EXHIBIT NO. 1

34
6-12-01

City of Alexandria, Virginia

MEMORANDUM

DATE: JUNE 12, 2001

TO: THE HONORABLE MAYOR AND MEMBERS OF CITY COUNCIL

FROM: PHILIP SUNDERLAND, CITY MANAGER PS

SUBJECT: CHILD WELFARE LEAGUE OF AMERICA REPORT

ISSUE: Receipt of Child Fatality Case Review Report from Child Welfare League of America.

RECOMMENDATION: That City Council receive the report (Attachment I).

BACKGROUND: On December 29, 2000, Katelyn Frazier, a three year old child, died as a result of blunt force trauma while in her mother's care. Katelyn had been in the custody of the Department of Human Services (DHS) since February 1998, and had only recently been reunited with her mother in mid-September 2000. Legal custody of Katelyn remained with DHS at the time of her death.

The primary mission of the City's child welfare services is to protect children from abuse and neglect. The tragic death of Katelyn demanded that we examine our policies, practices and actions to learn whether changes were needed to help assure protection for the City's vulnerable children.

Several actions, in addition to the criminal investigation by the Police Department, were taken by the City following the death of Katelyn. These included:

- Katelyn's three siblings were removed immediately from the home by DHS.
- A Child Protective Services investigation into the circumstances surrounding Katelyn's death was conducted.
- An internal review of DHS's actions in Katelyn's foster care case was conducted by the City.
- The City contracted for an independent review of Katelyn's foster care case by the Child Welfare League of America (CWLA), a national child welfare advocacy organization, which is the subject of this memorandum.

- DHS cooperated with the review of Katelyn's foster care case by a six member team from the State Department of Social Services (the results of which have not yet been released).

- DHS identified all of its active high-risk child welfare cases and then secured a review of those cases by a team of outside specialists and took appropriate action.

- The Directors of DHS and its Division of Social Services reviewed the Frazier case with the State Board of Social Services subcommittee on child protection and commented on various new State proposals for child welfare policy changes.

These multiple reviews, including that of CWLA, have given us the opportunity to examine and reexamine our actions in this case. More importantly, they have enabled us to identify, and to start to put into place, a number of changes that will enhance our efforts to protect the City's children from abuse and neglect.

DISCUSSION: At the City's request, the Child Welfare League of America conducted a Child Fatality Case Review of the death of Katelyn Frazier. CWLA is a nationally recognized advocate for "best practice" standards in the area of child welfare. Its case review report (Report) is attached as Attachment I; Attachment II includes the City's response to CWLA's findings and recommendations.

At the outset of its Report, CWLA emphasizes the complex nature of the child welfare system:

> The paramount responsibility of the child welfare system it to assure the protection of children from abuse and neglect, while assuring child well-being and providing permanency . . . . However, this concern must be placed in the larger context of the child's need for normal growth and development and the well accepted principle that children grow and develop best within their own families or when family connections are maintained. The dual mission to protect children from abuse and neglect and to support family unification drives the decision making processes of most child welfare agencies, and makes decision making a complex activity. [Report, p. 1; emphasis added]

Because of the complexities raised by the dual purpose -- protect and return to parent -- of the child welfare system, the Report recognizes that the best of child welfare law, policies and practices will not necessarily be sufficient to prevent the injury or death of a child:

> Federal and State Laws and child welfare policies and practices are designed to support the public child welfare agency's mandate to protect children and to provide services that are family-focused and child-centered. Sometimes this is not enough to prevent the death of a child. [Report, p. 1; emphasis added]

When a child in the system is seriously injured or dies, the Report states (p.1), "it is imperative that an examination is conducted of systemic and/or case specific performance factors that may have contributed to the outcome, and whether changes in laws, policies, and practices are needed."

CWLA's review of the circumstances of the Katelyn Frazier case was designed to (Report, p.1):

- Assess service planning and service delivery patterns;
- Identify areas for enhancement in agency policies, practices and procedures; and
- Provide recommendations that will facilitate improvements in service delivery to children and families.

CWLA's review focused on an examination of the Katelyn Frazier DHS case record, of DHS child welfare policies and manuals, and of relevant court documents, and included interviews with individuals who had direct or indirect responsibility and influence on decisions related to the family. Report, p. 1 (Appendix 1 to the Report identifies documents reviewed, and Appendix 2 identifies interviews conducted.)

The Report provides a "Case Summary" (pp. 3-16) that describes the services offered and provided to the Frazier family and a chronological summary of key milestones and events. This is followed by CWLA's "Findings and Recommendations" (pp. 17-24). Attachment II sets out each of these "Findings and Recommendations," followed by a City response.

CWLA recommends changes in a number of existing DHS policies, practices and procedures to enhance the work of the agency in providing assistance to children in foster care and child protective services. As indicated in the City's responses to the "Findings and Recommendations" (Attachment II), DHS has regularly been performing many of the practices recommended by CWLA, but because they were not always documented in the case file and because the League's review relied heavily on the written record, CWLA noted questions in the Report. Also, it is important to note, CWLA's recommendations are not derived from State laws, regulations or requirements, but from what CWLA sets as "best practice" standards.

The CWLA Report contains five major recommendations. These are described below, together with our plans to implement the recommendations and to take other actions that go beyond what CWLA recommends.

First, the Report recommends that DHS prepare a formal policy requiring the use of written risk and safety assessment tools to assist in evaluating the risks faced by children in foster care. We will implement this recommendation. DHS has already researched a number of risk and safety assessment tools, and plans to adopt written assessment tools now used in the State of Washington. Implementation of these assessment tools will begin this summer.

In addition, to further enhance its risk and safety assessments of children in foster care, efforts are underway to establish and implement new policies requiring the following:

a. periodic risk reviews by outside specialists in particularly high-risk child welfare cases;

b. random in-house case reviews of all child welfare cases;

c. assessments of every injury to a child in foster care by agency workers who are not assigned to and are unconnected with the foster care case (a "new eyes" approach);

d. criminal and child protective service background checks, to the extent permitted by law, on all adults residing in a household in which a child who is in DHS custody resides; and

e. a community advisory committee, the goals of which will include improving community education on the indicators of child abuse and neglect, and on the community's responsibility to report incidents of suspected abuse or neglect.

Second, the Report recommends practice changes intended to improve child welfare supervision. We will implement this recommendation. In this regard, DHS will:

a. hire two additional child welfare supervisors this summer;

b. hire a clinical psychologist to augment the agency's clinical supervision of child welfare cases this summer; and

c. establish a written policy by the fall that incorporates all current supervisory requirements applicable in child welfare, including that supervisory case conferences occur on a weekly basis and are fully documented.

Third, the Report recommends that DHS improve its communications with other providers of services and with other parties having an interest in foster care cases (e.g., foster parents and guardians ad litem). We will implement this recommendation immediately. In this regard, DHS will prepare a "protocol on case collaboration" this summer that will:

a. include an identification of the times for case conferences (including prior to the reunification of a child with his or her parent);

b. describe the frequency and form of the reporting to DHS that will be expected of service providers; and

c. provide for the agency's sharing (so long as allowed by law) of pertinent case information with other service providers and interested parties.

Fourth, the Report recommends that DHS obtain criminal and child protective service clearances on adults residing in any household in which a foster care child lives, including clearances from states of prior residence in the case of adults who have resided in Virginia less than three years. DHS has recommended to the State Board of Social Services that this request be added to State policy and also recommended that all necessary amendments to State law be sought by the Board. In addition, the City Attorney is reviewing Virginia statutes on criminal and child protective service clearances to identify legislative changes for possible inclusion in the City's legislative package.

Fifth, the Report recommends that guidelines be adopted by DHS and the City Attorney's Office relating to the appeals of court decisions in foster care cases, and that training be obtained by agency personnel and City attorneys on the Interstate Compact for the Placement of Children. The latter training has already been provided. DHS and the City Attorney have determined that "appeal guidelines" are not warranted, since decisions on appeals are so dependent on the individual facts and characteristics of the individual case. I share their determination.

Although CWLA did not address agency resources, to insure that sufficient resources are available to DHS to carry out the CWLA recommendations and undertake the new policies and procedures outlined above, I have authorized it to hire two new social work supervisors, a clinical psychologist and an administrative assistant (to help in the additional case documentation that will now be undertaken). I also have authorized funding for additional legal resources in child welfare cases on an "as needed" basis. The City Attorney has retained special counsel to work with staff attorneys in providing legal counsel to DHS. Funding for all these measures is anticipated to come from federal monies that DHS is slated to receive as reimbursement for its costs in delivering local social services.

Further, it is essential that we recognize that the entire Alexandria community is a key partner in our efforts to protect our children. To improve this partnership, DHS will establish a community advisory committee, which will include representatives from the Social Services Advisory Board, to advise DHS on the implementation of the policy and procedural changes identified above, and to join with it in planning and carrying out a program of community education. The committee also will assist the department in providing quarterly reports to City Council that will detail the progress being made in implementing the CWLA recommendations and the new policy and procedures outlined above.

The CWLA Report does not address how to integrate its recommended policy and procedural improvements into existing agency operations. On June 1, 2001, DHS began preparation of a local child welfare policy manual to be in place this fall that will incorporate the Report recommendations and will include the Department's additional policies and procedural changes that go beyond the recommendations in the Report.

Finally, apart from the efforts of CWLA, and with the assistance of the City Attorney, I have personally ~~con~~ducted my own review of this matter. This has included interviews with a number of individuals involved in the case, and an examination of case and court records. Based on this review, the views of the City Attorney, and the CWLA Report, I have concluded that the Department of Human Services (along with other participants in the City's overall child welfare system) acted properly and professionally in its efforts to assist the Frazier family through the provision of a broad range of services, to protect Katelyn and her siblings from abuse or neglect, and to reunify the family -- i.e., in the agency's effort to achieve its "dual mission" of protecting Katelyn, while simultaneously supporting her reunification with her mother.

Nonetheless, the system clearly did not succeed in protecting Katelyn Frazier. The death or serious injury of any child who has been entrusted to the child welfare system is unacceptable and must give rise to a search for improvements that will lessen the chance of another child suffering the same fate. This search we have done; and it has led to the identification of changes in DHS policies and practices that will be implemented forthwith and that will enhance substantially our ability to protect Alexandria's vulnerable children.

FISCAL IMPACT: The cost of the additional staffing and any additional legal resources will be funded with monies from federal reimbursement for local social services. There will be no impact on the City's General Fund. If additional resources are needed, I will return to City Council.

ATTACHMENTS:

I. Child Welfare League of America Child Fatality Case Review Report
II. City Responses to the Child Welfare League of America Findings and Recommendations

STAFF:

Meg O'Regan, Director of Human Services
Suzanne T. Chis, Director of Social Services

ALEXANDRIA CITY DEPARTMENT OF HUMAN SERVICES

CHILD FATALITY CASE REVIEW

June 8, 2001

Conducted by:
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Report on Alexandria Department of Social Services Case Review

I. INTRODUCTION

Purpose

The paramount responsibility of the child welfare system is to assure the protection of children from abuse and neglect, while assuring child well-being and providing permanency. Therefore, child safety must be the overriding concern during all stages of the delivery and management of a child welfare intervention. However, this concern must be placed in the larger context of the child's need for normal growth and development and the well accepted principle that children grow and develop best within their own families or when family connections are maintained. The dual mission to protect children from abuse and neglect and to support family unification drives the decision making processes of most child welfare agencies, and makes decision making a complex activity.

