



Special Review Report

COMPLETED BY

Child Welfare League of America

Submitted to

**Our Kids
Miami-Dade/Monroe, Inc.**

RE: JVM

DOB: 12/13/2010

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INTRODUCTION AND SCOPE

In July 2013, the Child Welfare League of America (CWLA) was contacted by Our Kids Miami-Dade/Monroe, Inc. Our Kids requested CWLA's assistance in conducting a review of the death of a two-year-old child at the hands of his father, one month after father was given custody of his son. Our Kids stated a desire to have a transparent third party review, one that would be inclusive and provide opportunities for staff and leadership alike to learn from the tragedy.

The CWLA Special Review process is based upon the understanding that a critical incident can happen anywhere, at any time, and can happen to the most competent, experienced and sensitive of professional teams. The Review uses a teaching and training focus designed to generate practical feedback and information for professional learning, organizational development, and staff support. The Review's humanistic approach acknowledges the personal and professional trauma associated with a child's death, and offers a consistent methodology that emphasizes respectful and relevant fact-finding and identification of key dimensions in case practice determined to be excellent, acceptable, or in need of improvement.

CWLA TEAM'S MODEL AND PROCESS

CWLA's Special Review process is designed as a quality improvement tool that aims to enhance an organization's capacity to ensure the safety, permanency, and well-being of the children/youth and families who are in need of its programs.

The review process is highly interactive and transparent, intended to engage all staff and stakeholders with direct knowledge of the case. The CWLA team conducted the following activities during this Special Review:

- Reviewed case record;
- Reviewed relevant Department of Children and Families (DCF) and Our Kids' policies/procedures;
- Conducted an Entrance Meeting that provided an orientation and introduction to the process;
- Conducted individual and small group interviews with Our Kids, DCF, Full Case Management Agency (FCMA) personnel, Court personnel, Children's Legal Services (CLS), Guardians Ad Litem (GAL), Child Protection Team (CPT) personnel, and Miami-Dade CBC Alliance members;
- Drafted initial report;
- Facilitated an Exit Meeting; and
- Revised the report and returned final report to Our Kids.

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Policies and Procedures Reviewed

Our Kids Operating Procedures¹

Sibling Placement Policy 8000-10-002
Infants Born into Families or Minor Parents with Open Dependency Cases 8000-10-008
Termination of Services - General 8000-10-012
Visitation and Other Contact with Children in Shelter-Care 8000-10-013
Ages and Stages Questionnaire 6000-10-001
Child Protection Teams and Sexual Abuse Treatment Programs 6000-20-003
Consent for Medical Care and Treatment 6000-20-004
Contract Monitoring Policy 1000-50-002
New Case Assignment Process 5000-20-001
Intake Policy 5000-20-003
Investigative Response 5000-20-005
Safe at Home 5000-50-005
Media Policy 9000-20-002
Health and Safety Policy 2000-10-015
Removal and Placement of Children 8000-10-011
Placement Review Staffing Policy 7000-10-005
Foster Home Overcapacity Waiver 7000-40-008
Child Death Review Procedure 7000-60-003
Structured Decision Making 7000-80-001

DCF Policies², Procedures, and Memos³

New Unified Home Study Memo, 3/18/13
Status of Children Placed with a Non-removal Parent Memo, 9/26/12
CFOP 60-30, Chapter 1, New Employee Orientation Program
CFOP 175-21 Investigative Response
CFOP 175-42 Case Documentation
CFOP 175-46 Duplicate and Sequence Merges
CFOP 175-47 Termination of Services
CFOP 175-69 Hospital/ER Abuse Reports
CFOP 175-94 Direct Access to Info for Background or Criminal History Checks for Investigations,
Emergency Placements,
Out of Ordinary
Ch1-FLPractModel - 062413v8
Other Parent Home Assessment Form

Florida Guardian ad Litem Program Standards⁴

¹ <http://www.ourkids.us/aboutus/Pages/pnp.aspx>

² [http://www.dcf.state.fl.us/admin/publications/policies.asp?path=060%20Personnel%20\(CFOP%2060-XX\)](http://www.dcf.state.fl.us/admin/publications/policies.asp?path=060%20Personnel%20(CFOP%2060-XX))

³ <http://centerforchildwelfare.fmhi.usf.edu/HorizontalTab/DCFPolicyMemo.shtml>

⁴ <http://www.guardianadlitem.org/standards.asp>

CASE SUMMARY

Jayden lived in a complex immediate and extended family with long-term involvement in the child welfare system. The histories surrounding Jayden and his family members are complicated. Jayden was the third of four children born to his mother and father. Jayden's father also had two other children, whose mother is GJ. Father actively parented all of these children. GJ also had four other children who were fathered by three different men. These children were not siblings to Jayden, but three of them lived in the household with father and GJ. The lives of Jayden and his siblings, their half siblings, and their parents intersected in numerous ways, including periods of time when the two mothers and most of the children lived in the same household with father. Review of the case history revealed a pattern of blurred boundaries, poor parenting, and an inability of the adult caretakers to engage with the various community-based family preservation service providers.

Family Constellation (See Appendix A)

Person	Age (at the time of Jayden's death)	Relationship to Jayden
LM	24	mother
AV	29	father
GJ	27	mother of Jayden's half siblings
OE	unknown	mother's partner living in her home when children were removed
AB	35	father of GJ's oldest child
LZ	31	father of two of GJ's children
JP	32	father of one of GJ's children
3 full siblings	11 months – 4.9 years	
2 half siblings	5 months – 1.6 years	
3 children of GJ	5.8 – 6.10 years	household members
1 child	8.6 years	GJ's child (not in the home)

Case History

A timeline of salient events, created by Our Kids personnel through a case deconstruction process with all involved providers, indicates that between 2005 and 2013, there were a total of 16 reports on these family systems. During this

time period both families were referred to a myriad of community supports and services. The case records indicate that the parents engaged in some of the services but more often than not, they did not follow through or stay connected to these family preservation and other services.

The information contained in the following case summary was obtained from the case records as well as from the timeline established by the Our Kids case deconstruction team.

In September 2005, GJ brought her infant son to a local police department, telling the authorities she could no longer care for him. At the time, she was 17-years-old. This triggered the first report on GJ. On 10/5/2005, the infant was taken into protective custody and placed with his father. On 2/3/2006, this case was closed with permanent custody granted to his father. GJ was approved for supervised visits with her child.

In 9/2006, GJ gave birth to her second child, a daughter. LZ was the father.

In May 2007, there was a second report on GJ. This report for "Family Violence Threatens Child," alleged that GJ's second child was exposed to violence when GJ was hit, scratched, and choked by the perpetrator, LZ, who was the father of the child victim. At the time of this report, GJ was pregnant. LZ was stated to be the father. As a result of the domestic assault, LZ was arrested and the report was closed as "Verified." The report indicated that intervention services were needed, but GJ had left the home to live with her mother. The case was not referred to Our Kids.

On 11/1/2007, GJ gave birth to her third child, a son, fathered by LZ.

On 5/12/2008, another report was received on the GJ family. Of the two children in the home, one was listed as the victim child, the other as a "child in the home." The alleged perpetrator was not the children's father, but a boyfriend of GJ. The report states that GJ and the boyfriend became involved in an argument when he tried to leave with the older child. GJ was punched in the face, dragged by the car, and had her car rammed by the boyfriend. He also rammed the car of an off-duty policeman, as well as hit the officer's car with a machete. The report was closed as "Verified." The overall Safety Assessment indicated "Intermediate Risk." Imminent risk was mitigated because the perpetrator was arrested and GJ stated she would protect her children. The Child Protection Investigator (CPI) stated in the report that GJ "did not appear to have any insight into the seriousness of the situation." A referral was made for community services for the family.

On 6/11/2008, the above-referenced perpetrator was released from jail on a bond.

On 7/24/2008, a fourth report was received on the GJ family following a report alleging "Family Violence Threatens Child", and stating that GJ had reunited with the alleged perpetrator from her previous domestic violence incident. The report stated that GJ had taken an injunction out against her abuser, who was not the father of the two children listed as "victim child," but that she had dropped the injunction and had reunited with him. The children were not "visible" in the community and GJ had refused a community referral to a domestic violence prevention program. A safety plan was implemented with GJ until a "Red Flag" staffing was held, during which it was determined that GJ had never accepted services after the first referral was made in May, 2008, by the assigned Child Protection Investigator (CPI). The case was referred to court for Court Ordered In-Home Services. An initial referral was made to Our Kids on this same date.

On 8/14/2008, an Initial Court Hearing was held on the GJ case. GJ was placed on a waiting list for services.

On 9/11/2008, the case manager was made aware that GJ had reunited with her perpetrator.

Jayden's oldest full sibling was born in September 2008.

From September 2008, through March 2009, GJ received case management services but did not always participate fully in them. She moved, reunited with the perpetrator (ignoring court orders to follow through on filing an injunction against him), left him again, completed a parenting skills course, and eventually participated in court action against the perpetrator. During this time a diligent search was also conducted to find the father of two of GJ's children. Notes in the case record indicate that GJ was "compliant," and participated in the case planning by attending meetings. By January 2009, the children were receiving early-intervention services. Recommended speech and occupational therapy for one of the children were not initiated until late February 2009. GJ also underwent a psychological evaluation. That report indicated that GJ had a history of domestic violence in her relationships and throughout her life. No mention was made of the oldest child she had relinquished in 2005.

