# Breaking down the breakdowns

# State investigates its response to abuses in an effort to prevent future tragedies

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Editor's note: This is the second story in an occasional series looking at Oregon's child welfare system following two recent, shocking child abuse cases in Lane County. In both of those cases, the state invoked its review system: the Critical Incident Response Team process.

Most of the 26 investigations the state Department of Human Services has launched under Oregon's six-year-old Critical Incident Response Team, or CIRT, mandate have targeted cases where children died or were severely injured in the hands of their biological parents.

But Assistant DHS Director Erinn Kelley-Siel, who runs the agency's Children, Adults and Families Division that oversees child welfare and foster care, said she wants the agency to conduct more discretionary CIRTs into foster care abuse, or possibly even establish a new process to examine foster care troubles.

"We should have a regular, institutionalized system to review foster care abuse," Kelley-Siel said in an interview earlier this month.

The CIRT process is designed to review agency actions related to child abuse cases and to propose policy changes that could avert future tragedies.

The DHS is finding more and more value in discretionary CIRTs, said Kelley-Siel, who added that if she had been with the agency at the time, she would have called a CIRT when allegations against former foster father Kirk Garrison Sr. of Waldport arose in the fall of 2007.

The CIRT process "is evolving and becoming a nationally recognized model," said Kelley-Siel, who came to DHS in July 2008 as the division's interim director after serving as Gov. Ted Kulongoski's human services adviser for 5½ years.

CIRT reports are the only records the DHS releases publicly on the horrors of abuse that some children face and that DHS is responsible for policing and preventing. All other cases of abuse and neglect, as well as all foster parent and foster child records, are secret under state law.

Kulongoski created the CIRT policy in 2004 to form rapid response teams of law enforcement, child advocates and other experts.

He took the action in response to the case of a 4-year-old Klamath Falls girl, Cassandra Hodges, who died from head injuries caused by her mother and her mother's live-in boyfriend, whom child welfare workers did not realize had previously been imprisoned in California for killing his infant daughter. Amanda Hodges and Erik Guillermo ultimately were convicted of manslaughter.

#### Under the radar

The two most recent CIRT investigations, which look to see if there are systemic problems in Oregon's child welfare system that caseworkers and others are missing, focused earlier this year on Lane County cases. They are the first CIRTs conducted in Lane County.

One was a mandatory CIRT looking at what happened in the Dec. 9, 2009, death of 15-year-old Jeanette Maples of Eugene. Her mother, Angela McAnulty, and stepfather, Richard McAnulty, have been charged with her murder.

The other was a discretionary CIRT called after the discovery last spring that a 9-year-old Blachly boy had been severely abused by his adoptive parents, Alona and Rodger Hartwig. In a July plea deal, the Hartwigs received lengthy prison terms for felony assault on the boy.

A CIRT conducted last year examined a case of abuse by a longtime foster father in Washington County. In that case, Warren Tripp admitted to sodomizing and sexually abusing his 15-year-old adopted daughter, who came into his home as a foster child in 1995. The CIRT recommended organizing a statewide Foster Care Safety Team to look into that case and others like it.

The team, chaired by Megan Shultz, executive director of Lane County CASA (Court Appointed Special Advocates), did not look at the Garrison case, which on its face bears many similarities to the Tripp case. Both involved foster parents sexually abusing over many years children placed in their home by the state.

With virtually no media attention, the case of the 48-year-old Garrison apparently fell under the radar of the state's top child welfare officials, despite his trial in Newport this past spring lasting 11 weeks. He was convicted and sentenced in July to 44½ years in prison for raping, sodomizing and sexually abusing an adopted son and daughter between 2002 and 2006. The two siblings came into his home as foster children in the late 1990s.

"Two cases on the outside may look similar, but when you actually delve into the case file, there may be some real differences that would make one a CIRT and one not a CIRT," said Lois Day, administrator of the DHS' Office of Safety and Permanency for Children, who has been with the agency for 23 years but in her current position for less than a year. "We have critical incidents

every day," she said. "The CIRT is really where it looks like there may be a systemic issue that we could identify that would impact practices around the state."

### A case for review

The director of DHS, Dr. Bruce Goldberg, is required to call a mandatory CIRT within 24 hours of the fatality of a child in state care or one who has been the subject of a Child Protective Services assessment in the past year. An initial report must be posted on the DHS website and made public within 30 days, with a subsequent report to follow.

Goldberg also has the discretion to call a CIRT when a child has been severely injured — as in the Hartwig case — and a review is likely to lead to changes that increase child safety; or any other child abuse or neglect case in which a review is likely to increase child safety.