Federal and State Laws and child welfare policies and practices are designed to support the public child welfare agency's mandate to protect children and to provide services that are family-focused and child-centered. Sometimes this is not enough to prevent the injury or death of a child. When a child dies or is seriously injured it is imperative that an examination is conducted of systemic and/or case specific performance factors that may have contributed to the outcome, and whether changes in laws, policies, and practices are needed.

The purpose of conducting a review of the circumstances of the Katelyn Frazier case is to:

- Assess service planning and service delivery patterns;
- Identify areas for enhancement in agency policies, practices, and procedures; and
- Provide recommendations that will facilitate improvements in service delivery to children and families.

Methodology

Three sources of information were used in reviewing the circumstances of Katelyn Frazier and her family:

- Case record;
- Agency policies, manuals, and court documents; and
- Interviews with individuals who had direct or indirect responsibility and influence on decisions related to the family.

Interviews were voluntary and conducted in private. The content of the interviews was kept confidential and was not shared among the participants.

Agency Information

The Alexandria Department of Human Services is located in Alexandria, Virginia, a suburb of Washington, D.C. According to the 2000 census, Alexandria's population numbers 128,000, with 17 percent of the population under 18 years old. On average, 52 reports of abuse and neglect are investigated each month. For fiscal year 2000, there were an average of 154 active foster care cases in Alexandria each month.

The Alexandria Department of Human Services (DHS) is organized into four divisions including Operations, Family Services, JobLINK, and Community Programs. The Family Services Division includes child welfare and financial assistance services that are aimed at meeting the basic needs of children and families, strengthening family life, and protecting children from abuse and neglect.

Child welfare services employs approximately 51 staff, according to the Department of Human Services Spring 2000 report. Child welfare service units include the Child Protective Services Unit, the Safety and Reunification Services Unit, the Reasonable Efforts and Therapeutic Foster Care Unit, and the Permanency and Independence Unit. These units provide the following services:

- Investigations to assess reports of child abuse and neglect;
- Family treatment to reduce risk to children and to resolve family problems;
- Independent living services for older youth;
- Foster care to provide substitute care to children who cannot safely live with their families; and
- Adoption to provide permanent homes for children.

Family services monitors the performance and outcomes of its programs and services. The measures and indicators for child welfare services were revised in Fiscal Year 1999 to "focus on client outcomes."[1] Some of the indicators and measures for child welfare include:

- Number of reports of child abuse or neglect,
- Percentage of child abuse investigations initiated within 24 hours,
- Percentage of abuse/neglect cases needing intervention,
- Percentage of cases without subsequent CPS complaints during the month,
- Average monthly foster care caseload, and
- Percentage of children who were stabilized within 18 months in foster care.

According to information provided by Alexandria child welfare services, there are 36 professional social work staff who average eight years of experience in Alexandria social

[1] Human Services, Measures and Indicators Report, FY 1998-FY 2002.

services. Of those 36 professional staff, 21 hold Master's Degrees in various disciplines. The 2000 child welfare budget was $4.1 million, or approximately 12 percent of the overall DHS budget.

In an effort to provide more collaborative, community-based services and funding for at-risk youth and families, Virginia passed the Comprehensive Services Act (CSA) in 1992. The CSA set up local Community Policy and Management Teams (CPMTs) with the stated mission of providing "a child and family-focused, efficient, and effective seamless system of community-based care focusing on strengths, with families as partners, [with] everyone needing help knowing where to turn." As part of providing more community-based services, the CPMTs developed several local interagency Family Assessment Planning Teams (FAPTs) charged with developing individualized family service plans.

II. CASE SUMMARY

Circumstances of Initial Agency Intervention

The circumstances of the Department of Social Services intervention with Ms. Pennee Frazier, mother of Child A and Katelyn Frazier are found in the April 2, 1998 Child Protective Services Intake Assessment.

The family composition at that time included:

Mother:	Pennee Frazier	Date of Birth: August 18, 1975
Children:	Child A Frazier	Date of Birth: May 29, 1995
	Katelyn Frazier	Date of Birth: December 17, 1997

Subsequently, Ms Frazier gave birth to:

Children:	Child C Frazier	Date of Birth: February 3, 1999
	Child D Frazier	Date of Birth: August 19, 2000

On February 24, 1998, Ms. Frazier and her two daughters, Child A and Katelyn, became known to the Alexandria Department of Social Services due to homelessness. Ms. Frazier had recently moved to Alexandria from Maryland and was requesting a referral to a local emergency shelter. She was with her boyfriend and another male friend.

On February 26, 1998, Ms. Frazier signed an entrustment agreement that allowed the voluntary placement of Child A and Katelyn into temporary foster care. While bathing the children in preparation for the placement, DHS staff became suspicious that Child A might have been sexually molested. This suspicion was reinforced by the foster parents when they tried to bathe her. On March 3, 1998, Child A was referred to an organization that conducts sexual abuse evaluations. The organization confirmed that she had been sexually abused.

On March 4, 1998, an Emergency Restraining Order, Ex-parte was granted by the Juvenile Court giving legal custody of Child A and Katelyn to Alexandria DHS due to the sexual abuse of Child A.

On March 20, 1998, the agency founded the three complaints: 1) Level 1 Physical Neglect, Inadequate Shelter, Inadequate Hygiene, Inadequate Supervision of Child A and Katelyn by their mother Pennee Frazier. 2) Level 1 Physical Abuse of Child A by unknown perpetrator. 3) Level 1 Sexual Molestation of Child A by unknown perpetrator.

Family Demographics

Katelyn Frazier
Physical description:
Katelyn was born December 17, 1997. She died on December 29, 2000 after suffering a head trauma while living with her biological mother, Ms. Pennee Frazier. Katelyn had been described as physically small and delicate. She had an orthopedic problem that may have had some impact on her ability to walk and run like other children her age. Katelyn suffered from ear infections that were treated with the placement of tubes in her ears at approximately age one-and-a-half.

Interactions with others:
In reports, service providers and foster parents described Katelyn as a normal, outgoing, and friendly child. In interviews, all of Katelyn's foster parents described her as a child for whom it was easy to provide care.

The case record indicates that Katelyn and her mother experienced difficulty bonding with each other. The relationship was described as somewhat distant. One of the in-home service goals that was identified by a provider was to assist Ms. Frazier and Katelyn in strengthening the parent-child bond. Reports indicate that Ms. Frazier was having difficulty supervising Katelyn as Katelyn refused to follow her and her boyfriend's directions. In December 2000, a service provider reported that Ms. Frazier believed that Katelyn had been "overly indulged by her foster mother."

Observations by an in-home service provider indicated that Katelyn was the object of teasing and was "bossed" by her siblings.

Pennee Frazier
Physical description:
The record does not provide detailed information about Ms. Frazier's physical appearance. One source interviewed during the case review indicated that Ms. Frazier initially dressed in an "anti-establishment manner," but later appeared more conventional. When she initially became involved with the Department of Human Services she was unkempt and exhibited poor hygiene. Later reports indicate some positive change in how she presented herself.

Interactions with others:
Ms. Frazier had a history of involvement with child welfare agencies as a youth. Ms. Frazier is described as having a difficult relationship with her parents as a teenager. She would run away from home. On one occasion she reported being sexually abused by her father. She later rescinded the accusation. In general, Ms. Frazier's relationship with her mother was close. Her mother was very supportive of her and helped her take care of her children.

Ms. Frazier's relationships with men were of concern to DHS. She seemed to select men who had problem childhoods and were unable to meet her needs and the needs of her children.

Ms. Frazier was described in interviews as exhibiting confrontational, "in your face" behavior, but would calm down after a period of time passed. Service providers also described her as being compliant and cooperative.

Ms. Frazier was described as having an intense desire to have her children returned to her. She exhibited this desire by her determination to visit her children while they were in foster care. She would often travel twice a week from Gaithersburg, Maryland to the Alexandria DHS office on public transportation to comply with her visitation schedule.

Mental health
Ms. Frazier was hospitalized for bi-polar disorder. In February 1998, she described herself to the Alexandria Department of Human Services as bi-polar and a drug user in recovery. Later, she was diagnosed with a bi-polar disorder, not-otherwise-specified, and alcohol and cocaine abuse. In January 1999 Ms. Frazier was terminated from a Drug and Alcohol Outpatient Treatment Program due to excessive absences. In September 1999 she completed the Montgomery County General Hospital Dual Diagnosis Treatment Program (MCGHDDP). The prognosis at that time was fair as long as she maintained her recovery plan and stayed medication compliant. In February 2000, on an application for services, Ms. Frazier reported a diagnosis of "borderline." In April 2000, she was diagnosed by a psychiatrist with "bi-polar illness, mixed/alcohol dependent (in sobriety), on medication since March 2000."

Ms. Frazier has been described as having difficulty organizing her household, keeping track of appointments, and following through on directions given to her for the care of her infant son. She has also been described as "parroting" what others say to her.

Ms. Frazier's compliance with medication for the treatment of her bi-polar illness has been described as erratic. She is depicted as being a self-medicator, taking her medication and asking for increases in dosages based on how anxious she felt. During her pregnancies with her two youngest children, her dosages were reduced. She did request an increase in her medication after the birth of her fourth child due to sleeplessness.

Physical health

Ms. Frazier's physical health is not documented in the case dictation. Reports from mental health providers included information that Ms. Frazier had asthma and that two of her pregnancies were considered high risk. Her fourth child was delivered by Cesarean section on August 18, 2000.

Service Goals and Objectives

The following service goals and objectives are based on the review of the case record, including the Foster Care Service Plans and the court documents.

On February 26, 1998, Ms. Frazier temporarily entrusted her two children to the agency and signed a Service Plan with a goal of Return to Parent on February 27, 1998. Ms. Frazier was required to establish a suitable stable living environment for the children; secure a consistent source of income, adequate to support her children; avail herself of all services in the community that would assist her in her substance abuse recovery, continue mental health treatment and parenting endeavors.

Subsequent to the entrustment, on March 12, 1998, the agency was granted legal custody of the children due to the abuse and neglect of the children.

The court, as cited in the record, accepted the goal of Return to Parent, on June 19, 1998. The objective was to have Ms. Frazier demonstrate that she could maintain stable housing, maintain sobriety from drugs and alcohol, and remain compliant with her medication.

On November 11, 1998, the goal was changed to Adoption because Ms. Frazier had been erratic in complying with DHS requirements and did not make herself available for the services that were provided. On April 21, 1999, the DHS petition for the Termination of Parental Rights (TPR) was denied by the Juvenile Court because Ms. Frazier was making progress. On May 5, 1999, the goal was changed back to Return to Parent. The objectives were to have Ms. Frazier demonstrate that she could maintain housing, maintain sobriety from drugs and alcohol, maximize her mental health functioning and demonstrate that she could protect her children from physical abuse, sexual abuse, and neglect.