On 3/5/2009, GJ completed domestic violence classes.

On 3/23/2009, a supervisory review of the case was held. It was concluded that GJ had successfully completed all services and that a recommendation would be made to the court to terminate services.

On 3/27/2009, a Court hearing on Termination of Services (TOS) was held. GJ was present; case notes indicate one child had a serious speech delay and that

GJ should comply with the criminal prosecution of her former perpetrator. TOS was granted.

On 4/7/2009, the case manager completed a closing home visit with GJ. No concerns were noted.

On 5/11/2009, LZ was found guilty on four charges stemming from the May 2008 domestic violence. He received jail time for felonies related to the attack of the off-duty officer who intervened in the incident.

In 5/2009, GJ gave birth to a child fathered by JP.

In 9/2009, a second child was born to mother and father.

Between 10/13/2009 and 9/30/2010, there were three reports filed. The first one related to GJ's oldest child, whom she had relinquished in 2005. The allegation was Sexual Abuse. This report was closed with "No Indicators."

The next two reports involved GJ and the children living with her. The allegations ranged from "Physical Neglect, Physical Abuse" by GJ, absence from day care, to "Family Violence Threatens Child" and "Inadequate Supervision." The first report indicated, "Risk is Moderate"; however, the case was closed with "No Indicators." The second report was also closed with "Not Substantiated as to Family Violence" and "No Indicator as to Environmental Hazards." The case record indicates that the CPI completed a community referral for GJ to receive domestic violence prevention services.

On 10/22/2010, the first report on Jayden's mother and family was received. Mother was seven months pregnant. The allegations were that her infant child had stopped breathing and that mother had to perform CPR. The child responded, but mother did not follow up with medical treatment until the following day. From October 2010 through early December 2010, the CPI met with the family several times, met with identified extended family members, made collateral contacts with the child's pediatrician, and made a referral to a community agency for services for mother who was then enrolled in parenting classes that were to start 12/9/2010. There is no indication in the case notes as to whether or not mother actually attended these classes.

The case record also indicates that a referral was made to an early intervention program specializing in services to children with intellectual and developmental delays. The CPI was informed that a class would begin on 12/6/2010. There is no indication in the case record that this information was provided to mother.

On 12/6/2010, the report was closed with "No Indicators." The report did not contain Structured Decision Making (SDM) information and therefore it could not

be determined if SDM tools were used to determine the "No Indicators" decision. Once again, there was not a referral to Our Kids.

On 12/13/2010, Jayden was born to mother and father.

On 2/16 and 3/21/2011 respectively, two more reports were filed on Jayden's family. Allegations in the first report included "environmental hazards," i.e., dirty home and parents smoking marijuana. Mother tested negative for marijuana; father tested positive. It was determined that the home was not a hazard to the children. CPI reported SDM risk level as "Safe with Moderate Risk." The report was closed with a finding of "Not Substantiated for Environmental Hazards." Father was offered services for substance abuse. The second report contained similar allegations with an additional allegation of physical abuse of the two boys. One child was seen at the hospital for bites and a rash; the nursing staff was not concerned about the child's status, but felt the family needed assistance. Services were already in place for the family. The report was closed with "No Indicator," as the CPI reported SDM assessment to be "Safe with Moderate Risk."

On 3/22/2011, a referral was made to the Child Protection Team (CPT). An appointment was scheduled for 3/25/2011. The family failed to show up for this appointment. Between 3/25/2011 and 4/28/2011, the CPT made four attempts to notify the CPI of the family's failure to attend the scheduled appointment. There is no indication of a response from the CPI.

On 11/17/2011, another report was received on Jayden's family, alleging "Environmental Hazards and Family Violence Threatens Child." The report stated the three children in the home were dirty and that father had grabbed mother by the neck, and occasionally "whacks" her in the face. The children were also reported to have anger issues. Mother was described as being "overwhelmed." The CPI reported the family to be living with father's mother, who herself had had her children removed from her care. The family was reported as still being engaged in community services. Also living in the home was GJ, father's new girlfriend. The CPI reported SDM as "Safe with Moderate Risk." The report was closed. The case was not referred to Our Kids or CLS, although it was the fourth report within a year.

On 12/12/2011, a referral for the family was made to another community agency, which made several attempts to contact mother but did not have face-to-face contact until 3/5/2012. The two younger children were placed on an early education waiting list. Mother was offered domestic violence services but she denied any domestic violence with father at the time.

In 1/2012 another child was born to GJ and father.

On 3/12/2012 another report was received alleging "Environmental Hazards." The children and home were described as "dirty." Mother was the alleged perpetrator and father was listed as the primary caretaker. GJ was listed as "Household Member."

Throughout the month of March 2012, there was much contact among mother, community services agencies, and the CPI. Mother admitted to ongoing domestic violence by father. She was fearful of him, his mother, and GJ, as they were all still living together. Mother agreed to take her children and move to a shelter, and was escorted to the home by police to gather her belongings. When interviewed by the CPI, father denied the domestic violence allegation, and stated that mother was just upset about the living arrangements. SDM decision was reported as "Moderate."

On 3/22/2012, neither the CPI nor mother attended a scheduled meeting with a community agency. Mother remained at the shelter with her children through April 2012.

On 5/11/2012 another report was received and closed with "No Indicators." Domestic violence allegations were not included against father at that time.

On 5/23/2012, the community services for mother and her children were terminated due to lack of participation.

On 8/15/2012, the fourth child was born to mother and father. The community service agency reopened mother's case, as she had four young children. Referrals were made for counseling for mother and early childhood services for the children. A follow-up appointment was scheduled for mother on 8/23/2012, but she did not attend.

On 9/3/2012, a report was filed alleging "Inadequate Supervision" and listing mother as the alleged perpetrator. One of the younger children received a bruise on his head when his older brother climbed into the playpen. He was taken to the hospital for treatment. Mother was offered voluntary services, which she declined. The CPI reported SDM decision to be "Safe with Moderate Risk," and referred the family to CPT. The case was not mandated for review. The report was closed with a finding of "Not Substantiated for Inadequate Supervision." No referral to Our Kids was made.

On 11/27/2012 another report was received alleging "Inadequate Supervision" by mother, as her son sustained a cut to his forehead. The report stated that mother no longer resided with father and that their oldest son was residing with father and GJ, leaving the other three children with mother. Mother reported that father wanted the oldest child with him as he received SSI funds. The CPI reported SDM to be "Safe with High Risk." At this time, the case was referred to

Our Kids. The family accepted voluntary services and the case was referred to a family preservation provider.

During the months of December 2012 and January 2013, mother engaged with the provider and utilized services that were offered, e.g., daycare, improving parenting, and personal counseling. A thirty-day staffing held on 1/23/2013 indicated that the CPI Safety Assessment determined the children were "Safe," while the provider's initial assessment indicated the children to be "Conditionally Safe," with the identified concern being mother's ability to "protect her children from harm by others." It was also reported that transportation was an issue for mother in accessing services.

On 1/25/2013, another child was born to GJ and father. This was father's second child with GJ, and the sixth child fathered by him.

During the month of February 2013, one community agency closed its case with mother, as she was receiving services through the family preservation provider. Father made several allegations against mother, including that she had married her cousin's stepson. Law enforcement investigation did not support this allegation. The case record indicated that father and mother's cousin had an angry confrontation on 2/15/2013 regarding the law enforcement investigation. Although father appropriately reported the incident to the family program provider, when asked if there had been an alternative way to handle the discussion, father was not able to offer options other than by physical confrontation.

Father also told the case manager that his oldest son (who was living with him but visited with his mother) was displaying angry behaviors such as yelling and hitting teachers at his daycare, despite receiving therapy. Father attributed this behavior to the child's visits with his mother.

In late February 2013, during a CPT evaluation, mother disclosed that she had moved in with a new boyfriend.

On 3/6/2013, a supervisory closing staffing was held. The case record indicates the following issues were identified:

- The family preservation provider had little engagement with father;
- Father declined visitation agreements for his oldest son to visit with mother;
- Father stated that his son's behavior problems were a result of his visits with his mother; and,
- Mother's children were not in daycare.

It was determined that services would continue until "closing approval" to help children obtain daycare services.

On 3/13/2013, Father reported he had been unable to see his children. He also alleged that mother was using substances, but he did not have proof to support this allegation.

On 4/12/2013, Our Kids approved the case closing. The children had been referred for childcare, but were not yet enrolled.

On 4/23/2013, a domestic violence incident occurred between mother and father. Father was arrested and appeared in court on 4/25 on the domestic violence charge. A "stay away" order was issued.

On 6/16/2013, a report was received alleging that one of Jayden's brothers suffered a fracture to his right femur caused by another brother. The report also stated the child had bruising on his forehead and cheek, as well as an old fracture to his left tibia. The child was reported to be underweight, weighing only ten pounds, at age ten months. The case was assigned to a CPI who was informed by the reporter that the child's injury might require surgery. The reporter also indicated that the child was quite small and appeared to be delayed.