The Washington County case occurred in Aloha, west of Portland. Tripp, now 61, pleaded guilty in July 2009 to sodomy and first-degree sexual abuse of his adopted daughter. Child welfare officials had received numerous reports of suspected child abuse over the years but many were never investigated, according to the CIRT report on the case.

"K.T. was sexually abused by her adoptive father ... and the adoptive family was also a DHS-certified foster provider," reads the initial CIRT report of Sept. 2, 2009. "This report reflects a pattern of inappropriate physical discipline and intimidation by a DHS-certified foster family — a family that was supposed to be a safe-haven for children who had been hurt or neglected by their biological families. The record shows that DHS was aware of those reports, and did not act appropriately to address them. The issues identified in this report are significant and cause for serious concern."

When child welfare officials took the initial report on Tripp in January 2009, he and his wife, Melody Tripp, were certified foster parents with children still in their care. They had been certified for 13 years with more than 90 children in their home over the years, and had adopted three of them.

Despite allegations against the Tripps of such physical abuse as hitting children in the head with thrown telephone books, throwing a child against a wall and children being beaten with sticks and a wooden back scratcher, DHS recertified the Tripp home year after year, according to the CIRT report.

The CIRT team identified a significant systemic issue related to how information pertaining to foster families and prospective adoptive families is stored and shared between program areas, namely Child Protective Services and Foster Care Certification, according to the report.

In addition to recommending the immediate formation of the Foster Care Safety Team, recommendations by the CIRT team in the Tripp case included: reviewing all incidents of foster care abuse and neglect for the previous year, 2008, to try to identify issues or factors contributing to the abuse or neglect; reviewing a number of foster home certification files; and reviewing a sample of calls "closed at screening."

## A scarcity of homes

The Foster Care Safety Team also examined what was not a CIRT, but a sensitive case review report done in 2009 on a case that occurred a few years earlier involving a foster parent couple in their late 60s from Gresham, Marvin and Gail Thompson.

In December 2005, DHS removed six children from the home after it was reported that medically fragile infants and toddlers were spending hours unattended in their cribs in a small, cluttered storage room. The couple had been certified foster parents since 1967.

In 2007, attorneys representing adoptive parents in Michigan of two twins who they say suffered brain damage in the Thompson home because of a lack of medical attention, sued DHS, which agreed last year to pay a \$2 million settlement, the largest in agency history.

The sensitive case review, released publicly, focused on what happened in the Thompson home between 1995 and 2005. Findings included: a lack of ongoing DHS assessment; lack of face-to-face contact by the DHS foster care certifier; unapproved exceptions to what was then an eight-child limit for two-parent foster homes; and DHS certifiers not checking every room in the house.

The Foster Care Safety Team was given a 90-day deadline to report its findings, which concluded that workload, communication and documentation were the primary issues to be resolved to help stop foster care abuse.

According to the team's final report released in January, foster care certifiers carry average caseloads of 55 homes. In addition to certifying the homes, these workers also recruit, train and monitor foster parents, the report says. The team recommended splitting the recruitment and retention duties of the certifier. But DHS is dealing with a worker shortage in light of state budget cuts.

Other findings of the Foster Care Safety Team included that "a scarcity of foster homes in Oregon drives compromise, and certification violations may be overlooked due to the need for homes."

Oregon had 4,432 certified foster homes last year, compared with 5,373 in 2005.

The team also found that the lack of communication among DHS staff and/or foster parents contributed to the initial and long-term abuse of children in foster care. The team suggested that all 16 DHS offices around the state use a process such as the one in Lane County, in which a "sensitive review committee" consisting of caseworkers, supervisors, certifiers and Child Protective Services workers meet weekly to discuss concerns about any incidents with foster children that could rise to the level of an allegation, said Jerry Waybrant, a deputy assistant director and field office supervisor in the Children, Adults and Families Division.

A major finding of the team was that abuse allegations against foster parents are only documented in individual foster children's files, which makes it impossible to know if there have

been other allegations against a foster parent by other children, or if there is a history of concerns about a particular foster parent.

The agency will correct this with a new statewide database, to be launched in February, Day said.

"They obviously made mistakes, and we need to make sure those mistakes don't happen again," CASA's Shultz said during an interview in June, referring to caseworkers and others in the Tripp and Thompson cases. "But as a community, we know the system is broken. We continue to push more and more kids into the system."

Lack of communication is a big problem with the DHS system, Shultz said. "It's such a big bureaucracy that they don't communicate with each other," she said.

"I think what people don't realize is it's a very complicated bureaucratic system. It's not something that's easy to fix. I think we are part of the solution for DHS," Shultz said, referring to the entire state of Oregon. "Citizens need to ask questions and hold the agency accountable."