The Foster Care Service Plans for August 1999, February 2000, and August 2000 retained the goal of Return to Parent. The objectives were to have Ms. Frazier find and maintain suitable housing, complete the Montgomery County General Hospital Dual Diagnoses Program (MCGHDDP), complete parenting education classes, maintain visitation schedules, continue receiving services such as Early Head Start, and transition the children fully into her care.

In May 2000, Ms. Frazier moved to Alexandria, Virginia, after the Maryland Interstate Compact for the Placement of Children (ICPC) denied the placement of her children with her in her parent's home in Maryland. The November 1999 denial was based on a 20-

year-old barrier crime on the part of Ms. Frazier's father, as well as specific concerns regarding Ms. Frazier.

In moving Ms. Frazier to Alexandria, DHS' objectives were to stabilize Ms. Frazier in a suitable home environment; provide in-home services to assist with Katelyn's transition home; connect Ms. Frazier with local mental health services (including medication supervision) and public health services; and provide home management training and parenting skills training.

Summary of Offered and Provided Services

The Alexandria Department of Human Services provided a wide array of services to this family from the date that Ms. Frazier signed the entrustment on February 26, 1998 until Katelyn's death on December 29, 2000. The children received foster home care, child care, medical and psychological treatment, respite care, parent and child services, home health care, and court monitoring and oversight. Ms. Frazier was provided visitations with the children, housing assistance, public welfare, transportation, medical and psychiatric treatment, substance abuse treatment, home management counseling, parenting skills training, home health services, prenatal care, and a court appointed attorney.

Also, either the DHS worker, Institute for Family Centered Services (ICFS) home based services worker, or other service provider was in the home or in contact with the family on a weekly basis.

The following is a summary of the services that were offered and provided to Katelyn Frazier and Ms. Pennee Frazier from February 26, 1998 to December 27, 2000:

Katelyn Frazier

Services	Date Initiated	Date Completed	Outcome of Services Provided
Alexandria Department of Human Services (DHS)	2/26/98	12/29/00	See following list of services that were provided.
Foster Home #1	2/26/98	3/27/98	Placed in Temporary Emergency Home.
Foster Home #2	3/27/98	11/20/98	Placed with sister Child A.
Foster Home #3	11/20/98	2/11/00	Placed in separate home from Child A.
Foster Home #4	3/1/00	9/18/00	Placed in home until returned to Ms. Frazier.

Alexandria Juvenile and Domestic Relations District Court	3/5/98	12/29/00	Judicial review and oversight on behalf of the child.
Guardian ad Litem	3/98	12/29/00	Advocated on behalf of the child.
Parenting Education Program	4/98	4/99	Assisted Ms. Frazier in her parenting Katelyn.
Visits with Ms. Frazier	3/98	9/18/00	Initial weekly visits, extended to overnight visits to help Katelyn adjust to the return to Ms. Frazier.
Medical Treatments, Public Health Services	2/98	12/29/00	Tubes inserted in ears to address chronic ear infections. Well baby care to monitor growth and development. Identified orthopedic condition for future treatment.
Child Care	3/98	9/28/00	Three childcare homes were used. Childcare services were terminated. Reason not documented in case dictation.
Parent Infant Education (PIE)	5/23/99	6/99	Child's growth and development evaluated and determined to be within normal range.
Interstate Compact for the Placement of Children (ICPC)	7/98	2/99	DHS requested study of relative's home. Relative withdraws due to health and financial reasons.
ICPC	5/99	11/99	DHS requests ICPC to study Ms. Frazier and parents' home in MD for return of child to parent.
Montgomery County MD Early Head Start Program	12/99	6/00	Undated court transcript cites testimony that child was included in services when she visited family in MD.
CASA Court Appointed Special Advocate	1/99	12/29/00	CASA volunteer appointed by court to provide independent assessments of family and child relationships and child safety.
Child Find	12/13/00	12/13/00	Evaluation of child's growth and development.
Commonwealth of VA, Department of Health, Child Specialty Services	12/18/00	12/18/00	Orthopedic Evaluation indicated that "femoral antiversion bilaterally right greater than left" is a normal variant and that spontaneous correction is the rule..." She "will be followed on a yearly basis to make sure that nothing is progressively worsening."

Pennee Frazier

Services	Date Initiated	Date Completed	Outcome of Services Provided
Alexandria DHS	2/26/98	12/29/00	Family accepted for services due to abuse and neglect, need for housing, substance abuse treatment, mental health treatment, medication maintenance, and parenting skills development.
Homeless Shelter	2/26/98	8/98	Ms. Frazier returned to MD to live with her parents.
Drug and Alcohol Outpatient Treatment Services	8/98	1/99	Terminated from program due to lack of attendance.
Psychological, Psychiatric Evals	3/98	Not completed	Evaluations scheduled, but Ms. Frazier did not keep appointments.
Court Appointed Attorney	3/98	Ongoing	Represented Ms. Frazier in all court appearances regarding her children.
Parenting Education Program	4/98	4/99	Regularly attended classes, little progress in taking care of Katelyn was noted.
Montgomery Co. Public Health Healthy Start Program	8/10/98	11/99	Ms. Frazier failed to schedule appointments and the case was closed.
Montgomery Co. MD DHHS, Child Welfare	2/3/99	5/00	DHS requests family services for Ms. Frazier and newborn son. DHHS Opens Child In Need of Assistance case (CINA) due to Ms. Frazier's neglect of infant son. CINA dismissed in July 1999.
Montgomery Co. MD General Hospital Dual Diagnosis Program	4/14/99	9/29/99	Program completed. Prognosis was fair as long as she follows her recovery plan.
Family Services Agency	4/99	4/00	Ongoing psychiatric or psychological treatment. Provided a minimum of 23 sessions.
Montgomery Co. Early Head Start Program (EHSP)	3/99	6/00	Mother bonded well with infant son and participated in all EHSP activities.

Institute for Family Centered Services	VA 8/20/98 MD 10/4/99, VA 2/16/00	VA 3/99 MD 5/00, VA 12/27/00	IFCS provided intensive home-based services, focused on parenting skills, home organization/management while Ms. Frazier lived in MD. IFCS services provided to Ms. Frazier after moving to VA focused on bonding with Katelyn, home management, parenting, relationship with partner, etc. Contracted for 15 hours a week of in-home services.
Associated Psychotherapy Centers, Montgomery Co.	8/99	4/11/00	Psychiatric Evaluation: Diagnosis of bi-polar, mixed/alcohol dependent. Parenting skills not assessed. Recommended placement of children with periodic visitation by DHS for next year. Continue Psychiatric treatment, to be monitored by court for compliance. Continue monitoring AA meetings.
Alexandria Mental Health Services and treatment	7/00	12/00	Services provided: psychiatric evaluation, community education, medication management, case management, crisis intervention, and. nursing activities.
Alexandria Public Health	9/14/00	12/21/00	Initially involved due to newborn son's health problems. Identified Katelyn's orthopedic difficulties.
Housing Assistance	VA 9/99	10/99	DHS provided first month's rent in larger apartment in MD.
Housing Assistance	MD 10/4/99	5/00	Helped secure larger apartment for Ms. Frazier, her parents, and Child C in MD.
Housing Assistance	VA 5/20/00	12/27/00	DHS helped secure Family Unification voucher from MD for Ms. Frazier to rent housing in Alexandria.
Public Welfare	MD 8/98 VA 5/00	5/00 12/00	Income assistance, food stamps, and Medicaid for Ms. Frazier and her children.
Transportation	3/98	12/27/00	Tokens, taxi vouchers, Metro vouchers, and other direct transportation to visits, doctors' appointments, etc.
Prenatal Care	Unknown	8/19/00	Infant son born with health problems. Placed in the ICU.

Pattern of Service Utilization

Initial Service Utilization

According to the DHS case record and service agencies reports, for the period from February 27, 1998 to April 1999, Ms. Frazier did not fully engage in the services provided and her participation was described as erratic and disruptive. She was terminated from the Outpatient Addiction Services program due to her absences. Her behavior in the Parenting Education Program was disruptive. Also, Ms. Frazier did not keep the appointments for psychiatric and psychological evaluations, even though transportation was made available. The lack of participation and follow through on her part were the basis for the DHS decision to request that the Court terminate her parental rights (TPR).

Continued Service Utilization

According to the DHS case record and service provider reports, from May 1999 to December 2000, Ms. Frazier's utilization of services improved. The goal change to adoption appears to have been pivotal to Ms. Frazier's beginning compliance with the service plan objectives. In April 1999, the Juvenile Domestic and Relations District Court denied the TPR petition due to Ms. Frazier being drug free for a period of time and attending substance abuse treatment programs. Foster Care Service Plans after May 1999 describe Ms. Frazier as compliant and cooperative. However, Ms. Frazier's progress in meeting service goals and requirements varies depending upon the time periods that she was involved in the programs. For example, the Maryland Adult Mental Health and Substance Abuse Services, Outpatient Addiction Services (OAS) Termination Summary covered the period from August 21, 1998 to February 5, 1999 and described Ms Frazier as having difficulty following the program and cited her outbursts of anger and difficulty in organizing her schedule to be on time for meetings.

However, the September 23, 1999 Services Discharge Report from the MCGHDDP described her overall progress after "16 treatment visits as being compliant with medications and attended the medication clinic program. She was superficial in groups and had a hard time accepting feedback and building trust. She made some progress in controlling her poor impulses. Although active in AA she did not obtain a sponsor. All her alcohol sensor and urinalysis tests were negative." Her prognosis was given as "fair as long as she follows her recovery plan." The report also recommended that Ms. Frazier "follow DHS advice, continue to build a sober peer network, maintain sobriety, and stay medication compliant."

The report from the Montgomery County Early Head Start Program (EHSP) cited not only her improved care of her son born 2/3/99, but also her involvement with other EHSP groups and activities. During the period from February 1999 to July, 1999, Montgomery County, Maryland Department of Health and Human Services (MCDHHS) had an open Child In Need of Assistance (CINA) case for Ms. Frazier's infant son. According to copies of MCDHHS documents, the Maryland District Court, on July 23, 1999, granted

their petition to dismiss the CINA case based on Ms. Frazier's progress. The report also stated ~~that~~ the case was kept open to monitor Ms. Frazier's progress and to assist the Alexandria DHS with the return of her children.

The Alexandria case record dictation indicated that Ms. Frazier was engaged with the services available to her in Gaithersburg, Maryland. Ms. Frazier moved to Alexandria, Virginia in May 2000. It was necessary for DHS to replicate the array of services that had been available to her in Maryland. Ms. Frazier had been receiving services from the Institute for Family Centered Services (IFCS) in Maryland while living in her parents' home. After her move to Virginia, the Alexandria IFCS provided intensive home-based services to Ms. Frazier. Their reports and the DHS case dictation identified Ms. Frazier as cooperative, compliant, and making improvements. After moving to Virginia, the Alexandria Health Department found Ms. Frazier to be cooperative and willing to accept help. In contrast, the Montgomery County Maryland Healthy Start program had been terminated in February 2000 because Ms. Frazier failed to keep and schedule appointments.