Following a visit to the child at the hospital, the CPI met with mother. She stated that the injured child's brother jumped on his right leg. Mother explained that she "examined" the child, gave him a bottle and he went to sleep. The next morning she noticed his thigh was swollen and she took the child to the hospital. In addition to his injured leg, the child was found to have bruises to his cheek and forehead. Mother could provide no explanation for those bruises. Mother stated the oldest child was out of control and had Attention Deficit Hyperactivity Disorder (ADHD), and told the CPI he had been diagnosed in Puerto Rico. When asked about the injured child's weight, mother told the CPI that the pediatrician had stated he was not underweight. The issue of mother's lack of supervision of the children was addressed. She denied being negligent, stating she just could not quickly get to the injured child as he was crawling away. Mother also denied that her boyfriend mistreated the children. The CPI confirmed that the children were not in school/daycare and advised mother that a referral would be made for daycare services.

On 6/17/2013, the CPT assessed both mother and the injured child, and reported several concerns to the CPI. A bone scan report indicated the child had a current fracture to the femur, a healing fracture to his left tibia, and older, healed breaks in his left ulna radius, right ulna, and left foot.

On 6/18/2013, the CPI made collateral contacts with former service providers and other individuals. It was reported that mother had complied with care coordination but had not followed through with other services, including behavioral/counseling services for the children, and counseling services for

herself. Neighbors and management staff where mother was residing verbalized their hope that DCF would remove the children from mother and her boyfriend. They also advised the CPI not to go to the home alone, as there were two large pit bulls present.

On this same date, the CPI went with law enforcement to the home of mother and her boyfriend to remove the two remaining children. As this was occurring, mother's boyfriend arrived home and provided a different story as to how the injury occurred. The CPI then contacted the children's father, and informed him that the children had been removed from other's home and taken to the DCF office. Father met with the CPI at the DCF office and was informed about the injury to his other son. According to the report, father stated mother did not tell the truth about the domestic violence for which he had been arrested. He stated the incident did not occur because he was at work at the time, but the police still believed mother. He also told the CPI that Jayden had broken his hand while under mother's care. Father was advised that the CPI would be coming to his home to assess whether or not the children could be placed with him as the "non-offending" parent. Father told the CPI he lived with his girlfriend and her five children, two of whom were his. Notification of the children's removal was made to Our Kids.

On 6/19/2013, the CPI met with father to complete a home study. The case record described a two-room efficiency that was clean with ample food. The CPI told father and his girlfriend, GJ, that the children were to be supervised at all times; they were also informed that the CPI would make a request for bunk beds. A Shelter Hearing was held on 6/19/2013. Father and GJ met with court personnel. Between them, they had ten children, nine of whom would be living with them once the injured child was released from the hospital. They were informed that the CPI would complete referrals for childcare.

On 6/20/2013, the case manager made a home visit to father and GJ. The case manager noted that one child had bruises on his cheek and did not speak; the other appeared very needy, wanting to be carried by GJ. He also did not speak much. Notes from the case record indicated that the apartment had one bedroom for what would be nine children and a puppy. Bunk beds were needed as some children were sleeping on the floor. Father was reported to be starting a new job the next day. He asked the case manager for assistance with Section 8 housing, and was described as seeming "frustrated" with the situation. The case manager also noted that father needed services to help him cope and parent the children better. Father disclosed that he had been in the foster care system.

On 6/21/2013, the case manager visited the injured child at the hospital.

On 6/21 and 6/23/2013 respectively, the CPI requested bunk beds and submitted a childcare referral for the children. CPI was informed that flex funds for bunk beds would not be available until after 7/1/2013.

A court hearing on the Dependency petition was held on 6/24/2013. At that time, mother was allowed to have supervised visits with two of her sons. She was not allowed contact with her injured son. Court personnel met with father and mother. By 7/1/2013, they were advised of the visitation schedule.

On 7/2/2013, the injured child was released from the hospital to his father's care, bringing the total number of household residents to eleven.

On 7/5/2013, the first supervised visit occurred between mother, Jayden, and one brother. The case manager noted the two boys had scratches on their faces, arms, and hands. Father reported these to be the result of a sibling argument.

On 7/8/2013, bunk beds were delivered.

On 7/11/2013, Mother informed the case manager she would not make the supervised visit. Mother also called on 7/12 to say she was in the hospital for back surgery, and would not make the visit. On 7/16/2013, mother called the case manager and stated she was having gall bladder surgery and would be unable to make a visit.

On 7/17/2013, a report was received indicating that Jayden was at the hospital, presenting as unresponsive. CPR was performed and he was given a shot of Epinephrine before being transferred to another hospital. A CT scan suggested injuries consistent with Shaken Baby Syndrome. Father was arrested as the perpetrator of Jayden's injury, and charged with aggravated child abuse and attempted second-degree murder. Two or three days prior Jayden had been seen by a pediatrician for a cough, congestion, and vomiting. According to the report, antibiotics were prescribed, as it was suspected that the child was suffering from "status asthmaticus." News reports indicate that father was frustrated by Jayden's vomiting and threw him on a bed, which caused him to hit his head on the wall.⁵

On 7/20/2013, Jayden was declared brain dead by ICU personnel, and the organ transplant protocol was initiated. Father was charged with second-degree murder.

On 7/21/2013, Jayden was removed from artificial supports.

⁵ Father Charged After Throwing 2-Year-Old Son, Leaving Him Brain Dead: Cops. NBC6.com. July 20, 2013

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Medical Examiner's Report

The Medical Examiner's Report was not available before completion of the Special Review Report.

FINDINGS AND RECOMMENDATIONS

The CWLA Team commends Our Kids for its desire for an external review of this complex case, its sincere commitment to learn from Jayden's tragic death, and its commitment to transparency and practice improvement.

Our Kids' management team launched an immediate internal review, assembling most of the providers involved with the family constellation to "deconstruct" their cases and develop a chronology detailing the family units' engagement with DCF, community-based providers, and ultimately with Our Kids, from the birth of the oldest child in 2004 until Jayden's death in July 2013. Our Kids' timely and vigorous efforts established a positive tenor, and set a solid foundation for the CWLA Team's comprehensive and probing Special Review.

The CWLA Team thanks all Review participants for their investment in the process, their willingness to participate in interviews, their provision of information requested by the CWLA Team, and for their commitment to identifying needed changes. The CWLA Team recognizes that Review participants have been working under very challenging and stressful circumstances, while carrying out their job responsibilities in a professional, caring manner. Their honest, transparent discussions provided the foundation for the findings and recommendations that follow.

The case histories document numerous incidents of domestic violence perpetrated on each mother by the fathers of their respective children and by other men. In addition, issues of substance abuse and a chronic lack of even marginal parental nurturing are documented throughout the case record. The records indicate that the children were constantly exposed to negative and often violent behaviors. Several of the children suffered from serious developmental delays impacting speech, cognitive function, physical, and emotional development. Although numerous notations in the case records indicated that social service staff were aware of the special needs of these children and that referrals for services were made, when the parents did not follow through, these services were terminated, thereby leaving the critical needs of the children unattended. In spite of repeated reports on the same issues, these cases were not given managerial review. There are multi-generational patterns, indicating many years of systemic failure. Changing a checklist or hiring additional staff cannot solve these pervasive problems. These issues can only be changed when the entire system is ready to examine itself and take responsibility for its contribution to tragic case outcomes such as Jayden's death. Such examination must include personnel representing every level of activity from first contact with a child and family through preventive work, and ultimately court involvement. All personnel must be ready to advocate for overhaul of the parts of the system that do not protect children adequately.

The CWLA Team has used the recently published *CWLA National Blueprint for Excellence in Child Welfare*,⁶ as the framework for these findings and recommendations. The *National Blueprint* can also serve as a guide for Our Kids' leadership and staff, as they move forward to better serve the children, youth, and families of Miami-Dade/Monroe Counties, and improve collaboration among DCF and community partners. (See *Appendix B* for Executive Summary CWLA National Blueprint.)

These findings and recommendations align with the principles of the CWLA National Blueprint. Their presentation is not intended to represent priority. The CWLA Team recognizes that many of the recommendations address systemic issues that are beyond the purview of Our Kids, and their adoption and implementation would require action by DCF, courts, and/or legislative bodies.

Rights of Children

Findings

The perceived rights of parents in this case appear to have been given greater weight than the rights of the children to have their basic needs met, and their rights to safety and protection from abuse and neglect.

The Florida Guardian ad Litem Program⁷ is designed to ensure that children's best interests are represented in dependency cases. The statewide program does not have sufficient resources to assign a GAL to each child, but has criteria for prioritizing, including children in out-of-home care. The program advocates for increased availability so that the program will have the capacity to assign a GAL to each child who needs one. In this case, a GAL was assigned and visited Jayden's sibling in the hospital immediately after his injury, but had not yet been able to visit the other children at their father's home before Jayden's fatal injury.

