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Utah Office of Child Protection Ombudsman (OCPO)
Investigative Report
Assistant Ombudsman: Tonya Myrup 3½ yrs.
OCPO Case #: 01-203-396
Date of Report: September 11, 2001

Children:	Date of Birth:	Mother:	Father:
Peter Bierly	17 Sep 1984 (16 years old)	Elizabeth Bierly	Unknown to OCPO
Jordan Bierly	09 Apr 1983 (8 years old)	Elizabeth Bierly	Mohammad Safarpour
Leigh Bierly	13 Jun 1998 (3 years old)	Elizabeth Bierly	Daryl Taylor

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Summary:

On September 28, 2000, the Division of Child and Family Services (DCFS) removed Jordan Bierly due to allegations of medical neglect by his mother, Lisa Bierly. Jordan's sister, Leigh Bierly, was removed as a sibling at risk on October 3, 2000. OCPO received a complaint that DCFS did not make efforts to work with the family prior to the removal of Jordan. A complainant reported concerns that since being in custody, Jordan's medical needs have not been cared for appropriately. A complainant is also concerned that Ms. Bierly was not appropriately notified that Leigh was vacationing with her foster parents out of the state. A separate complaint was reported to the Ombudsman's Office indicating that DCFS prematurely introduced Jordan and Leigh to a potential foster family although the family was not approved by DCFS as a foster care placement. OCPO concurs with the complainant's concern that DCFS did not attempt to provide services prior to Jordan's removal and that Jordan did not receive a medical examination within 24 hours of his removal. OCPO was unable to determine that Jordan's foster mother did not appropriately care for his needs while in her home; however, OCPO is concerned as there is no documentation that DCFS obtained verification from Jordan's doctor whether Jordan's low glucose levels were of concern. OCPO concurs that Ms. Bierly should have been given timely notice of the foster parents plan to take Leigh out of state for a vacation and that the children were prematurely introduced to a potential foster family. During OCPO's review of the case, OCPO identified additional concerns. These include concerns about the thoroughness of the CPS investigation, lack of notification to Jordan's natural father when Jordan was placed in custody, and that Jordan was recently placed in a new foster home although licensed as foster home, had not been authorized by DCFS to accept foster care placements.

Current Situation of the Child(ren):

DCFS reports that Leigh is doing well in her current foster care placement. OCPO interviewed Leigh's foster parents who report that she is doing "incredibly well." During the three times that Leigh has entered DCFS custody, she has been able to return to the same foster care placement. The foster parents report that she appears happy and her verbal skills are progressing very well. DCFS reports that Jordan is doing well in his current placement. OCPO has made several attempts to contact the foster parents by telephone, however, at the time of OCPO's report; OCPO was unable to reach them.

DCFS informed OCPO that Ms. Bierly is not in compliance with the service plan. Specifically, DCFS reports that Ms. Bierly has not recently attended therapy, obtained employment, addressed issues of domestic violence, consistently attended Jordan's medical appointments or demonstrated the knowledge to care for Jordan's medical needs. Ms. Bierly reports to OCPO that she has complied with everything she has been asked to do on her service plan. The Guardian ad Litem has filed a petition for the termination of Ms. Bierly's parental rights. The trial is scheduled for September 17, 2001.

Complainant Concerns:

Concern #1: *A complainant is concerned that DCFS inappropriately removed Jordan from his mother's care. The complainant reported that DCFS met with the family for only 20 minutes and that no services were offered before Jordan was removed from the home.*

Finding: On September 12, 2000, DCFS received a priority three allegation that Jordan was being medically neglected as his mother, Lisa Bierly, was not adequately caring for Jordan's diabetes. The referent, , reported to DCFS that Jordan was at risk for kidney failure, heart attack, and even death if his diabetes went untreated. The CPS intake states that the family had been staying at a motel for one week. Considering the allegations indicated an immediate risk of harm and that the long-term residence of the family was questionable, OCPO is concerned that the investigation was not opened as a priority two referral.