Additionally, some of the service provider reports and information obtained in interviews are not in agreement regarding Ms. Frazier's level of involvement in services when she moved to Alexandria. The CASA report and the Guardian Ad Litem report identified concerns that Ms. Frazier had not been continuously involved in therapy or AA meetings. All reports indicated that she maintained her sobriety.

Everyone involved with Ms. Frazier agreed that she relied heavily on others (e.g., her mother, IFCS worker, and DHS social worker) to help her care for her children and to keep medical and other appointments. It also was agreed that Ms. Frazier would continue to need that level of support when her children were returned to her.

Chronology Summary, Key Milestones and Events

The following key milestones and events are taken from the DHS case record, court documents, other agency reports, and information provided by the Commonwealth's Attorney:

Dates	Events
February 26, 1998	Ms. Frazier signed entrustment for placement of children.
February 27, 1998	Ms. Frazier signed Service Plan agreement.
March 5, 1998	Emergency removal order obtained from the court by DHS.
March 12, 1998	Juvenile Court granted Legal Custody to DHS.
March 27, 1998	Katelyn moved with her sister from emergency Foster home to new foster home.
August 1998	Ms. Frazier moved back to parents' home in Gaithersburg, MD.
November 18,1998	Agency changed goal to Adoption.

November 20, 1998	Katelyn placed in new foster home. Could not be placed with sister because a foster home was not available that could care for both of them.
February 3, 1999	Child C Frazier born. Montgomery Co. DHS requested MD DHHS provide family services. MD DHHS opens neglect case.
April 21, 1999	Juvenile Court denied Termination of Parental Rights.
May 21,1999	Goal changed to Return to Parent.
July 23, 1999	MD District Court dismissed CINA petition due Montgomery County DHHS report of Ms. Frazier's progress in following through with necessary treatment and services. MCDHHS kept case open to monitor progress and to coordinate with Alexandria DHS to facilitate reunification.
August 4, 1999	MD Interstate Compact for Placement of Children (ICPC) delayed home study as requested by Ms. Frazier because she was looking for a larger place to live.
September 23, 1999	Ms. Frazier completed Montgomery County General Hospital Dual Diagnoses Program. Prognosis: Fair. Recommendation: To follow advice of Social Services. Continue to build a sober peer network. Maintain sobriety and stay medication compliant.
September 27, 1999	Children started overnight visits with Ms. Frazier in her parent's home in MD.
October 18, 1999	Foster mother suspected Katelyn sexually abused. Took Katelyn to Emergency Room for examination. Hospital referred case to Alexandria DHS, Child Protective Services and Alexandria Police. Montgomery County police set up sexual abuse examination for 10/19/99.
October 19, 1999	Montgomery County Police and CPS unfound sexual abuse report. Doctor indicated that Katelyn had diaper rash. Foster mother requested Katelyn's immediate removal from home. (No information in case dictation of action taken.)
October 25,1999	Day Care provider informed foster mother that Katelyn is ill and had diaper rash. Foster mother tried to schedule Sexual Abuse Nurse Exam (SANE). DHS responded to report and determined child has diaper rash.
November 3, 1999	School reported bruise on Child A's back. DHS referred complaint to Montgomery Co. DHHS for investigation. (Report was unfounded.)
November 19, 1999	MD ICPC disapproved return home due to Mr. Frazier's child sexual abuse conviction and other concerns about Ms. Frazier's care of her children.

November 19,1999	DHS Supervisor and worker discussed implications of disapproval of return home. Children in foster care for more than 12 months. Considered asking for an early court review to get guidance on what to do.
December 2, 1999	Case staffed between DHS social worker and supervisor. Case dictation quoted: "Child needed to go with Pennee. Pennee could not live alone and take care of children. All services are in Montgomery Co., MD." City Attorney advised that an early motion could be filed with court for review.
January 12, 2000	DHS worker had telephone conversation with MDDHHS worker who reportedly said that Ms. Frazier was doing so well she had been thinking about closing their case. (This statement has been refuted by MDDHHS.)
February 2000	DHS filed a motion to be relieved of legal custody of Child A and Katelyn based on a U.S. Court of Appeals ruling that the ICPC did not have to approve the placement of children with their parents in another state. Motion denied.
February 11, 2000	Juvenile Court ordered "Legal custody of above named child (Child A and Katelyn) remains with DHS with physical custody being placed with her mother, Pennee Frazier, until further order of Court."
February 16, 2000	Former foster mother filed emergency petition for custody of Katelyn in Juvenile Court.
February 18, 2000	Katelyn and sister are placed with Ms. Frazier in Maryland. Court approved placement with parent in home of grandparents in MD.
February 18, 2000	VA ICPC indicated intention to have Attorney General file a motion to prevent children's placement in MD because of DHS noncompliance with VA. Code on ICPC placements.
February 25, 2000	Juvenile court vacated physical custody order for both children.
February 28, 2000	Katelyn placed in new foster home in VA.
April 11, 2000	Psychiatric diagnosis received for Ms. Frazier. Axis I: Bi-polar illness, mixed/alcohol dependent (in sobriety) on medication since March 2000. Parenting skills were not assessed. Recommendation: Placement of children with periodic visitation by DHS for next year. Continue psychiatric treatment, to be monitored by court for compliance. Continue monitoring AA meetings.
May 12, 2000	Ms. Frazier moved to Alexandria.
May 13, 2000	Child A permanently returned to physical custody of mother by court order.
May 16, 2000	Katelyn had half day visit with Ms. Frazier and siblings.
June 19, 2000	Ms. Frazier completed parenting class with Montgomery Co. Early Head Start Program.

June 21, 2000	Katelyn had first overnight visit.
August ~~8,~~ 2000	Guardian ad Litem visited family at home. Reported that the grandmother, IFCS worker, Mr. Levin (male companion) and children were seen.
August 11, 2000	Ms. Frazier reported that Katelyn had a bruise on her hip. Reportedly the injury occurred when she fell off the bed onto a toy.
August 11 and 14, 2000	DHS worker visited home. Talked to Katelyn. Determined that the bruise was consistent with explanation given by Ms. Frazier.
August 18, 2000	Ms. Frazier's fourth pregnancy mentioned in the case dictation for the first time. (Had been mentioned previously in IFCS reports to DHS.)
August 19, 2000	Ms. Frazier had son by Cesarean section. Baby in ICU.
August 23, 2000	Ms. Frazier released from hospital with infant son. Katelyn visited her mother and siblings.
September 13, 2000	Ms. Frazier moved with three of her children into a larger apartment.
September 15, 2000	Katelyn placed with Ms. Frazier. Living in home with siblings ages 5, 20 months, and 1 month.
September 18, 2000	DHS worker visited home. Katelyn had bruise on left side of her face. Ms. Frazier stated that the girls had been playing and she did not know what had happened. DHS worker told Ms. Frazier that she needed to "help take care of Katelyn because she can not stand up to her sister."
September 22, 2000	Asher Levin, Ms. Frazier's male companion, is mentioned in case dictation for the first time. (Mentioned in IFCS report on 2/2/00.)
September 26, 2000	DHS worker observed that Katelyn was not wearing socks and saw that her shoe had been rubbing on her foot. DHS worker told the child care provider that she would talk to Ms. Frazier about the socks.
October and November 2000	IFCS worker and DHS social worker expressed concerns about Ms. Frazier and Katelyn's difficulty bonding. Plans developed for Katelyn to spend more time alone with Ms. Frazier.
October 10, 2000	Unannounced home visit by DHS worker. House was dirty and worker talked to Ms. Frazier about the need to keep up with house cleaning.
October 31, 2000	DHS worker told by sister that Katelyn had hit her with her head. Katelyn has bruise beginning to appear on her forehead. The house was dirty. DHS worker talked to Ms. Frazier and Mr. Levin about the house. They said that they would work on it.
October 31 to November 1, 2000	Circuit Court held trial on foster mother's custody appeal.

November 1, 2000	Circuit Court ruled for Ms. Frazier to have custody of Katelyn. Returned case to Juvenile Court.
November 6, 2000	DHS worker visited home. Recorded in case dictation that house is looking better this week.
November 21, 2000	IFCS worker in telephone conversation with DHS worker mentioned everything going well. Katelyn's sister had left a mark on her face. ICFS worker talked to Ms. Frazier about the need to watch the children closer.
November 28, 2000	According to note on purchase order, Katelyn's childcare was terminated. Other documents place termination in September 2000.
December 4, 2000	DHS worker visited home. Recorded in case dictation that house is "not as bad this time".
December 14, 2000	Unannounced visit by DHS social worker finds house dirty, food all over kitchen. Told Ms. Frazier that she really needed to work on cleaning up the house. Also talked about what she needed to do and asked if she needed more help with the children.
December 15, 2000	IFCS worker stated in notes the concern about Mr. Levin not accepting Ms. Frazier and her children. Goal to work with them on better communication and agreement on parenting.
December 22, 2000	IFCS worker reported that Ms. Frazier had concerns about Katelyn not playing with siblings and not obeying her. Ms. Frazier admitted getting frustrated with Katelyn.
December 27, 2000	Katelyn injured. Suspicious head trauma.
December 29, 2000	Katelyn dies from injury.

The Commonwealth's Attorney provided photographs of bruises to Katelyn's face that were obtained during his investigation of her death. These photographs have been dated by the Commonwealth's Attorney as December 2 or 9, 2000 and December 17, 2000. Also, the apartment manager, neighbor, and pest exterminator gave observations of bruises and home conditions to investigators. According to the Commonwealth's Attorney, DHS had not been given the photographs nor had the observations been reported to the agency.

III. AGENCY STRENGTHS

Within every child welfare agency there are individual and organizational strengths that enable the effective delivery of services to meet the needs of children and their families.

The following strengths were observed in the Alexandria City Department of Human Services:

- A wide array of services available to children and parents;
- Manageable caseload size;
- Mandatory training for new and experienced caseworkers;
- Individualized training plans for caseworkers; and
- Positive relationship with Alexandria Juvenile and Domestic Relations Court.

IV. FINDINGS AND RECOMMENDATIONS

The agency provided the Virginia Department of Social Services manuals for Foster Care and Child Protective Services and the Interstate Compact for the Placement of Children. Although these were reviewed and taken into consideration, CWLA is not in a position to determine if the agency is in compliance with the state requirements. The findings and recommendations that follow do not relate to state regulations, laws, or requirements, but reflect best practice.

Policy

1. **Finding**

   Ms. Frazier is a young, inexperienced mother of three surviving children. Until securing her own residence in Alexandria, at the age of 25, she had never lived independently or had full responsibility for the daily care of her children. At the time that Katelyn was returned from foster care to her mother, Ms. Frazier, who was 26 at the time, was caring for a one-month-old baby (her fourth child) and two other children under the age of 6. Two of the children had identified special needs. Her church and family support system was in Maryland.