Any decision to place a child with a non-custodial parent should be made only with consideration of both the parent's rights and the child's rights, including consideration of the child's best interests. In addition to rights to safety and protection, children have a right to live with their parents, unless parents cannot care for them safely. Child protection is not an exact science and there are numerous factors to consider when weighing whether or not a parent can care for a child safely. In this case, however, there is ample evidence that the adults could not care for their children safely. Throughout these cases numerous decisions were made that do not reflect sufficient consideration of children's best

⁶CWLA National Blueprint for Excellence in Child Welfare, CWLA Press, April, 2013

⁷<http://guardianadlitem.org/index1.asp>

interests, of family history, of parents' ability to keep their children safe, of current and potential risks, including risks from other adults living in the home and/or providing care for children. The decisions made to place Jayden and siblings with his father did not examine fully his father's ability to care for the children safely. Placing Jayden and his siblings with their father was not in their best interests.

DCF had recently revised home study expectations and had called for implementation of a new "Unified Home Study." A plan for training all Child Protective Investigators (CPIs) was developed for Circuit 11, as required by a DCF memo⁸ issued March 8, 2013, however, interviews indicated that staff had not completed the training. Interviews indicated that there is inconsistent understanding concerning the applicability of the Unified Home Study tool in cases when children are moving to a non-custodial parent as a result of protective activity. The "Unified Home Study" was not used to assess father and father's home.

The brief "home study" done on non-custodial father was inadequate to determine his ability to keep his children safe and to protect them from abuse and neglect. Father's history of anger and alleged domestic violence was not examined sufficiently, nor were his history of substance use, or his own experience with foster care. GJ was not subject to the home study, although she was living in the home, was mother to children living in the home, and it was clear that she would be a caregiver of Jayden and his siblings moving into the home.

The home itself already housed two adults and six children in what was alternately described as an efficiency apartment, a one-bedroom apartment, and a two-room apartment. Interviews indicated that the physical layout was a single room, subdivided with a partial wall that did not extend to the ceiling. Father's home did not provide adequate space for three additional children, nor were there beds available for them at placement. Although application was submitted for funds to assist the family in purchasing bunk beds, funds were not made available immediately, and beds were not delivered until approximately three weeks after placement. (See *Funding and Resources*, p. 27)

Recommendations

1) All personnel in every organization providing services to children and families should be trained in children's rights, as defined in the *Rights of the Child* section

⁸ <http://centerforchildwelfare2.fmhi.usf.edu/kb/policymemos/Memo-UnifiedHomeStudy2013.pdf>

of the *CWLA National Blueprint*,⁹ and should be charged with upholding and protecting those rights.

2) It should not be assumed by child protective investigators, case managers, attorneys, or courts that a non-custodial parent can care adequately for children without sufficient review. Everyone involved in a case should be responsible for ensuring that whenever a child is removed from one home and placed in another, including the home of a non-custodial parent, the new placement is safe and the caregiver(s) can meet the child's need.

3) The Unified Home Study should be implemented and used for all placements, including those with non-custodial parents.

4) Children in shelter status should be visited by a case manager within seven days of placement, regardless of placement type. Children under five and non-verbal children of all ages should be visited within 48 hours of placement, regardless of placement type. Each child should be visited at least weekly thereafter, with the expressed goal of ensuring children's rights are upheld and their basic needs are met.

5) To ensure that every child in dependency has a GAL, DCF, CBCs, community partners, and the legislature should support GAL resource development initiatives - including financial and volunteer growth - at both the local and State levels.

Shared Responsibility and Leadership

Findings

Interviews indicated that personnel at DCF, Our Kids, and Full Case Management Agencies (FCMAs) do not have consistent views of their missions, their relationships with each other, their collective responsibility for delivery of supports and services, or the importance of shared leadership. Interviews indicated that some personnel did not view their own job responsibilities in the larger context of the continuum of services or the ultimate context of children's well-being. Without a shared vision, DCF, CBCs, and community providers cannot provide seamless services to Florida's children and families, nor can they promote shared responsibility of everyone in the community for ensuring a firm foundation for meeting children's needs and helping them to flourish.

At a systemic level, interviews indicated that numerous reports in recent years – DCF Strategic Plan 2010 – 2014,¹⁰ 2009 Child and Family Service Plan,¹¹ and

⁹ CWLA National Blueprint for Excellence in Child Welfare, CWLA Press, April, 2013 p. 25 - 35

The Nubia Report¹² were among those mentioned most frequently – have called for systemic change. There is deep and abiding frustration that so little substantive change has resulted from these calls for action. At the same time, there is frustration that Florida continues to call for new and different opinions from a host of consultants and experts without having implemented policy and procedural changes already recommended. Each child fatality inspires new reaction, and each reactive response results in piecemeal solutions without addressing fundamental systemic issues of inconsistency, poor communication, underfunding, and a compartmentalized privatization model.

Special Review participants were consistent in their understanding that Florida does not have a practice model. The Center for Child Welfare, however, has posted on its website¹³ several chapters of a draft manual including, “Chapter 1 Florida Practice Model.”¹⁴ The Practice Model, dated July 2013, does not indicate a projected implementation date.

Recommendations

6) Florida should finalize and implement a framework that will guide and support all child protective work and preventive work in the State, regardless of whether that work is performed by DCF, law enforcement officers, lead agencies, or community based providers.

7) The framework should address children’s rights, and should specify the responsibility of all child welfare personnel for upholding children’s rights as discussed in *Recommendation 1)* above.

8) DCF, Our Kids, FCMAAs, and other community providers should maintain the same level of communication that they have achieved during review of this case, with an eye toward improving co-operative and collaborative work in every case.

9) DCF and contractors should develop clearer definitions of roles and responsibilities; DCF should demonstrate a higher level of responsiveness to observations/reports from CBCs and FCMAAs.

¹⁰ <http://centerforchildwelfare2.fmhi.usf.edu/kb/flres/strategicIntent.pdf>

¹¹ <http://centerforchildwelfare2.fmhi.usf.edu/kb/resource/Child%20and%20Family%20Services%205%20Year%20Plan%202010%20-%202014.pdf>

¹² <http://centerforchildwelfare2.fmhi.usf.edu/kb/bppub/NubiasStory.pdf>

¹³ <http://centerforchildwelfare.fmhi.usf.edu>

¹⁴ http://centerforchildwelfare2.fmhi.usf.edu/kb/DCF_Pol/Ch1-FLPractModel-062413v8.pdf

Engagement/Participation

Findings

Statements made during child protective investigations were taken at face value, without recognition of patterns of behavior indicative of domestic violence. Each of the mothers in these cases had had multiple relationships that included domestic violence. There were allegations that Jayden's mother and GJ experienced domestic violence perpetrated by father. There were unidentified patterns of behavior which, had they been noted, might have led to earlier, more intensive, court-ordered, intervention for many of the children. Instead, service remained voluntary for years, family members continued to be victims of domestic violence, and risks were not properly assessed.

Both women were certainly victims of trauma. It is possible that father was also a victim, having been removed from his parent's home and placed in foster care. Father expressed his frustration and was identified as needing support in coping with parenting.

Several of the children demonstrated behavior that by all accounts was challenging and unruly. Their behavior, developmental issues, and learning challenges should have been interpreted as possible indicators of their exposure to domestic violence and their experience of trauma. A trauma-informed lens was not used to engage these adult victims or assess the children. Instead, cases were sometimes closed prematurely, and children and parents were not engaged in appropriate services.

Interviews indicated that there is often tacit acceptance by decision-makers of reports by case managers and CPIs, when additional questions by an attorney, guardian ad litem, and/or judge might reveal areas of concern.

Recommendations

10) Every individual who touches cases in any capacity – from frontline workers to judges – should receive training in trauma-informed services, and should be competent in recognizing and responding to signs of trauma and domestic violence.

11) Our Kids should develop and share with DCF and FCMA's a protocol for trauma-informed engagement. The CWLA National Blueprint can serve as a guide for developing the protocol.¹⁵

¹⁵ CWLA National Blueprint for Excellence in Child Welfare, p. 48, and p. 69-70.

Supports and Services

Findings

There are not clear guidelines or understanding of the circumstances under which a referral to Our Kids should be made. There were a total of six reports and investigations on Jayden's mother's household before removal of the children. There were seven reports on GJ and various partners between 2005 and 2010. Referral to Our Kids intake did not occur. In retrospect, many Special Review participants identified numerous "critical junctures" when referrals should have been made, and additional times when referrals could have been made.

It is important to note that Our Kids Intake "is intended to receive cases referred by DCF where the children have been determined to be "Unsafe," "Conditionally Safe" or when risk for future maltreatment is "High" or "Very High."¹⁶ GJ's case met one or more of these criteria on more than one occasion but was not referred to Our Kids. In addition, the case should have been staffed with the Children's Legal Services (CLS) division since she had previously received court ordered in-home services for similar allegations. Mother's case was not referred to Our Kids in spite of repeated allegations indicating the children were at risk for future maltreatment.

By June 2013, there was ample evidence that father and GJ had been involved in domestic violence, drug use, inappropriate discipline of children, and had not been sufficiently responsive to past service delivery. The CWLA Team believes Jayden and his brothers should not have been placed with their father and GJ. (See *Rights of Children* section on pages 15 - 16.)

The services provided to the children were not adequate. Although parents had requested childcare and referrals had been made multiple times, children had not been enrolled. Mother had a history of not showing for service appointments and there was inadequate follow-up to ensure that children's needs were met.

As previously mentioned, father's dwelling space was not adequate to accommodate everyone, and there was not a bed for each child. At the time of the CWLA Team conducted interviews, neither speech therapy nor trauma services were in place for Jayden's surviving siblings.

