire into Amariana's well-being were missed because referrals were not investigated in accordance with guidelines and mandates.

Seven referrals received regarding specific maltreatment of Amariana while in Ms. Dossman's foster home were not investigated according to standards. At the time Division policy directed subsequent reports of abuse be investigated by the case carrying social worker rather than by additionally trained and experienced emergency response investigators. Specific investigative oversights included:

- Most investigations of referrals were limited to the testimony of Ms. Dossman and a visual observation of Amariana.
- Individual interviews with all household members and required collateral contacts with affiliated child welfare workers, the reporting party and health care providers were missing in each of the investigations related to Amariana's case.
- Concerns related to Amariana's eating behaviors and lack of growth were not addressed in the course of the investigation.

- Two reports which met the criteria for investigation were incorrectly deemed inappropriate for an in-person CPS investigation.

Finding #5 - Critical thinking errors were a common theme throughout Amariana's CPS case.

Evident in this review was the belief that all reports of alleged maltreatment emanated from the mother and were driven not by her concern for her children, but by her anger at Ms. Dossman.

- Numerous allegations appear to have been discounted based upon a bias in favor of the foster parent and against the credibility of the reporting party.
- This bias also contributed to unresolved discrepancies in findings among oversight agencies which were further exacerbated by a lack of inter-agency communication.

Finding #6 - CPS and partners lacked a cohesive response to Amariana's death and the concerns uncovered in the aftermath.

Disjointed or absent communication and coordination both within CPS and with child welfare and community partners contributed to a lack of response and action on behalf of the children remaining in Ms. Dossman's foster care.

- Despite SAFE center interviews uncovering concerns, involved agencies did not coordinate an appropriate response.
- Communication between CPS, FFA and licensing agency was disjointed or absent.
- Amariana's death triggered a response and action by different CPS programs, but their combined efforts were not coordinated.

Finding #7 – Two years after Amariana's death there continues to be unresolved questions about whether CPS can place a "hold" on a certified foster home. There is no apparent system in place to track concerns for these homes.

Despite a history of concerns, CPS continued to place children in the Dossman home after Amariana's death. The continued use of the Dossman home appeared to be predicated on the lack of action by CCL, not on an independent assessment by CPS of the placement's risk and benefits. Part of the problem entailed the lack of an internal system to track and communicate concerns about a foster home. In addition, there was lack of clarity regarding the mechanism to discontinue placement.

- Lack of clarity regarding county authority to place restrictions on a foster family home and a lack of communication and coordination within CPS and between involved agencies led to the continued use of the Dossman home.
- CPS did not have a system for tracking, communicating and acting upon quality of care concerns about FFA homes.

- Reports of abuse or neglect against a foster parent are entered in the computer under the child's biological mother's name rather than the foster parent's name. This makes it difficult to track multiple reports against a foster parent.

Action Items

CPS takes seriously these findings and is committed to a thorough review and response. In addition to the systemic changes underway in recent months, we are initiating the following immediate changes internal to CPS and across systems with our partners. We welcome open dialogue and continued input from our community partners, families and stakeholders as we continue to identify what needs to be done internally and collectively to increase safety, improve permanence and greater accountability for children and families.

Improved Safety

Quality Investigations

- To ensure all reports of abuse and neglect are investigated by social workers with experience in investigatory practices, including the use of standardized assessment tools, investigations will be fully centralized in the Emergency Response program. This will also protect against possible bias by the case carrying social worker.
- To quickly identify and track reports of abuse involving foster parents, allegations of child abuse and neglect are now entered into the CWS/CMS system under the foster parent's name.

Communication and Partnership

- To ensure better coordination, CPS and Community Care Licensing (CCL) are developing a process for a multi-agency review when two or more complaints are received against a foster home.
- To enhance communication and coordination between CPS and partners, protocols are being developed for joint investigations including use of the CPS Special Assault Forensic Evaluation (SAFE) Center.

Monitoring and Oversight of Child HealthCare

- To obtain accurate health information about children in foster care, social workers will contact medical providers every six months. This frequency of interaction will be reflected in policies and procedures. The health information obtained by social workers will be included in court reports.
- To confirm children less than 6 years old and those with serious medical conditions receive appropriate medical and dental care, CHDP nurses will now prioritize this population for monitoring and follow-up.

- To verify the Health and Education Passport is updated by CPS social workers prior to all court review hearings, supervisors will include this requirement in their ongoing case and quality assurance review process. Updated health and education information will be obtained through direct contact with the child's medical provider, consultations with CHDP nurses, quarterly reports from the FFA and monthly interviews with the foster parent. The updated HEP will be provided to the child's attorney prior to each review hearing.
- To confirm mental health treatment for children in foster care and identify trends of missed appointments CPS has developed a new centralized reporting system. Missed appointments will be reported within 5 days by mental health providers and reviewed by a CPS program specialist for follow-up and coordination with social worker, FFA, county licensing and CCL.

Increased Permanency

- To improve child and caretaker matching, the Centralized Placement Support Unit will be responsible for arranging all placements. This practice is currently in effect for all children coming into care and will be expanded to all placement programs by the end of the year.
- To promote a strong relationship between social worker and child, CPS is reorganizing to assign one primary case worker to a child during the child's stay in foster care.
- To increase the quality and consistency of interaction, children 0-5 will be contacted by their assigned social worker every month. Social workers are no longer able to request a face to face contact be made by another social worker, for children less than six years of age, without program manager approval.

Greater Accountability

Quality of Care

- To identify any concern that may not rise to the level of a formal complaint or violation regarding the quality of care provided in foster homes, a system has been developed to receive information from CCL, CPS social workers, County Foster Home Licensing and Sacramento Child Advocates. The information received is reviewed daily for appropriate resolution.
- To identify concerns about foster homes, an alert will be placed in the CWS/CMS placement notebook. A draft policy and procedure, providing direction on using the CWS/CMS placement notebook, has been written and will be placed on the intranet for staff's use once finalized.

- To ensure a comprehensive assessment occurs at each monthly contact, a standardized format will be used by FFA and CPS social workers to obtain and document important child-related information.
- To ensure case plans are updated to reflect the child's specific needs and address new concerns, supervisors will review case plans with staff during regular supervision and as part of the quality assurance process.

Continuous Evaluation

- To provide a comprehensive and coordinated response, all child deaths or near deaths, with current or recent CPS involvement, will receive a quality assurance review by the Office of the Director.
- To ensure all reports that meet the criteria for an investigation receive an in-person response, Quality Assurance is reviewing a random sample of evaluated out reports. Findings are reported to management and corrective measures, if necessary, are put in place.
- To ensure no conflict of interest exists for staff, a protocol is under development that will require any concerns to be submitted in writing and reviewed by a panel consisting of department representatives and Human Resources. Legal consultation will be available if the panel does not reach a consensus. The panel will issue decisions in writing.