   The agency management indicated during interviews that risk assessments are expected to be done at each contact with the child and family. This expectation is not written in agency policy.

   Recommendation

   The agency should establish policy and practice guidelines for decision-making related to family reunification which should include the use of structured risk, safety, and family assessment tools. Time frames for the use of such tools should be established to ensure safety at every contact and to facilitate structured decision-making, highlighting key risk and safety indicators. Additionally, assessment tools would provide documentation of the basis for specific decisions. Reunification should not occur without a risk and safety assessment that incorporates the review of informal supports, formal services available, mental

health condition of caregiver, special needs of children, caregiver parenting ability, and household composition. Safety must be assessed and documented at each contact.

2. **Finding**

Interviews and review of the case record indicates a series of incidents in which bruises were observed on Katelyn's face, back, and hip. The case record shows a pattern of injuries observed by the DHS worker or reported by the mother beginning on August 11, 2000 and continuing on September 18, 2000, September 26, 2000, and October 31, 2000. The case record dictation indicates that the DHS worker determined that the injuries were consistent with the explanations given by the mother. The DHS worker advised the mother to pay closer attention to the care of the child and her siblings.

Recommendation

The agency should implement policies and procedures that require the review of all active cases in which the child is injured on more than one occasion. Agency policy should require that the Child Protective Service Unit assess all injuries occurring in active cases. Investigation and assessments of injuries by the ongoing caseworker risks over-identification of the worker with the family, application of differential standards, and lack of objectivity.

Multidisciplinary teams, composed of agency and non-agency professionals, should be convened routinely to review high-risk cases.

3. **Finding**

Recently the agency convened a group of child welfare specialists from Virginia counties and the state office, and a professor who heads a university child welfare initiative to review all high-risk reunification cases. This is a positive reaction to the death of a child. However, the agency does not have a formal written plan and documented procedures for quality improvement, quality assurance, and quality control programs. Quality improvement involves the continuous assessment of existing programs and services and planning for program and service enhancements. Quality assurance activities enable an agency to assess whether policies, best practices, and program and service enhancements are implemented. Quality control activities assure that policies and best practice occur consistently across the agency and on a regular basis.

Supervisory review of cases should occur on a regular basis as a means of quality assurance and control within a unit. Individual case reviews of this nature provide insight into the dynamics of specific families. The application of policies and practice are measured against service delivery in a specific case. On an organizational level, a sample of cases should be reviewed periodically to measure the achievement of agency goals, objectives, and child and family outcomes.

Recommendation

~~In~~ addition to direct supervisory review of cases the agency should establish written policy that requires random reviews of cases by staff other than the direct supervisor and caseworker. The results of the reviews should be shared with the supervisor and caseworker.

The agency should provide resources that will institutionalize quality improvement, quality assurance, and quality control processes within the organizational structure.

The agency should develop a mechanism for producing management reports based on the results of quality assurance activities. These reports should be used to improve practice and/or change policies.

4. **Finding**

According to interviews the agency provides training opportunities for staff. Individuals may self-select training topics and workshops. Staff are not assigned to attend specific training based on assessed individual need. Agency management clarified this information. Documents from the Virginia Department of Social Services were provided that included information on mandatory training for social workers and supervisors. Agency management also stated that workers have an individual education plan, based on their assessed needs and skill levels. Supervisors approve all of the training requests based on the plan.

Recommendation

The agency should continue individualized education plans for staff, based on assessed needs and skill levels. Additionally the agency should track the transfer of learning through case documentation and supervisory conferences.

5. **Finding**

Communication among the agency and service providers and parties representing the interest of Ms. Frazier and Katelyn was not consistent. Interviews with parties who had an interest and role in the case indicated that responses to telephone calls, requests for information, and reports often were delayed or unanswered.

Recommendation

The agency should establish written policy that requires routine collateral contacts with service providers and other parties to the case.

The agency should develop related protocols with social service providers; legal counsel for the agency, parents, and children, and medical and behavioral health systems.

6. **Finding**

Documentation of Ms. Frazier's last male companion's addition to the household does not occur in the agency's case record dictation until after the birth of her youngest child in August 2000. (A report from IFCS identified him as being in the household on February 2, 2000.) It is not clear when Mr. Levin relocated to Virginia. A child abuse clearance and criminal record check for Mr. Levin were obtained from the Commonwealth of Virginia records. These records did not indicate a child abuse or criminal history against children in the State of Virginia. Child abuse and criminal history records were not obtained from Maryland State records. An interview suggested that a process was initiated by Virginia to obtain records from Maryland, but was not completed.

Agency management indicated that child abuse and criminal history records for household members are not required by Virginia DSS unless the person is the subject of an abuse or neglect report.

Recommendation

Clearances should be obtained for every adult member in a household as a routine matter of policy and procedure. The agency should review and revise existing policy and related procedure to require that child abuse and criminal history clearances be obtained on all adults in the household, and that findings be documented and incorporated as key factors in decision-making.

The policy should be specific that when an adult has resided in the current state for less than three to five years, clearances from the former state of residence should be obtained and included as a key factor in decision making.

Practice

1. **Finding**

Information provided by the agency indicated that the size of the worker's caseload was within Child Welfare League standards for foster care. Caseload size only indicates that the caseworker's workload is manageable. The quality and effectiveness of the work done on each case must be monitored regularly by the supervisor. The case record does not document that this level of supervision was done.

The agency management indicated that supervisors are expected to meet each week with workers for supervisory conferences. This expectation is not written in agency policy. The case record dictation indicates that supervisory meetings were held on the following dates: November 19, 1999, December 2, 1999, February 18, 1999, March 20, 2000, April 18, 2000, June 8, 2000, June 30, 2000, July 31, 2000, October 26, 2000 and December 21, 2000.

Recommendation

~~The~~ agency should establish written policy that requires weekly formal supervisory conferences between caseworkers and supervisors. Supervisory conferences provide support for caseworkers and an opportunity for supervisors to monitor casework activities. Supervisor-manager conferences facilitate identification of key service program issues, agency management issues, and opportunity to develop strategies for enhanced services to children and families.

2. **Finding**

A wide array of services were offered and provided to the Frazier family. It is not clear from the case dictation how service outcomes were used to assess and measure achievement of service plan goals. Ms. Frazier's opportunity to participate in a variety of services was a positive factor in the case. Equally important is the process of assessing how services are being used and whether they are having the desired outcome. Assessing the outcome of a specific service allows the caseworker to determine whether the level and intensity of service should be increased, decreased, or modified in some other way.

Recommendation

The agency should require that the case dictation document the use of and participation in services, and the evaluation of service effectiveness.

3. **Finding**

The case record dictation does not contain information related to service goals and objectives. Reports from service providers that were made available for this case review contained information about service delivery that was not in the case record dictation. Agency management indicated that it is not agency practice to make reference to the content of these reports in case notes. As a result, it is difficult to determine the basis for decision-making and service planning.

Recommendation

The agency should develop written instructions to staff that outline the need for documentation in the case notes that includes concrete and therapeutic services provided, and related information from service and treatment providers. Both types of services should match the assessed level of safety and risk.

4. **Finding**

Interviews indicated that the agency and some service providers relied on Ms. Frazier's self-reports of progress with programs and services. In some instances Ms. Frazier's assessment of her achievements was not verified.

Recommendation
The agency should have standards of practice that require the verification of information related to a parent or caregiver's participation in services. Verification should include the frequency of participation and the quality of participation. This information should be documented in the case record dictation.

5. **Finding**
There are discrepancies among interviews and the case record regarding agency visits to the last foster home. The agency foster care manual requires visitation of the child in the foster home at least once every three months. The case dictation indicates that the worker visited the home on February 28, 2000, March 3, 2000, August 21, 2000, August 23, 2000, and on September 15, 2000 when Katelyn was placed with her mother. An agency foster home worker visited the foster home on May 4, 2000 to conduct a re-licensing visit and observed the child.

Agency management indicated that the DHS caseworker's primary contact was with the child care provider because the foster mother worked and the child-care provider contacts were considered part of the reunification plan.

Child Welfare League Foster Care Standards recommend contact with foster children should occur monthly in the foster home. The frequency and quality of contact with children in the foster home and contact with the foster parents is important in assessing the child's needs.

Recommendation
The monitoring of caseworker contacts with foster children and foster parents should be an element in the quality assurance system and monitored by the supervisor through case record reviews.

6. **Finding**
The information obtained by the Office of the Commonwealth's Attorney indicated that individuals who were not party to the case, including an apartment manager, a neighbor, and a pest control technician, observed bruises on Katelyn and household conditions that suggested Ms. Frazier was having difficulty managing the care of the children and housekeeping. This information was not reported to the agency.

The case dictation indicated concerns about the household conditions and efforts were made to assist Ms. Frazier. The case dictation does not indicate that the risk to the children's safety, and well being was assessed.

Recommendation
Agency managers stated that all workers receive training on how to identity indicators of abuse and neglect. The State of Virginia mandates this training. The

agency should ensure that all caseworkers, after receiving the training, are applying the learning to their documented risk and safety assessments.

In addition, the agency should develop a plan for educating all service providers and the public on the characteristics of child abuse and neglect and how to report it.

7. **Finding**
The case dictation does not indicate that Ms. Frazier's pattern of service utilization and command of life skills was seen as clinical diagnostic tools.

Recommendations
The agency should provide caseworkers with clear practice guidelines on how to make clinical connections between key observations related to the casework process, and case and service goals and objectives.

Practice guidelines should include direction as to when and how to use technical assistance from clinical consultants such as psychologist and psychiatrists.

Procedures

1. **Finding**
Interviews indicated that the agency had the option of filing an appeal when the petition to terminate parental rights was denied by the court on April 21, 1999. The agency did not pursue this option. Subsequent to the court's decision the permanency goal was changed to Return to Parent. According to information obtained from interviews, the decision not to use the appeal process was based, in part, on the belief that Ms. Frazier would not be able to sustain the same level of progress and the agency would have another opportunity to petition the court.

Agency management indicated that filing an appeal is considered a legal decision and that there was not a legal basis for an appeal in this case.

Recommendation

The agency, with the city attorney, should develop written guidelines for determining when appeals of court decisions are needed and when other court actions should be used to assure the safety, permanency, and well being of the child.

2. **Finding**
Agency management indicated that the disapproval of the Maryland Interstate Compact for the Placement of Children (ICPC) was pivotal to the decision for Ms. Frazier to move to Virginia.

The Interstate Compact for the Placement of Children (ICPC) is a legally binding agreement, codified in State law, to assure that children who are placed in foster and adoptive homes across state borders are protected from abuse and neglect. The Compact is law in all 50 States, the District of Columbia, and the U.S. Virgin Islands. Each State appoints an ICPC Administrator to carry out the functions prescribed in the Articles and Regulations of the Compact. The Association of Public Human Services Administrators is the Secretariat for the Compact and has an ICPC manager who provides technical assistance and other supports to ICPC States.