On September 14, 2000, the caseworker met with Ms. Bierly. The CPS activity logs document that the worker talked with Ms. Bierly about the allegations, which she denied. Ms. Bierly reported that she had an appointment scheduled for September 18, 2000, and that Dr. Allen would be able to confirm that she is "protective of Jordan and...right on top of Jordan's needs..." The CPS activity logs also document that the CPS worker attempted casework counseling "regarding relevant factors and circumstances on the wellbeing of PV-Jordan as well as other children; attempting to influence [Ms. Bierly's] thinking about how to best prevent further problems." There is no documentation in the activity logs that Jordan was interviewed or that a safety plan was created. The CPS worker informed Ms. Bierly that he would be continuing the investigation. The CPS worker provided Ms. Bierly with bus tokens; however, no other services were offered. There is no documentation that Jordan's current medical condition was assessed.

Although the allegations included serious concerns for the medical well-being of Jordan, the CPS worker did not take further action on the case until September 28, 2000, two weeks later, when he returned from a conference. On September 28, 2000, the CPS worker documented that during the week of September 18, 2000, several voice messages were left for him from reporting that Ms. Bierly had been in contact with the facility but had "created a scene" and was "uncooperative." The caseworker returned calls to who reported "growing and significant major concerns about the medical wellbeing of [Jordan]." The caseworker also documented talking with the school, medical professionals working with Jordan, his supervisor and an Assistant Attorney General. DCFS determined that custody of Jordan would be pursued.

Based on the seriousness of the allegations, OCPO is concerned about the caseworker's delay in investigation and that a more thorough assessment of safety and protection as well as an assessment

of the child's medical well-being was not completed. It appears that a more timely assessment and intervention may have precluded the need for removal.

OCPO contacted DCFS Regional Administration regarding the concern about the CPS worker's actions in this case. DCFS Regional Administration informed OCPO that they are currently addressing the concerns identified by OCPO.

Recommendation: OCPO concurs with the complainant's concerns regarding the lack of service prior to the removal of Jordan. Please refer to recommendations made for Concern #4.

Concern #2 *A complainant is concerned that Jordan was not adequately cared for while in state's custody as the Christmas Box House shelter staff did not know how to care for Jordan's medical needs resulting in a delay in Jordan's insulin shot the night he was removed and a subsequent hospitalization.*

Finding: The CPS worker documented that there were enough "vocal reports, comments from concerned bystanders etc. and had enough contact with MO-Leesa to observe (clinically) that [Jordan] is at high risk for serious medical complications." After taking custody of Jordan, the caseworker documented that on September 28, 2000, Jordan was seen "briefly" by "nurse Kim Mason" at the "Elderidge Medical Center." The caseworker did not document the outcome of this examination. OCPO was unable to locate an Elderidge Medical Center in the Salt Lake Valley. The shelter documentation completed by the CPS worker provided a telephone number for the Elderidge Medical Center. OCPO contacted this number which is for the "Westridge Medical Center." There is also documentation that Jordan had previously been seen at the "Westridge Medical Center," which is where Kim Mason was employed. OCPO contacted the Westridge Medical Center and found that Kim Mason is no longer employed by the center. They reviewed their records and found no documentation that Jordan was seen at the center on September 28, 2000. They also indicated that Ms. Mason is not a nurse, rather she is a medical assistant whose responsibilities include patient referrals. Reportedly, Ms. Mason does not conduct medical examinations of patients. OCPO notes that the removal papers, which were provided to Ms. Bierly document that Jordan was removed because the "Child needs immediate medical care." OCPO interviewed the CPS worker, Barry Richards, who recalled taking Jordan to the medical center but could not recall whether the child was seen by a medical professional. OCPO is extremely concerned, as there is no documentation that Jordan immediately received a medical examination when concern for his medical well being was the basis for removal. DCFS Policy requires that children taken into custody for medical neglect have a medical examination within 24 hours. Additionally, DCFS policy requires that a child in need of acute medical treatment (i.e. serious illness) should be assessed and receive treatment at a medical facility before being placed in shelter.

When the CPS worker placed Jordan in the Christmas Box House, he informed the staff about Jordan's diabetic condition and documented "emphasizing with [shelter staff member] the need to keep in close contact with [Ms. Bierly] to ensure that the medical instructions for PV's insulin injections were followed precisely." There is an attached note written by Ms. Bierly, which describes Jordan's insulin and feeding schedule. DCFS referred the shelter staff to Jordan's mother for medical direction despite the fact that DCFS removed Jordan based on allegations Ms. Bierly was not providing Jordan with appropriate medical care. There is no indication that DCFS determined if Ms. Bierly's instruction were consistent with that recommended by the medical professionals treating Jordan.