Jayden and his siblings had not received adequate medical services. Although various personnel had checked with their pediatrician, there was not sufficient questioning about the children's health status. For example, the pediatrician reported no concerns about growth and development although one child's weight and height, if reported accurately, was in the 5th percentile on the standard CDC

¹⁶ <http://www.ourkids.us/ourpartners/Documents/Intake%20Process/Intake%20Policy.pdf>

growth chart, another child reportedly exhibited developmental delays, while the oldest had reportedly been diagnosed with ADHD.

Recommendations

12) Investigations should always include collateral contact with past providers to determine services provided, successes and challenges, including level of participation and responsiveness.

13) CPIs and case managers should have written guidance for questioning medical providers to ensure that well-child services are up-to-date, and that any medical needs are identified and addressed. Workers who have access to Florida Shots¹⁷ should check to determine whether immunizations are up-to-date, however, they should be aware that since parents are not required to use the database, information obtained from the child's pediatrician might be more accurate in some cases.

14) A domestic violence specialist should be consulted in every case that includes allegations of, or behaviors suggestive of, domestic violence. A substance abuse specialist should be consulted in every case that includes allegations of, or behaviors suggestive of, substance abuse.

15) When there have been multiple reports concerning a child or family constellation, especially when there are repeated or similar allegations, the case should be discussed with managers who can guide decision-making and appropriate referral for services.

Quality Improvement

Findings

Interviews indicated that some entities do not have in place routine quality improvement practices such as satisfaction surveys, case reviews, records reviews, and/or peer review.

The CWLA Team observed that some record entries were not signed, some were entered weeks or months after the documented contact, and some were entered by an individual other than the person responsible. These concerns came to light because the records in question were subject to review after Jayden's death. There does not appear to be a systematic mechanism for routine review of case records or for ensuring that all documentation is completed according to applicable DCF and Our Kids procedures.

¹⁷ <https://www.flshots.com>

At least some of the lack of attention to prior reports appears to have stemmed from an alternate spelling of one person's name. There does not appear to be a system for scanning the database for alternate spellings.

Interviews indicated that some personnel did not have access to criminal history information, and some were not able to access prior case records of reports and investigations on the family units. Cross-system access to necessary background information and prior case history is essential for successful screening, investigation, and intervention with children and families.

Recommendations

16) Florida should have a clearly articulated vision, values, and mission for its child welfare system that defines the purpose and direction of each entity involved, and sets the parameters for accomplishments by each. Once there is clear articulation of every aspect of the system, there must be collaborative efforts to develop a quality improvement, learning environment that is not driven by crisis.

17) Our Kids and DCF should require that all tools used to assess children and families and all interventions used to provide services be evidence-based. Resources such as the California Evidence-Based Clearinghouse¹⁸ and the U.S. Substance Abuse and Mental Health Administration's National Registry of Evidence-Based Programs and Practices¹⁹ will be helpful resources for identifying and vetting evidence-based tools and interventions.

18) Each entity in the system should have a quality improvement program that includes, at minimum, the following components:

- Clearly articulated goals and plans for achieving them;
- Structure and mechanisms for gathering quantitative and qualitative data about work processes, quality, and outcomes;
- Effective and ongoing processes for examining information, sharing information with people who need it, evaluating information, and making decisions based upon it;
- Processes for making change;
- Processes for evaluating effects of change; and
- Multiple opportunities and mechanism for reporting results, including regular reporting on key measures and special reporting on emerging or urgent issues.²⁰

¹⁸ www.cachildwelfareclearinghouse.org

¹⁹ <http://nrepp.samhsa.gov>

²⁰ CWLA National Blueprint, p. 82

19) Our Kids and DCF should develop a joint quality improvement case review protocol for review of cases and records outside of crisis situations. The case review process should include staff representing investigations, legal, case management, and GAL, as well as DCF and Our Kids.

20) Our Kids and DCF should review documentation requirements to reduce multiple entries, streamline record keeping, and make it easier for staff to locate information when needed. They should ensure that all personnel who need the information have access to background information and previous reports.

Workforce

Findings

Throughout the system, direct service staff, supervisors, managers, administrative staff, and court personnel are exposed regularly to secondary trauma, and have experienced secondary traumatic stress. The work itself is ordinarily stressful. A serious incident or child fatality adds to the stress. Multiple child fatalities and multiple case reviews are extraordinarily stressful. All personnel involved in child fatalities may need additional support, and should have opportunities to debrief.

Coincident with the CWLA Team's first site visit, Our Kids arranged for debriefing and secondary traumatic stress training by Dr. Michael Schultz of CT DCF. Our Kids had convened people directly involved in the case, however for many DCF and community provider staff, this was the first opportunity to discuss their experiences outside of forensic interviews.

Our Kids Human Resources Department personnel are well versed in secondary traumatic stress, and can serve as a model of staff support for DCF, FCMA's, and other CBC's.

Postings for CPI positions indicate that current qualifications include a bachelor's degree from an accredited college or university; preferred qualifications are a bachelor's degree in social work, behavioral science, criminal justice, nursing or education field. Interviews indicated, however, that these preferred qualifications have not been utilized, and many current CPIs do not meet them.

All direct service child welfare employees working for the DCF, sheriff's offices conducting protective investigations, CBC lead agencies, and CBC-contracted provider agencies are required to obtain child welfare certification. In addition, CPIs are supposed to obtain certification as a Florida Child Protective

Investigator within 12 months of hire.²¹ The CWLA Team's interviews indicated that certification requirements have not been enforced consistently, although DCF personnel refuted interview information.

Special Review interviews indicated significant concern that the current minimum required qualifications for CPIs and their supervisors, for case managers and their supervisors, and for Children's Legal Services attorneys are too low. The CWLA Team concurs that minimum qualifications are not high enough. In order to protect children from abuse and neglect, the system must employ people who have the knowledge, skills, and ability to make complex decisions, weigh conflicting information from a variety of sources, determine the veracity of information presented, and ultimately, to act in the best interests of children. In Florida, as in many other child welfare systems, people making critical decisions are not always qualified or prepared for their positions.

Interviews indicated that there are not uniform qualifications across providers. In addition, in-service training is not consistent across the system, resulting in varying levels of staff knowledge in areas where consistency of understanding and competence is essential. Case managers and supervisors in different FCMA's cannot be expected to perform equally well if they do not have comparable qualifications and have not been afforded equivalent training.

Turnover is high among all positions and there are many vacancies, resulting in increased expectations of already overloaded workers and supervisors. DCF data indicates that as of November 22, 2013, 55% of the CPIs in the Circuit had open caseloads exceeding Florida's caseload ratio. The number of open cases ranged from 0 – 38, and the average was 16 open cases per CPI. It is not possible for CPIs, no matter how qualified, experienced, and well-trained, to work effectively on caseloads that are too high. In contrast, CWLA recommends that workers responsible for initial investigation and assessment be assigned no more than 12 active cases.²²

Several Special Review participants expressed interest in developing a Team Approach to investigations and to case management in complex cases. There is a distinct advantage in having multiple observers in some situations. In addition, participants believe it would be beneficial to have multi-disciplinary teams including experts in law enforcement, domestic violence, substance abuse, child development, nursing, and, of course, social work collaborate on complex cases. There is also concern about worker safety, which could be addressed in a teaming model.

²¹ Child Welfare Certification as a condition of employment, s. 402.40, F.S.

²² CWLA RECOMMENDED CASELOAD/WORKLOAD STANDARDS, Excerpted from CWLA Standards of Excellence for Child Welfare Practice, November 2008

Recommendations

21) Each entity (including CBCs, FCMA, other community providers, courts, CLS and CPTs) should have access to comprehensive training for all staff on the effects of secondary trauma. Supervisors should be able to recognize signs of secondary traumatic stress, and should have knowledge of the internal and external resources available to support staff. The CWLA Team recommends the following valuable resources for information concerning secondary traumatic stress and its effect on the workforce: National Child Traumatic Stress Network (NCTSN),²³ and CW360.²⁴ (Authors and researchers Erika Tullberg, Claude Chemtob, Alison Hendricks, Joy Osofsky, and James Caringi offer their valuable perspectives on secondary traumatic stress in a special issue.)

22) DCF should undertake a study of qualifications for positions in Florida as compared to states with similar largely privatized child welfare systems.

23) Qualifications should be standardized for case managers and supervisors across all FCMA.

24) Minimum educational and certification qualifications should be enforced for all positions. Personnel currently holding positions for which they do not meet minimum qualifications should be assisted in meeting those qualifications within prescribed timeframes.

25) CPI caseloads should be lowered to conform to CWLA recommended caseload limits of no more than 12 active cases.²⁵

26) Our Kids, DCF, FCMA, law enforcement, and court personnel should have access to and should participate in cross-system training to ensure that everyone has the same foundation for their pieces of child welfare work.

27) Our Kids should explore and pilot a multi-disciplinary teaming model that can be accessed for its most complex cases.