The Virginia State Code, Sections 63.1-195 and 63.1-219.1, requires that the child placing agency file a request with the Virginia ICPC Administrator for the approval of the placement of a child in another state when the child is under the agency's legal custody. This requirement pertains to all children regardless of the type of placement. The procedures for filing the request are delineated in the ICPC regulations.

Under ICPC, the State that is to receive the child has the final authority to approve or deny the placement of the child in the State. The decision is based on "what is in the best interest of the child." There are severe penalties for the State that does not comply with the decision and places the child. The violation of ICPC can result in the State losing the right to place any child in any out-of-state foster home, adoptive home, or facility.

In this case situation, DHS acted according to ICPC regulations when the request was made to the Virginia ICPC to have the Maryland ICPC approve Child A and Katelyn's placement with Ms. Frazier in the grandparents' home. The placement of the children in Maryland without approval was not in compliance with ICPC regulations.

Because the placement was in violation of Virginia State Law, the Attorney General, as legal counsel to the Virginia ICPC, filed a motion with the Alexandria Juvenile Court to prevent the placement of the children with Ms. Frazier in Maryland. As a result, the Court vacated the order that permitted the placement and the children were returned to foster care in Alexandria.

Recommendation

The Virginia ICPC Deputy Administrator provides training on all aspects of ICPC and is available for technical assistance. DHS supervisors and managers, and the Alexandria city attorneys, who provide counsel to the agency, should participate in training and request technical assistance when appropriate.

Appendix 1
DOCUMENTS REVIEWED

Alexandria City Department of Human Services provided:

Frazier Family Case Records, including Foster Care Service Plans, reports from various service agencies, Montgomery County MD CPS, dependency intake information, etc.

Frazier Family Court Documents

Comprehensive Services Act (CSA) Manual

Child Protective Services Manual

Foster Care and Adoption Services Manual

Child Welfare Staff (Years of experience and credentials)

Staff Resumes

2000 Foster Care/Adoption Face Sheet

Human Services Measures and Indicators

Alexandria System of Care (Youth Policy Commission Meeting 5/3/00)

Department of Human Services—Organization Chart

Department of Human Services JobLink

VISSTA Course Catalog

News Articles

Guide to the Interstate Compact on the Placement of Children (written by American Public Human Services Association)

Appendix 2

ORGANIZATIONS AND PERSONS REPRESENTED IN INTERVIEWS

- Maryland and Virginia Interstate Compact Staff
- Virginia Department of Social Services
- Alexandria Department of Human Services
- Montgomery County Child Welfare
- Alexandria Juvenile and Domestic Relations Court
- Foster Parents
- Office of Commonwealth's Attorney
- Day Care Provider
- Institute for Family Centered Services
- CASA Volunteer Program
- Legal Counsels
- Alexandria City Mental Health Department
- Montgomery County, Maryland Public Health Department
- Alexandria City Department of Public Health
- American Public Human Services Association

Policy

1. **Finding**

Ms. Frazier is a young, inexperienced mother of three surviving children. Until securing her own residence in Alexandria, at the age of 25, she had never lived independently or had full responsibility for the daily care of her children. At the time that Katelyn was returned from foster care to her mother, Ms. Frazier, who was 26 at the time, was caring for a one-month-old baby (her fourth child) and two other children under the age of 6. Two of the children had identified special needs. Her church and family support system was in Maryland.

The agency management indicated during interviews that risk assessments are expected to be done at each contact with the child and family. This expectation is not written in agency policy.

Recommendation

The agency should establish policy and practice guidelines for decision-making related to family reunification which should include the use of structured risk, safety, and family assessment tools. Time frames for the use of such tools should be established to ensure safety at every contact and to facilitate structured decision-making, highlighting key risk and safety indicators. Additionally, assessment tools would provide documentation of the basis for specific decisions. Reunification should not occur without a risk and safety assessment that incorporates the review of informal supports, formal services available, mental health condition of caregiver, special needs of children, caregiver parenting ability, and household composition. Safety must be assessed and documented at each contact.

CITY RESPONSE

The agency concurs that the use of a written structured risk and safety assessment tool at key points in child protective service and foster care cases, including at the initial intake into the child welfare systems and prior to family reunification, will enhance social work practice and provide case documentation of key decisions. DHS does a structured written risk assessment as required by State policy in the investigation of reported child abuse and neglect. In addition to this required risk assessment, State policy was expanded in May 2001 to require a separate structured written safety assessment at the first meaningful contact in the investigation of reported child abuse and neglect.

In foster care cases, State policy does not require a structured written risk or safety assessment. The State has recently established a work group of State and local professionals to begin to review risk and safety assessment tools and recommend policy for their use in the Commonwealth.

DHS social workers handling child protective service cases and foster care cases have always assessed risk and safety of children on a continuous basis. This was done in this case, including on each occasion when a foster care services plan (which set out the ultimate goal (reunification or adoption) for Katelyn and a series of services to be provided the family) was prepared and presented to the Juvenile Court. Social workers, we note, can

assume immediate custody of a child in danger only if, in their judgment, there is imminent risk ~~of~~ harm to a child. It is the social worker's judgment of risk and safety factors that lead to the Juvenile Court's determination to remove a child from a parent's custody or to issue a protective order. These judgments are made daily by the approximately thirty social workers providing child welfare services.

There is no agreement nationally regarding the most effective way to determine risk in child welfare because ultimately it relies on the knowledge, judgment, and expertise of the social worker. DHS is currently reviewing the risk assessment tools from Washington State, which include factors relating to parental characteristics, child characteristics, family functioning and environmental factors. The Washington State risk assessment tool guides decision making in several areas including service planning, child removal and reunification.

DHS will implement a written structured risk and safety assessment, based on the Washington State model, this summer.

2. **Finding**

Interviews and review of the case record indicates a series of incidents in which bruises were observed on Katelyn's face, back, and hip. The case record shows a pattern of injuries observed by the DHS worker or reported by the mother beginning on August 11, 2000 and continuing on September 18, 2000, September 26, 2000, and October 31, 2000. The case record dictation indicates that the DHS worker determined that the injuries were consistent with the explanations given by the mother. The DHS worker advised the mother to pay closer attention to the care of the child and her siblings.

Recommendation

The agency should implement policies and procedures that require the review of all active cases in which the child is injured on more than one occasion. Agency policy should require that the Child Protective Service Unit assess all injuries occurring in active cases. Investigation and assessments of injuries by the ongoing caseworker risks over-identification of the worker with the family, application of differential standards, and lack of objectivity.

Multidisciplinary teams, composed of agency and non-agency professionals, should be convened routinely to review high-risk cases.

CITY RESPONSE

The four injuries between August and November noted in Katelyn's case record were injuries observed by the social worker or injuries reported to the social worker by Katelyn's mother. All injuries were assessed by the social worker and the injuries were determined to be consistent with the explanations provided. None of these injuries was suspected to be abuse. In situations where abuse is, in fact, suspected by the social worker assigned to an active foster care case or where abuse or neglect is reported by others, current local policy requires an investigation by the Child Protective Service Unit, not the social worker or the unit assigned to the case, assuring objectivity. In this family's situation, several reports of child abuse which came from others were investigated by the City's Child Protective Service Unit or referred to Maryland Child Protective Services for investigation.

DHS will establish an additional safeguard, a "new eyes approach." This will entail every injury of a child in an active foster care case to be assessed by the Child Protective Service Unit, whether or not abuse is suspected by the assigned social worker. If the injury is assessed by that unit to be suspicious of abuse or neglect, a full child protective service investigation, conducted by the Child Protective Services Unit, will occur.

A fundamental safeguard for children is the community's ability to recognize potential abuse and neglect and the willingness to report suspicions. To enhance community reporting, DHS will establish a community advisory group that will have as one of its goals community education on the indicators of abuse and neglect and on the importance of reporting.

In addition, DHS will establish a practice of outside reviews of high-risk child protective service and foster care cases. In fact, the agency has already started these reviews. Beginning in March 2001, an internal risk assessment was conducted of all active child protective service and foster care cases. The internal review identified all high-risk cases which were then reviewed by staff with a team of five outside child welfare specialists from local and State government, a private clinician and a Virginia Commonwealth University professor who leads the University's child welfare initiative. The agency will institutionalize this outside review process as a regular part of its implementation of structured risk assessments.

3. **Finding**

Recently the agency convened a group of child welfare specialists from Virginia counties and the state office, and a professor who heads a university child welfare initiative to review all high-risk reunification cases. This is a positive reaction to the death of a child. However, the agency does not have a formal written plan and documented procedures for quality improvement, quality assurance, and quality control programs. Quality improvement involves the continuous assessment of existing programs and services and planning for program and service enhancements. Quality assurance activities enable an agency to assess whether policies, best practices, and program and service enhancements are implemented. Quality control activities assure that policies and best practice occur consistently across the agency and on a regular basis.

Supervisory review of cases should occur on a regular basis as a means of quality assurance and control within a unit. Individual case reviews of this nature provide insight into the dynamics of specific families. The application of policies and practice are measured against service delivery in a specific case. On an organizational level, a sample of cases should be reviewed periodically to measure the achievement of agency goals, objectives, and child and family outcomes.

Recommendation

In addition to direct supervisory review of cases the agency should establish written policy that requires random reviews of cases by staff other than the direct supervisor and caseworker. The results of the reviews should be shared with the supervisor and caseworker.

The agency should provide resources that will institutionalize quality improvement, quality assurance, and quality control processes within the organizational structure.

The agency should develop a mechanism for producing management reports based on the results of quality assurance activities. These reports should be used to improve practice and/or change policies.

CITY RESPONSE

The agency has routine methods of quality improvement, quality assurance and quality control, although it does not have a formal written plan.

Quality improvement activities occur during weekly child welfare supervisory team meetings, where current service initiatives are assessed and plans for service and program enhancements are made. Examples include involvement as key members of the model court initiative and the current planning for a Drug Court that would provide intensive monitoring of cases where substance abuse is involved. It is through the supervisory team that practice changes are made to meet the challenge of adhering to legal requirements, while balancing agency policy, such as the new timelines of the federal Adoption & Safe Families Act of 1997. New initiatives to enhance service to children and families result from these sessions, some of which are therapeutic foster care services, enhanced foster home recruitment in the City and the provision of parenting classes for high-risk cases.

Quality assurance is carried out by the supervisory team as it continuously assesses implementation of service enhancements, and practice and program changes. In addition, the Department and Division Directors provide quality assurance through review of all adoption cases, review of and consultation on difficult foster care and child protective service cases, and involvement in planning and oversight of service enhancements.

Quality control is also provided through supervisory review of cases, the family assessment and planning team review of cases, and routine service utilization review processes such as the completion of the Child & Adolescent Family Assessment Scale (CAFAS), a tool that assesses a child's behavioral functioning or impairment. In addition, agency quality control is complemented by State review of selected cases, and routine review of cases appealed in the State administrative process. Also, all foster care service plans, in all foster care cases, are reviewed by the court or an administrative panel every six months.