On the Shelter Information Forms, the CPS worker documented under "Current Medical Situation" that the child is "Diabetic: see physician letter describing critical condition. (attached)." However, the letters attached do not provide specific information regarding the medical care of Jordan. The "Current Medications" states only "insulin" with an arrow to the next section which is "Allergies" that states "acquire from Eldridge 964-2300." OCPO does not believe that this provides sufficient information to the shelter staff or the shelter family necessary to provide Jordan with adequate care.

Prior to the removal, DCFS had contact with medical professionals who had been working with Jordan, which appear to have been the appropriate resource for providing instructions regarding Jordan's insulin injections. Additionally, DCFS has access to the Health Care Team who is available for consultation regarding the medical needs of children in custody.

Several hours after placing Jordan in shelter, the caseworker received a telephone call from Ms. Bierly's friend. She reported that, "[Jordan] had not yet received his insulin injection and indicating great distress and fear about his condition." The caseworker assured Ms. Bierly's friend that the shelter staff "would not disregard the medical urgency of the matter and would attend to it expediently." There is no documentation that the caseworker contacted the shelter staff to assess the situation. The caseworker assured Ms. Bierly and her friend that he would follow up with this in the morning. At 7:20 am the next day, the caseworker documented contact with Mrs. Bierly. Ms. Bierly explained that Jordan was "taken to a nighttime pediatric center…four hours after he was suppose to receive his insulin…as instructed."

OCPO obtained the Christmas Box House documents, which indicate that the child arrived at the shelter at 6:45 p.m. Ms. Bierly's instructions indicate that Jordan needed an insulin shot between 5:00 p.m. and 7:00 p.m. At 8:00 p.m. the shelter staff was leaving to transport Jordan to the shelter home where the shelter mother knew how to administer insulin. Jordan reported that he did not feel well. Jordan took his glucose level, which was 341 and the shelter staff documented that this was not a "critical or threatening glucose level" based on the instruction provided by Ms. Bierly, which indicated that a high level was 425. Jordan was reportedly apprehensive about leaving the shelter and reported that he did not want to go to the shelter home. The staff reportedly attempted to explain to him about the home and that they knew how to care for him. At 9:00 p.m. the staff documented contacting Nighttime Pediatrics to inform them that the shelter staff were bringing in a child who needed to have an insulin shot administered. Jordan received the shot and was transported to the shelter home. OCPO was unable to determine why Jordan was taken to the clinic rather than the foster home to have the insulin shot administered.

On October 2, 2000, Jordan was seen at PCMC by Dr. Hardin. Dr. Hardin determined that Jordan would be hospitalized for two to three days to make changes in Jordan's insulin and to provide Ms. Bierly with education and counseling on diabetes. OCPO interviewed Dr. Hardin who reported that Jordan's subsequent hospitalization was not the result of one missed insulin shot. Reportedly Jordan's hemoglobin level was at 12%. Dr. Hardin indicated that anything above 9% is considered a great risk and that he was hospitalized in order to get him stabilized. Dr. Hardin further explained that this is not something that would have occurred quickly as the "sea of change" is approximately three months. Dr. Hardin explained that Jordan's high hemoglobin level is not something that was the result of the delay in the insulin shot his first night in custody or his care during his first few days in custody. OCPO also interviewed Dr. O'kubo regarding the impact of a delay in the bedtime insulin shot. Dr. O'kubo reported that although it is good to have a routine and give the shots at a regular time, that a 4-5 hour delay in this shot is not a problem.

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OCPO notes that although Jordan's hospitalization was not the result of improper care while in custody, OCPO is concerned that DCFS relied on Ms. Bierly for instructions on Jordan's medical care as the basis of Jordan's removal was that Ms. Bierly's care of Jordan was inadequate. Although there is no indication that the delay in Jordan's insulin shot at the Christmas Box House had an impact on his health, OCPO is concerned as a procedure should be in place to ensure that children with medical conditions receive medications in a timely manner.

Recommendation: OCPO recommends that Barry Richards receive specific training on the appropriate actions that should be taken when children with chronic medical conditions are taken into custody. This should include obtaining information about the care of child's medical condition directly from the child's doctor, coordinating with the Health Care Team, and ensuring that a medical evaluation is obtained as soon as possible.