²³ <http://www.nctsn.org>

²⁴ CW 360 Secondary Trauma and the Child Welfare Workforce (2012). Center for Advanced Studies in Child Welfare, Spring 2012, U of MN, School of Social Work
http://www.cehd.umn.edu/ssw/cascw/attributes/PDF/publications/CW360_2012.pdf

²⁵ CWLA RECOMMENDED CASELOAD/WORKLOAD STANDARDS, Excerpted from CWLA Standards of Excellence for Child Welfare Practice, November 2008

Race, Ethnicity and Culture

Findings

Our Kids personnel are representative of the communities served by the CBC and FCMA's, and are cognizant of the effect of culture on families' responsiveness to services. The desire of all concerned to be culturally sensitive, understand, and respect cultural differences, and to refrain from imposing arbitrary standards is admirable.

Having cultural competence and approaching work with cultural humility, however, should not translate into justifying a dearth of standards to protect children and provide minimum requirements for living space.

While it is understood that there are cultural differences pertaining to living space among the various ethnic groups in Miami-Dade and throughout Florida, the lack of clear standards concerning household composition, limitations on number of people who can live in an apartment or other dwelling, and expectations for sleeping areas and bedding were problematic in this case.

Recommendations

28) DCF and Our Kids should set clear cross-cultural minimum standards and develop clear protocols for evaluating living space and determining the adequacy of sleeping arrangements, beds, and room sharing.

Funding and Resources

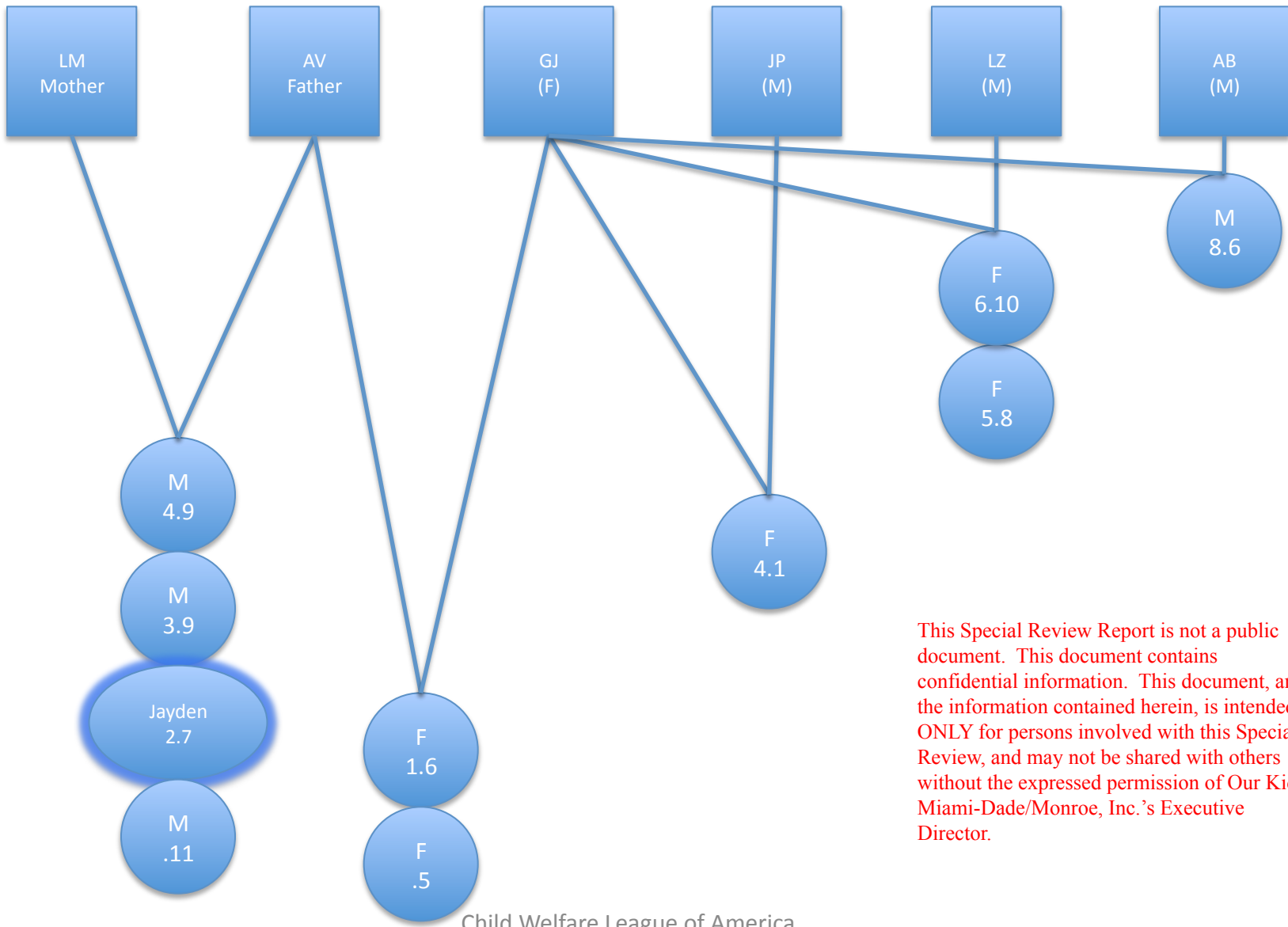
Findings

Interviews indicated that when a need for bunk beds was identified and funds were requested and delayed until the new fiscal year, personnel were not aware of a mechanism for escalating the request. Whenever children and families have basic unmet needs, there should be a way to expedite requests and obtain funds.

Recommendation

29) Our Kids and DCF should reiterate to all staff the protocol for obtaining emergency funds, so that expenditure of those funds can be accomplished immediately in order to meet basic needs.

Appendix A - Family Constellation



This Special Review Report is not a public document. This document contains confidential information. This document, and the information contained herein, is intended ONLY for persons involved with this Special Review, and may not be shared with others without the expressed permission of Our Kids Miami-Dade/Monroe, Inc.'s Executive Director.



NATIONAL BLUEPRINT

FOR EXCELLENCE IN CHILD WELFARE

EXECUTIVE SUMMARY:

*Raising the Bar for Children,
Families, and Communities*



NATIONAL BLUEPRINT

FOR EXCELLENCE IN CHILD WELFARE

Executive Summary

The Child Welfare League of America's (CWLA) National Blueprint is intended to be a catalyst for change: to broaden the thinking of communities, individuals, and groups, including public and private organizations within and outside of the child welfare system, and help them understand how their roles and responsibilities fit in the overall strategy to improve outcomes for children and youth. The CWLA National Blueprint also serves as the basis for updating and creating CWLA program-specific Standards of Excellence, which play a unique and pivotal role in moving child welfare practice forward.

As a coalition of private and public entities and individuals dedicated to ensuring the safety, permanency, and well-being of children, youth, and their families, CWLA advocates for policies, best practices, and collaborative strategies that advance positive outcomes for children and youth. In recent years, actualizing our mission has become increasingly complex. The reality is that many children in this country experience challenges because of issues with immigration, education, housing, and health care or because they live in communities where there is violence and poverty.

Unless the community has what it needs and takes ownership for ensuring the well-being of all of its children and families, neither children and families who are vulnerable nor children and families in general will flourish. The National Blueprint returns CWLA to its historic roots of advocating for a multisystem, community-based approach to protecting children and supporting families. This approach is grounded in practice improvement work that is specific to the child welfare system and inclusive of its advocacy efforts on behalf of all children and families.

Through the National Blueprint, CWLA articulates the foundation and framework for achieving the vision *that all children will grow up safely, in loving families and supportive communities, with everything they need to flourish—and with connections to their culture, ethnicity, race, and language.* As each community, organization, family, and individual is unique, the obstacles to implementation will only be identified as these entities work together to achieve the goals of the National Blueprint. This will require them to set priorities and make compromises along the way. The change might not be easy, and will take time.

The National Blueprint was developed by an advisory committee of more than 30 professionals representing child welfare agencies and organizations at federal, state, county, and community levels, and with experience as policymakers, researchers, academicians, clinicians, workers, supervisors, parents (birth, foster and adoptive), advocates, foster care alumni, and members of the legal system. The Committee met twice for two-day, face-to-face meetings, during which members developed the parameters for the Vision, Principles, and Standards. Subgroups continued the Committee's work through a series of teleconferences.

To help all children and youth flourish, society must provide services, supports, and resources so that families can ensure the safety, permanency, and well-being of their children with equal emphasis on all three. One cannot take precedence over another. Communities must be able to invest in the supports and services required to ensure that all children, youth, and families will have optimal opportunities to succeed. To facilitate community leadership and decisionmaking, current child welfare, education, social services, and health care systems will be required to transform their thinking and retool their mechanisms for allocating funds. Reform is required at the federal, tribal, state, and local levels, as is greater participation and investment from the foundation and corporate sectors.

The National Blueprint may be used by policymakers, community and organizational leaders, teachers, child advocates, licensing specialists, accrediting bodies, researchers, academics, and government entities. To establish common

ground for meaningful discussions, often-used terms are defined within the National Blueprint.

The National Blueprint includes a Vision and Values statement and eight core Principles with accompanying Standards. The following section provides an overview of the content of this document.

VISION, VALUES, AND PRINCIPLES

VISION

All children will grow up safely, in loving families and supportive communities, with everything they need to flourish—and with connections to their culture, ethnicity, race, and language.