As part of its overall enhanced risk assessment process, DHS will establish the practice in foster care cases of conducting random case reviews by staff from units not involved with the case. In addition, increased supervisory staff will be hired to reduce the supervisor-worker ratio and enhance the supervisory process. The agency also will include its quality improvement, assurance and control processes in a local policy manual.

4. **Finding**

According to interviews the agency provides training opportunities for staff. Individuals may self-select training topics and workshops. Staff are not assigned to attend specific training based on assessed individual need. Agency management clarified this information. Documents from the Virginia Department of Social Services were provided that included information on mandatory training for social workers and supervisors. Agency management also stated that workers have an individual education plan, based on their assessed needs and skill levels. Supervisors approve all of the training requests based on the plan.

Recommendation

The agency should continue individualized education plans for staff, based on assessed needs and skill levels. Additionally the agency should track the transfer of learning through case documentation and supervisory conferences.

CITY RESPONSE

Training is conducted through the Virginia Institute of Social Services Training Activities (VISSTA). Training is needs based, developed through the Virginia Commonwealth University School of Social Work and provided statewide for consistency of approach and application. There is mandatory training in child protection which includes investigation methodology, case documentation, decision-making, and out of family and sexual abuse specialties. Because all child welfare social workers share 24-hour child protection coverage, all must have completed the mandatory State courses in child protection, even if their primary responsibility is adoption services. Social workers take advantage of the many other training opportunities available in the area, as well as education toward advanced degrees. The agency will continue providing individualized education plans for staff, based on assessed needs and skill levels. Transfer of learning is, and will continue to be, regularly assessed through supervisory review of individual casework practice and best practices are acknowledged.

5. **Finding**

Communication among the agency and service providers and parties representing the interest of Ms. Frazier and Katelyn was not consistent. Interviews with parties who had an interest and role in the case indicated that responses to telephone calls, requests for information, and reports often were delayed or unanswered.

Recommendation

The agency should establish written policy that requires routine collateral contacts with service providers and other parties to the case.

The agency should develop related protocols with social service providers; legal counsel for the agency, parents, and children, and medical and behavioral health systems.

CITY RESPONSE

The social worker handling a case has regular contact with all of the collateral agencies involved in the case. The agency will, however, formalize its case collaboration by preparing a protocol on case collaboration with service providers and interested parties that specify key points in time for case conferences with such providers and parties, including conferences prior to reunification. Also, the agency will set expectations of service that require regular reporting by providers of services delivered. It is the agency's policy to return phone calls and provide information in a timely manner. The protocol on collaboration will reinforce this basic policy.

6. **Finding**

Documentation of Ms. Frazier's last male companion's addition to the household does not occur in the agency's case record dictation until after the birth of her youngest child in August 2000. (A report from IFCS identified him as being in the household on February 2, 2000.) It is not clear when Mr. Levin relocated to Virginia. A child abuse clearance and criminal record check for Mr. Levin were obtained from the Commonwealth of Virginia records. These records did not indicate a child abuse or criminal history against children in the State of Virginia. Child abuse and criminal history records were not obtained from Maryland State records. An interview suggested that a process was initiated by Virginia to obtain records from Maryland, but was not completed.

Agency management indicated that child abuse and criminal history records for household members are not required by Virginia DSS unless the person is the subject of an abuse or neglect report.

Recommendation

Clearances should be obtained for every adult member in a household as a routine matter of policy and procedure. The agency should review and revise existing policy and related procedure to require that child abuse and criminal history clearances be obtained on all adults in the household, and that findings be documented and incorporated as key factors in decision-making.

The policy should be specific that when an adult has resided in the current state for less than three to five years, clearances from the former state of residence should be obtained and included as a key factor in decision making.

CITY RESPONSE

The agency did obtain criminal and child abuse clearances on Asher Levin from Virginia. However, obtaining these clearances was dependent on Asher Levin's voluntary agreement, and his authorization was required to obtain these records. Virginia statutes do not provide authority for the agency, on its own, to access these criminal records. The agency has authority to access child abuse information without the subject's agreement only when the person is the subject of a child abuse complaint. Also, in the regulatory function of the

Department, criminal and child abuse clearances are required to become a child care provider or foster parent, but are obtained only with the applicant's authorization.

The agency agrees that clearances should be required for all adults residing in a household where a child over whom the agency has legal custody has been placed and also has recommended to the State Board of Social Services that this requirement be added to State policy and that all necessary amendments to State law be sought by the Board.

Practice

1. **Finding**

Information provided by the agency indicated that the size of the worker's caseload was within Child Welfare League standards for foster care. Caseload size only indicates that the caseworker's workload is manageable. The quality and effectiveness of the work done on each case must be monitored regularly by the supervisor. The case record does not document that this level of supervision was done.

The agency management indicated that supervisors are expected to meet each week with workers for supervisory conferences. This expectation is not written in agency policy. The case record dictation indicates that supervisory meetings were held on the following dates: November 19, 1999, December 2, 1999, February 18, 1999, March 20, 2000, April 18, 2000, June 8, 2000, June 30, 2000, July 31, 2000, October 26, 2000 and December 21, 2000.

Recommendation

The agency should establish written policy that requires weekly formal supervisory conferences between caseworkers and supervisors. Supervisory conferences provide support for caseworkers and an opportunity for supervisors to monitor casework activities. Supervisor-manager conferences facilitate identification of key service program issues, agency management issues, and opportunity to develop strategies for enhanced services to children and families.

CITY RESPONSE

State policy does not require documentation of supervisory conferences or of the frequency and nature of supervisory consultations. It is agency policy, albeit unwritten, that supervision and consultation occur weekly at a minimum. The frequency and nature of supervisory consultations is not relegated to a fixed time and appointment, but is, instead, weighted in favor of the risk assessment, the service plan and treatment requirements for a family. The Frazier family had many service complexities that necessitated the supervisor and social worker meeting weekly and, during some periods, daily to explore issues such as cross jurisdictional barriers to service planning, reunification services, transitional planning, managing multiple party interests, litigation issues, changes in case direction and securing resources to support the therapeutic process, such as additional clinical support through the consultation with our agency consultant, who is a licensed structural family therapist.

The agency will establish a written policy which incorporates all current supervisory requirements, as well as a new supervisory conferencing form that will document dates of supervision and the recommendations and strategies that are developed during the consultations.

2 **Finding**

A wide array of services were offered and provided to the Frazier family. It is not clear from the case dictation how service outcomes were used to assess and measure achievement of service plan goals. Ms. Frazier's opportunity to participate in a variety of services was a positive factor in the case. Equally important is the process of assessing how services are being used and whether they are having the desired outcome. Assessing the outcome of a specific service allows the caseworker to determine whether the level and intensity of service should be increased, decreased, or modified in some other way.

Recommendation

The agency should require that the case dictation document the use of and participation in services, and the evaluation of service effectiveness.

CITY RESPONSE

Assessing the outcome and effectiveness of services is the responsibility of the agency. The wide array of services for the Frazier family was initiated with an overall mission to reduce risk of abuse and neglect, strengthen family functioning, address mental health and substance abuse issues, support relapse prevention, improve competency in parenting and home management skills, and improve the cognitive and developmental abilities of the children. Ultimately, the outcome measurements and service evaluation are related to categories of child safety, child and family functioning and family preservation.

Measuring service outcomes is a nationwide challenge for child welfare services. There is a limited consensus on standards or tools to measure outcomes and establish the level of service needed for children. A tool used in the Frazier case for determining services was the Preschool and Early Childhood Functioning Scale. Utilization reviews were instituted to guide whether the level and intensity of services should be increased, decreased, or modified.

The agency has been involved for three years in the implementation of Harmony which is a comprehensive integrated information system designed to track case management, financial and outcome data for Human Service agencies. A component of Harmony is a service-planning module with clearly stated needs, measures for long term goals and short-term objectives. The agency will continue the implementation and utilization of this system of management.

3. **Finding**

The case record dictation does not contain information related to service goals and objectives. Reports from service providers that were made available for this case review

contained information about service delivery that was not in the case record dictation. Agency management indicated that it is not agency practice to make reference to the content of these reports in case notes. As a result, it is difficult to determine the basis for decision-making and service planning.

Recommendation
The agency should develop written instructions to staff that outline the need for documentation in the case notes that includes concrete and therapeutic services provided, and related information from service and treatment providers. Both types of services should match the assessed level of safety and risk.

CITY RESPONSE
The case record dictation is primarily a log of key contacts with family and service providers. It identifies the visitation plans, court hearings, injuries, child protective service complaints and contacts with service providers to request information. The dictation does not summarize case status, and is not used to establish or review service plans.

Separate foster care service plans are required and presented to the Juvenile Court where case progress is reviewed every six months. In addition, the provision of services in foster care cases is reviewed by the family assessment and planning teams on a regular basis. Reports from service providers are included as part of the record and are not summarized in dictation.

Supervisors provide oversight that addresses the need for concrete as well as therapeutic services. Services are tied to goals in the foster care service plan and family assessment plan. The Frazier family had a wide variety of therapeutic and other services provided to them that covered the essential areas of mental health, health, parenting, housing, transportation, financial assistance and childcare. Concrete services are manifestations of therapeutic service needs, as well as practical supports needed for success of the client in service plan requirements.

The agency intends to establish a protocol and use a structured written risk assessment tool to document decision-making.

4. **Finding**
Interviews indicated that the agency and some service providers relied on Ms. Frazier's self-reports of progress with programs and services. In some instances Ms. Frazier's assessment of her achievements was not verified.

Recommendation
The agency should have standards of practice that require the verification of information related to a parent or caregiver's participation in services. Verification should include the frequency of participation and the quality of participation. This information should be documented in the case record dictation.

CITY RESPONSE

The agency regularly verifies all information in a case from a provider outside the agency and does not rely on a client's statement about progress. However, Alcoholics Anonymous and Narcotics Anonymous are anonymous, confidential services and verification of attendance is not available. The case record reflects outside provider contacts in an objective way, stating that the contact was made and a brief summary of it. Reports from providers include the frequency of participation and summary statements about progress. Standard requirements for reporting will be included in the protocol on collaboratism.

5. **Finding**

There are discrepancies among interviews and the case record regarding agency visits to the last foster home. The agency foster care manual requires visitation of the child in the foster home at least once every three months. The case dictation indicates that the worker visited the home on February 28, 2000, March 3, 2000, August 21, 2000, August 23, 2000, and on September 15, 2000 when Katelyn was placed with her mother. An agency foster home worker visited the foster home on May 4, 2000 to conduct a re-licensing visit and observed the child.

Agency management indicated that the DHS caseworker's primary contact was with the child care provider because the foster mother worked and the child-care provider contacts were considered part of the reunification plan.

Child Welfare League Foster Care Standards recommend contact with foster children should occur monthly in the foster home. The frequency and quality of contact with children in the foster home and contact with the foster parents is important in assessing the child's needs.

Recommendation

The monitoring of caseworker contacts with foster children and foster parents should be an element in the quality assurance system and monitored by the supervisor through case record reviews.

CITY RESPONSE

Current State policy requires visitation of the child in the foster home once every three months. Many contacts between the agency and the child occurred at the childcare provider's home where the agency was facilitating visitation between the child and the parent. The agency social worker observed the child both at the child care provider's home and with her parent during visits at the parent's home and on occasion when accompanying the parent and child to doctor's visits. Approximately 30 visits were made from March 2000 through August 2000. These visitations are recorded in the summary of contacts. The observations of the child at the home of the foster parent, at the child care provider and with the parent are key to the assessment of needs and the quality of services provided the child. The parent child visitation and observations also enhanced the social worker's ability to evaluate the parent child interaction.

6. **Finding**

The information obtained by the Office of the Commonwealth's Attorney indicated that individuals who were not party to the case, including an apartment manager, a neighbor, and a pest control technician, observed bruises on Katelyn and household conditions that suggested Ms. Frazier was having difficulty managing the care of the children and housekeeping. This information was not reported to the agency.

The case dictation indicated concerns about the household conditions and efforts were made to assist Ms. Frazier. The case dictation does not indicate that the risk to the children's safety, and well being was assessed.

Recommendation

Agency managers stated that all workers receive training on how to identity indicators of abuse and neglect. The State of Virginia mandates this training. The agency should ensure that all caseworkers, after receiving the training, are applying the learning to their documented risk and safety assessments.

In addition, the agency should develop a plan for educating all service providers and the public on the characteristics of child abuse and neglect and how to report it.

CITY RESPONSE

Indicators of abuse and neglect are a required area of training for all child welfare staff. All staff receive individual case specific supervision and direction which is geared toward assessing the degree to which staff has absorbed the training and is applying the principles to all aspects of their cases. Risk and safety assessments are consistently and regularly made by staff with supervisors. This work is the basis for all the judgments made in cases, including a plan to return home. As noted earlier, DHS will implement a written structured risk and safety assessment, based on the Washington State model, that will assist workers in applying these indicators of abuse and neglect.

In addition, the agency provides training for service providers and also the public upon request. Training includes, but is not limited to, the characteristics of child abuse and neglect, the role of the agency in taking reports, reporting and confidentiality.

A fundamental safeguard for children is the community's ability to recognize potential abuse and neglect and its willingness to report suspicions. As earlier noted, to enhance community reporting, DHS will establish a community advisory group that will have as one of its goals community education on indicators of abuse and neglect and the importance of reporting.

7. **Finding**

The case dictation does not indicate that Ms. Frazier's pattern of service utilization and command of life skills was seen as clinical diagnostic tools.

Recommendations
The agency should provide caseworkers with clear practice guidelines on how to make clinical connections between key observations related to the casework process, and case and service goals and objectives.

Practice guidelines should include direction as to when and how to use technical assistance from clinical consultants such as psychologist and psychiatrists.

CITY RESPONSE
While the case record does not document the agency's assessment of Ms. Frazier's pattern of service utilization and command of life skills, the process used in the family assessment and planning teams and the foster care service plans provides such documentation and analysis. Indeed, in this case, the early erratic pattern of service utilization prompted the agency's petition for termination of parental rights.

Further, the agency retains the services of a clinical consultant who is available to assist all social workers on difficult cases, and the consultant's expertise was utilized in this case. DHS will retain additional psychological consultation services for use in foster care and child protective services cases.

Procedures

1. **Finding**
Interviews indicated that the agency had the option of filing an appeal when the petition to terminate parental rights was denied by the court on April 21, 1999. The agency did not pursue this option. Subsequent to the court's decision the permanency goal was changed to Return to Parent. According to information obtained from interviews, the decision not to use the appeal process was based, in part, on the belief that Ms. Frazier would not be able to sustain the same level of progress and the agency would have another opportunity to petition the court.

Agency management indicated that filing an appeal is considered a legal decision and that there was not a legal basis for an appeal in this case.

Recommendation
The agency, with the city attorney, should develop written guidelines for determining when appeals of court decisions are needed and when other court actions should be used to assure the safety, permanency, and well being of the child.

CITY RESPONSE
In the event the agency does not prevail in the juvenile court, the case worker, agency supervisors and managers, and members of the city attorney's office review the available evidence, possible sources of additional evidence, and the applicable law, and determine

whether an appeal to the circuit court is warranted. All relevant factors, including the adequacy of the service plan provisions, if any, ordered by the lower court to protect the children, are routinely considered in arriving at the determination.

2. **Finding**

Agency management indicated that the disapproval of the Maryland Interstate Compact for the Placement of Children (ICPC) was pivotal to the decision for Ms. Frazier to move to Virginia.

The Interstate Compact for the Placement of Children (ICPC) is a legally binding agreement, codified in State law, to assure that children who are placed in foster and adoptive homes across state borders are protected from abuse and neglect. The Compact is law in all 50 States, the District of Columbia, and the U.S. Virgin Islands. Each State appoints an ICPC Administrator to carry out the functions prescribed in the Articles and Regulations of the Compact. The Association of Public Human Services Administrators is the Secretariat for the Compact and has an ICPC manager who provides technical assistance and other supports to ICPC States.

The Virginia State Code, Sections 63.1-195 and 63.1-219.1, requires that the child placing agency file a request with the Virginia ICPC Administrator for the approval of the placement of a child in another state when the child is under the agency's legal custody. This requirement pertains to all children regardless of the type of placement. The procedures for filing the request are delineated in the ICPC regulations.

Under ICPC, the State that is to receive the child has the final authority to approve or deny the placement of the child in the State. The decision is based on "what is in the best interest of the child." There are severe penalties for the State that does not comply with the decision and places the child. The violation of ICPC can result in the State losing the right to place any child in any out-of-state foster home, adoptive home, or facility.

In this case situation, DHS acted according to ICPC regulations when the request was made to the Virginia ICPC to have the Maryland ICPC approve Child A and Katelyn's placement with Ms. Frazier in the grandparents' home. The placement of the children in Maryland without approval was not in compliance with ICPC regulations.

Because the placement was in violation of Virginia State Law, the Attorney General, as legal counsel to the Virginia ICPC, filed a motion with the Alexandria Juvenile Court to prevent the placement of the children with Ms. Frazier in Maryland. As a result, the Court vacated the order that permitted the placement and the children were returned to foster care in Alexandria.

Recommendation

The Virginia ICPC Deputy Administrator provides training on all aspects of ICPC and is available for technical assistance. DHS supervisors and managers, and the Alexandria city attorneys, who provide counsel to the agency, should participate in training and request technical assistance when appropriate.

CITY RESPONSE

Training has already occurred in this area. However, it should be noted that federal appellate case law differentiates between interstate placement with a parent, and interstate placement in a foster home, and concludes that the ICPC is not applicable in the former context. In this case, due to absence of controlling Virginia precedent, the agency and juvenile court weighed the supportive role that Ms. Frazier's mother and other contacts might provide in the Maryland home, against the objections of the Maryland and Virginia ICPC agencies. This issue was fully litigated, and the court ultimately chose to vacate the Maryland placement. Ms. Frazier soon thereafter established Virginia residency.

EXHIBIT NO. 2

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6-12-01

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MEDIA ADVISORY

FOR IMMEDIATE RELEASE
DATE: Tuesday, June 12, 2001

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Alexandria City Manager Presents to City Council Results of Child Welfare League of America Report in the Katelyn Frazier Matter

On June 12, 2001, City Manager Philip Sunderland presented to City Council the results of the review commissioned by the City and conducted by the Child Welfare League of America of the death of Katelyn Frazier, and the City's response to the findings and recommendations in the League's report. At the time of her death, 3 year old Katelyn Frazier was living in her mother's apartment under the legal custody of the Alexandria Department of Human Services.

CWLA recommends changes in a number of existing policies, practice and procedures of the Department of Human Services to enhance the work of the Department in providing assistance to children in foster care and child protective services.

"Katelyn's death has been a sobering experience for all of us," says City Manager Philip Sunderland. "We welcome CWLA's recommendations. We intend to implement them as soon as possible, and to go beyond them, to ensure we have policies and procedures in place that will provide the best protection we can for Alexandria's children."

The City Manager also informed the City Council that, apart from the efforts of CWLA, and with the assistance of the City Attorney, he had personally conducted his own review of the Frazier matter. This included interviews with a number of individuals involved in the case, and an examination of case and court records. "Based on this review, the views of the City Attorney, and the CWLA report," Mr. Sunderland stated he had concluded that "the Department of Human Services, along with other participants in the City's overall child welfare system, had acted properly and professionally in their efforts to assist the Frazier family through the provision of a broad range of services, to protect Katelyn and her siblings from abuse or neglect, and to reunify the family."

The Child Welfare League, at the request of the City, conducted its review of the Katelyn Frazier case to:

- Assess service planning and service delivery patterns;
- Identify areas for enhancement in agency policies, practices and procedures; and
- Provide recommendations that will facilitate improvements in service delivery to children and families.

The League's report is based on a review of the case record and court documents, as well as interviews with individuals who had direct or indirect responsibility and influence on decisions related to the family.

CWLA's recommendations are not derived from State laws, regulations or requirements, but from what CWLA sets as "best practice" standards. The Child Welfare League of America is the nation's oldest and largest organization developing and promoting best practice policies for child welfare agencies and is nationally recognized for its advocacy of best practice standards for child welfare.

The League's report summarizes the "wide array of services . . . offered and provided to the Frazier family" from February 1998 to December 2000. For the Frazier children, these services included foster home care, child care, medical and psychological treatment, respite care, home health care, and court monitoring and oversight. For Ms. Frazier, the services included visitations with children, housing assistance, public welfare, transportation, medical and psychiatric treatment, substance abuse treatment, home management counseling, parental skills training, home health services, prenatal care, and a court appointed attorney, as well as frequent home visits and other contacts by a service provider.

Based on a series of findings, the League recommends a number of changes in DHS policy and procedures. These draw on "best practice" standards to formalize the agency's risk and safety assessment procedures, to strengthen supervisory oversight of cases, to improve communications with other providers of services, and to expand the criminal clearances obtained for adults residing in homes with foster children. All of these League recommendations will be implemented by DHS over the summer.

The City Manager emphasized to the City Council that the entire Alexandria community must become an active participant in the City's network of child protection. To this end, a community committee will be established to advise the Human Services Department on the implementation of the changes being taken in response to the League report, and to help plan and implement a community education program on the importance of reporting incidents of child abuse and neglect to the Department.

The League points out at the beginning of its report the complex nature of the child welfare system: "the dual mission to protect children from abuse and neglect and to support family reunification drives the decision making processes of most child welfare agencies, and makes

decision making a complex activity." It goes on to state that "Federal and State Laws and child welfare policies and practices are designed to support the public child welfare agency's mandate to protect children and to provide services that are family-focused and child-centered. Sometimes this is not enough to prevent the death of a child."

Copies of the League report are available in the City Clerk's office, Room 2300.

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