VALUES

We value children, youth, families, and communities. We believe in integrity, fairness, social justice, dignity, and honesty. We value these actions, qualities, and characteristics: respect, innovation, service, inclusiveness, collaboration, trust, flexibility, competence, and humility.

CORE PRINCIPLES

The following core principles guide the thinking, decisionmaking, and behavior of individuals, organizations, communities, and government entities committed to the promotion and enhancement of children's safety, permanency, and well-being.

RIGHTS OF CHILDREN

PRINCIPLE

It is the responsibility of all members of society to work toward the shared goal of advancing the fundamental rights and needs of children.



STANDARDS

Survival and Development

- Children should have access to food, clean and safe water, shelter, and clothing required for survival and healthy development.
- Children should have nurturing and loving families.
- Children should have connections with their family and communities.
- Children should have access to information about their family history and background information.
- Children should be able to preserve their racial, ethnic, cultural, and religious identity.

- Children should be able to have their own gender identity and sexual orientation.
- Children should have access to formal education.
- Children should have access to quality health care.
- Children should be able to live in a safe physical environment that is free of pollutants and toxins.
- Children should have access to leisure, cultural, and recreational activities; and to healthy social relationships.

Protection

- Children must be protected from abuse, neglect, maltreatment, exploitation, and abduction.
- Children should be protected from discrimination on the basis of race, color, age, disability, gender, familial status, religion, sexual orientation, gender identity, genetic information, language, religion, national, ethnic or social origin, political beliefs, or citizenship.
- Children must be protected under the law.
- Children must be protected from torture or other cruel, inhumane, or degrading treatment or punishment.
- Children should be protected from corporal punishment.
- Children must have decisions made in their best interests.
- Children should be protected from interference with their privacy.

Participation

- Children should be involved in all aspects of decisionmaking regarding plans for them.
- Children should be able to express themselves freely.

SHARED RESPONSIBILITY AND LEADERSHIP

PRINCIPLE

Families, individuals, organizations, and communities share responsibility for assuring the safety and well-being of children and youth. To help children and youth flourish, leaders at every level and in all realms ensure that individuals, families, organizations, and systems collaborate, communicate, create and nurture meaningful partnerships.

STANDARDS

Communities

- Community members (such as elders, leaders, and representatives) should have participatory roles at all levels and in all aspects of work with children, youth, and families.
- Community members should be present on governing boards, executive/management positions, advisory boards, task forces, committees, and focus groups, and should have an equal voice and decisionmaking power.

Leadership

- Leaders are responsible for building the capacity of their entities and communities to respond to the needs of children, youth, and families.

- Leaders are responsible for creating environments that build and support the hardiness and resilience among employees, volunteers, and communities.

Collaboration

- Each community, entity, individual and system should recognize that collaborative and cooperative relationships are essential to creating and sustaining the supports and services needed by children, youth, and families.



- There should be effective and meaningful partnership between the public and private sectors. To provide seamless integration of supports and services, systems should be designed to build on the individual and collective strengths of all partners.

Governance and Capacity

- Each entity, regardless of size, should have a governance structure that emphasizes sound policy and procedure, transparency and accountability, and information sharing.

ENGAGEMENT/ PARTICIPATION

PRINCIPLE

Children, youth, and families are engaged and empowered to promote family success and build community capacity. Service providers and organizations acknowledge, appreciate, and validate the voices and experiences of those whose lives they touch, so that responsive, community-based resources and services are developed, nurtured, and sustained.

STANDARDS

Positive Engagement Strategies

- Every entity should use strengths-based and family-focused approaches in their work.
- Every entity should work to ensure that families feel physically and psychologically safe. This can be done by asking families what is needed for their psychological safety.

Trauma-Informed Engagement

- Entities should use trauma-informed approaches, asking what has happened to individuals and families instead of asking what is wrong with them.

Youth and Family Involvement

- Each entity should fully engage youth and families in all aspects of the work, including program design and development, policy and procedure development, hiring, staff orientation and training, practice guidelines, evaluation, and quality improvement processes.

Experience as a Service Recipient

- People with experience as service recipients or family members of service recipients should serve as mentors; help to educate those working with children, youth, and families; and serve on governing and/or advisory boards.

Developing Trust, Building Relationships

- Everyone should recognize that having a trusting relationship is preliminary to engagement.

Youth Engagement

- Youth should be included in the process of designing and creating programs; developing, reviewing, and revising policies and procedures; and advancing quality improvement processes and program evaluation. Youth should be involved in all aspects of their own planning and decisionmaking.



Parental and Extended Family Engagement

- Parents and extended family members should be included in all aspects of planning and decisionmaking about them and their children.

Fathers

- All efforts should be made to include fathers throughout their children's involvement with supports and services.

Mothers

- All efforts should be made to include mothers throughout their children's involvement with supports and services.

Culturally Appropriate Engagement and Response

- Each entity should use culturally appropriate strategies to engage and respond to children, youth, and families.

Commitment of Workforce and Leadership

- The leadership and workforce of each entity and community should be committed to the active engagement of children, youth, and families in responding to the needs within communities.

SUPPORTS AND SERVICES

PRINCIPLE

Families, individuals, communities, organizations, and systems protect children from abuse and neglect, and provide an array of supports and services that help children, youth, and their families to accomplish developmental tasks, develop protective factors, and strengthen coping strategies.

STANDARDS

Community Voice in Policy and Program Development

- Community members should voice their opinions concerning development of policies and programs that meet the needs of the community, and the families and individuals that live and work in it.



Safe and Healthy Communities

- Every geographic community should strive to create and sustain a safe physical environment, and a culture that promotes making healthy lifestyle choices.

Meeting Basic Needs

- Entities and communities should collaborate to ensure that families have access to and eligibility for supports and services that address basic needs, including food, clothing, housing, employment, financial resources, mental health and substance abuse services, education, health care, and transportation.

- When necessary, families should be provided assistance to develop skills and/or assistance in meeting their children's basic needs, so that children can be safe in their homes.

Social Connections

- Children, youth, and families should have ample opportunities for safe, positive social connections within their own communities.

Food and Nutrition

- Every child, youth, and family should have sufficient food and nutrition.

Access to Health Care

- Children, youth, and families should have access to health care in their communities, and their health care needs should be met.
- Strategies should be in place to ensure comprehensive health care assessments for all children. Every child should have access to health services to address physical, dental, behavioral, mental, emotional, and/or developmental health needs.
- Each child and youth should have a comprehensive, accessible, central health record that contains all pertinent information about the child or youth and preserves confidentiality.

Normalizing Need for Support

- Each entity and community should develop plans for helping to reduce stigma and normalize the need for supports and services for the children, youth, and families it serves.

Caregiving Children and Youth

- Children and youth who have caregiving responsibilities within their families or households should be provided with appropriate assistance and support.

Trauma-Informed Approaches

- Each entity should take responsibility for ensuring that all parties providing supports and services are educated about the effects of trauma and the resulting symptoms of traumatic stress, as well as effective strategies for dealing with it.

Collaboration

- Entities and communities should endeavor to provide a holistic, comprehensive, and integrated experience for children, youth, and families seeking support and receiving services.

Assessment and Service Planning

- Each entity should have clearly articulated policies and procedures for assessment and service planning.

Gender-Appropriate Services

- Each entity should ensure that its supports and services are gender-appropriate and take gender differences into consideration.

Legal System

- Courts and other members of the legal system should become a part of the collaborative process to ensure that actions taken are in the best interests of children, protect their rights, and take every possible measure to help them flourish.

Social Media and Technology

- Each entity should have policies and procedures that govern the use of technology and social media by staff, volunteers, and people receiving supports and services.
- Parents, youth, employees, and volunteers within each entity should be educated concerning the risks of technology, internet, and social media use by children and youth, and informed of appropriate safety protocols. Children, youth, and families and everyone who works with them should have access to written recommendations and guidelines for safe usage.
- Each entity should have mechanisms for storing and protecting electronic data that are reviewed and updated to ensure continued efficacy.

QUALITY IMPROVEMENT

PRINCIPLE

Supports and services are designed and implemented based on evidence and knowledge; data collection is focused on measuring outcomes and achieving success; continuous quality improvement is emphasized and supported; and innovative practices and programs are encouraged.



STANDARDS

Components of Quality Improvement Programs

Each entity should have a quality improvement program that has the following components:

- Clearly articulated vision, values, and mission that define the purpose and direction of the entity and set the parameters for its accomplishments;
- Plans for achieving the entity's purpose and direction;
- Structure and mechanisms for gathering quantitative and qualitative information about work processes, quality, and outcomes;
- Effective and ongoing processes for examining information, sharing information with people who need it, evaluating information, and making decisions based upon it;
- Processes for making change;
- Processes for evaluating effects of change; and
- Multiple opportunities and mechanisms for reporting results, including regular reporting on key measures and special reporting on emerging or urgent issues.

Positive Culture and Climate

- Within each entity, everyone should be responsible for creating and sustaining a culture and climate in which accountability, communication, responsiveness, and commitment to improvement are valued and rewarded.

Transparency

- To assure accountability, build trust in the community, and contribute to collaborative relationships, each entity's quality improvement process should be transparent to children, youth, and families; to other stakeholders; and to the general public.
- Qualitative and quantitative data gathered by organizations and public entities should be available for review by stakeholders.

Soliciting and Considering Feedback

- Each entity should have mechanisms for soliciting and considering feedback—from children, youth, families, partners and collaborators, other stakeholders, and community members—that are appropriate to its size and the scope of its mission.

Meaningful Data

- Each entity should collect meaningful data to support its ability to make decisions; improve proactively; and help children, youth, and families to achieve identified outcomes.

Evidence-Based Programs and Practices

- Entities should develop and implement only those programs and practices that are based upon the best available evidence.

Practice-Based Evidence

- Practitioners and researchers should work together effectively to improve knowledge of what works in helping children, youth, and families to flourish.

Measuring Outcomes

- Outcome measures should reflect both aspirations and achievable impact on supports and services for children, youth, and families.

Benchmarks

- Each entity should establish benchmarks for all program areas and systems functions.

Making Improvements

- When evidence indicates that performance is not meeting expectations, the entity should take action to make improvements that are informed by evidence.

Research

- Organizations should collaborate with universities and other entities conducting research. Universities and other researchers should disseminate research findings widely to contribute to research to practice applications.

WORKFORCE

PRINCIPLE

The workforce consists of competent skilled people with a variety of experiences and representing varied disciplines. They are committed to high-quality service delivery and are provided with the training, tools, resources, and support necessary to perform their roles effectively.



STANDARDS

Leadership

- Entities at national, state, and local levels should have qualified and visionary leaders, who are equipped to transform the broader community response to the changing needs of children, youth, and families within their communities.
- Organizational leaders should have the skills, knowledge, and ability to facilitate good governance; help the organization focus on its mission; strive toward excellence; develop plans; and create and adhere to appropriate systems to help children, youth, and families.

Workforce Development

Orientation and training programs, and continuing education, whether at the academic or provider level, should be evidence-informed, competency-based, and should include, at minimum, the following topics:

- Children's rights
- Family and youth engagement strategies
- Familial rights and responsibilities
- The effects of trauma on children, youth, and families
- Child, youth, and adult development
- Communication and collaboration
- Community partnerships
- Appropriate boundaries, and prevention of sexual exploitation
- Cultural competence and cultural humility
- Policies and procedures
- Relevant law and regulation
- Topics relevant to the specific position
- Relevant evidence-informed programs and practices
- Self-care and stress management
- Effects of secondary traumatic stress

Experience as a Service Recipient

- Each entity should be committed to including people with experience as a service recipient among its employees, volunteers, board members, and advisory groups.

Professional Development

- Parents, youth, families, and communities should be part of the development of educational and training programs, and should be involved in the delivery of workforce orientation and training.
- Each employee and volunteer should have the education and experience appropriate for their position.

Performance Evaluation

- The performance of each employee and volunteer should be evaluated at least annually.

Positive Culture and Climate

- Each employer should cultivate a culture and climate within which accountability, trust, and communication are the norm among all staff, volunteers, and service recipients.

Workload

- There should be assurance that each person's workload is reasonable and allows the employee to perform the required duties. At a minimum, there should be adherence to workload criteria recommended by licensing authorities, the requirements of the specific evidence-based program, and/or accrediting bodies, whenever applicable.
- Each employer should develop and maintain a workforce of sufficient size to make possible the achievement of identified outcomes for the persons served.

- Each employer should have a system appropriate to its size and function for evaluating the effectiveness of its workforce and the efficacy of each person's workload.

Supervision

- Each employee and volunteer should have and report to a supervisor who has the skills, knowledge, and ability to provide guidance appropriate for the individual's needs, position, and responsibilities.

Continuous Learning

- Each employer should have a plan for furthering the professional growth and development of employees and volunteers, with an eye toward continuous learning and career advancement.
- Each person should have opportunities to engage in formal and informal learning—on the job; through continuing education, coaching or mentoring; and through collaboration with peers.

Secondary Traumatic Stress and Burnout

- Each employer should have mechanisms for encouraging and supporting staff self-care, engaging in appropriate prevention and wellness activities, and learning stress-management strategies.
- Each employer should recognize the potential for its employees to be exposed to many different forms of trauma and to secondary traumatic stress. The employer should have plans for responding appropriately to crises and minimizing the effects of secondary traumatic stress.

RACE, ETHNICITY, AND CULTURE

PRINCIPLE

Individuals, families, communities, organizations, and systems work together to understand, and promote equality; cultural humility, and strong racial, cultural, and ethnic identity, while showing consideration for individual difference, and respecting the sovereign rights of tribes.

STANDARDS

Nondiscrimination

- Each entity should have a nondiscrimination policy that conforms to applicable law and to the Rights of Children section of the CWLA National Blueprint.

Indigenous Nations

- In all relations with indigenous nations, each entity should adhere to the principles of self-determination, holistic approaches, elimination of structural risk, respect for culture and language, and nondiscrimination.

Indian Child Welfare

- Each entity should minimize cultural disruption and alienation for American Indian/Alaska Native children, youth, and families; use active efforts to prevent unnecessary removal from their families; and understand the Indian Child Welfare Act; and how it applies to their work with children, youth, and families.

Culturally Informed and Diverse

- All entities and their staff and volunteers should be culturally informed about the diverse individuals and groups in their respective communities and among their workforce.



Identity

- All entities, communities, and families should ensure that resources are available to help children, and youth understand their heritage, preserve their connections to culture and religion, learn and preserve their traditions, and have positive role models.

Individual and Systemic Bias

- Organizations and individuals should make commitments to becoming aware of and overcoming individual and systemic bias.

Disparity and Disproportionality

- Each entity should examine disparities in its service delivery, as well as the ways in which it contributes to racial, ethnic, and other disproportionalities that negatively impact children, youth, and families.

Youth and Families Identifying as LGBTQ

- Every entity should develop expertise in understanding the unique perspectives and needs of children, youth, and adults who identify as LGBTQ.

Immigrant Children and Families

- Entities and communities should develop and implement programs that are responsive to the unique needs of families who have immigrated to the United States.

Developmentally Informed

- Each entity should be well-informed about learning and developmental differences, cognitive limitations, physical and other disabilities, as well as normal growth and development.

FUNDING AND RESOURCES

PRINCIPLE

Funding decisions in the private sector and at federal, state, local, and tribal levels are informed by the certainty that the well-being of children, families, and communities are interconnected and that sufficient and equitable funding is essential to the well-being of all of them.

STANDARDS

Funding Priorities

- Funding decisions should be based upon the cost of effective services, the benefits such services are expected to bring, and the likely consequences

(including costs) of deferring or failing to make investments in children, youth, and families. Where necessary, priority should be given to those that are most vulnerable.

- Every individual, organization, and community has the responsibility to explain the impact of funding decisions and advocate for priority funding for supports and services for children, youth, and families.
- Funders should collaborate with each other, with communities, and with providers to identify needs and shared priorities, promote sensible application and eligibility criteria, identify obstacles, and allocate funds and other resources wisely.



Funding Implementation of the National Blueprint

- Funders should promote and fund concepts and strategies that are consistent with the CWLA National Blueprint's vision, values, principles and standards.

- Funders should support evidence-based and evidence-informed programs and practices.
- Funding sources should provide financial assistance to build evidence of the efficacy of promising practices.
- Public entities and other funders should provide financial incentives to support organizations' efforts to employ and engage people with lived experience as a service recipient.

Funding Equity

- Funding for supports and services should be equitable.

Public-Private Collaboration

- Entities with contractual and funding relationships should work together to be jointly accountable; to ensure that funding for supports and services for children, youth, and families is adequate, equitable, and that there is the wisest possible use of public and private funds.

Diverse Funding Streams

- Organizations should seek diverse funding streams to produce income from contracts, grants, investments, corporate and foundational giving, and individual donations.

Accountability and Transparency

- Funders, contractors, donors, and the general public should have access to accurate accounting of funds for supports and services for children, youth, and families.

Social Enterprise

- Business, philanthropic, venture capital, and public and private nonprofit entities should work together to harness the power of social enterprise.

NEXT STEPS/FUTURE

The National Blueprint was approved by the CWLA Board of Directors prior to its release to the public.

CWLA will be developing readiness assessment and implementation tools to help with the implementation of the CWLA National Blueprint. To ensure the clarity needed for child welfare's role in achieving the vision, CWLA will continue with and update its program-specific Standards of Excellence within the context of the National Blueprint. We will use our programs, practice guidelines, publications, research, conferences, professional development, and consultation to provide further guidance. CWLA advocacy efforts will include nudging other systems, parents, and communities toward helping achieve the vision. Our children, youth, and families deserve no less.

For a copy of the complete CWLA National Blueprint for Excellence in Child Welfare, please visit our website at www.cwla.org.



MISSION STATEMENT

Mission

CWLA leads and engages its network of public and private agencies and partners to advance policies, best practices and collaborative strategies that result in better outcomes for vulnerable children, youth, and families.

Vision

Our vision is that every child will grow up in a safe, loving, and stable family.

Focus

Our focus is children and youth who may have experienced abuse, neglect, family disruption, or a range of other factors that jeopardize their safety, permanence, or well-being. CWLA also focuses on the families, caregivers, and communities that care for and support these children.