Because this is the second case that OCPO has reviewed where there were concerns regarding the care of a foster child with diabetes and because juvenile diabetes is not an uncommon illness, OCPO recommends that DCFS incorporate diabetes training into the training on the investigations of medical neglect. OCPO believes this training is imperative to provide workers with a basic knowledge of the illness to provide parameters to questions necessary to clarify the specific needs of the child and facilitate coordination with medical professionals to assess risk. OCPO is scheduling a training for OCPO staff and invites anyone interested from DCFS to attend this training.

OCPO recommends that the DCFS contract monitor for the Christmas Box House review the concerns regarding Jordan's delay in insulin and determine what process should be used to ensure that children with chronic medical conditions receive medications in a timely manner. OCPO requests verification of the results of this review.

Concern #3 *A complainant alleges that PCMC records indicate Jordan's first foster mother is not a certified nurse, is not trained in caring for juvenile diabetes, and did not provide adequate care for Jordan and his medical needs or fed him when he was hungry.*

Finding: The complainant informed OCPO that Jordan frequently reported being hungry and that the foster mother was not feeding him. The complainant also reported that Jordan's glucose levels have been dangerously low since being in custody. OCPO notes that the complainant has reported this concern to DCFS on several occasions since November of 2000.

OCPO reviewed the Department of Professional Licensing (DOPL) web site and found that the foster parent in question, Andrea Caroll, is licensed as a registered nurse, license number 214572-3102. The license was issued on March 19, 1985, and is current through January 31, 2003 and that there is no disciplinary action against her license.

Dr. Hardin informed OCPO that Ms. Caroll maintained close contact with her office and called anytime she had questions regarding Jordan's care. Dr. Hardin indicated that in one instance, Jordan had dental surgery and that Ms. Caroll contacted her just to review what she had done to ensure that she was doing everything appropriately. Dr. Hardin also informed OCPO that since being in Ms. Caroll's home, Jordan has made significant progress in weight and height, which would not be possible if he had not been receiving adequate nutrition. OCPO notes that Dr. Hardin is currently a licensed physician and surgeon (License # 3083009-1205) and has no record with DOPL or any

disciplinary action against her license.

OCPO received information from Dr. Steve Allen, a doctor who had seen Jordan prior to his entering custody. Dr. Allen informed OCPO that he has no concerns regarding the foster care provider or DCFS in this case. He also indicated that has full confidence in the specialist providing Jordan's medical care. OCPO notes that the specialist Dr. Allen referred to is Dr. Hardin.

Jordan recently changed doctors and has been to one appointment with Dr. Lindsay. OCPO attempted to contact Dr. Lindsay; however, at the time of OCPO's report, OCPO has not been able to reach Dr. Lindsay. OCPO will continue to attempt to make contact with Dr. Lindsay and respond appropriately to any additional information provided.

OCPO spoke with Jordan's school teacher who reported that Ms. Caroll was very responsive and would immediately go to the school to administer a shot to Jordan when his glucose was high or inform them of what action to take when his glucose was low. Ms. Caroll also met with them about every other week to answer questions and see how Jordan was doing. Jordan's teacher indicated that she had no concerns about the care that Jordan received in the Caroll home and that she believed he was receiving the best care possible.

While Jordan has been in custody, Ms. Bierly has maintained contact with Dr. Okubo and sent him copies of Jordan's glucose levels. Dr. Okubo is a pediatrician who has a special interest in treating children with diabetes. OCPO interviewed Dr. Okubo on August 22, 2001. Dr. Okubo informed OCPO that he recently saw Jordan in the office for an exam. Dr. Okubo reported to OCPO that Jordan did have too many low levels while in the first foster home. OCPO informed Dr. Okubo of reports that Jordan was licking his testing strips. He stated that this would lower the test levels. Dr. Okubo reported that Jordan's levels were low and that he feels the state did not respond to this concern. Although Ms. Bierly reported that Dr. Okubo had been reviewing Jordan's glucose levels, there is no indication that DCFS contacted Dr. Okubo to explore his concerns.

The SAFE activity logs document that on November 16, 2000, the caseworker received a telephone call from Ms. Bierly. Ms. Bierly reported that Jordan had called his brother Tim and told him that the foster home was not feeding him. The caseworker documented "I tried to reassure [Ms. Bierly] that they were feeding him, and that he just says that to get her all upset like she was." There is no indication that the caseworker addressed Ms. Bierly's concern by talking privately with Jordan or discussing the concerns with the foster parent.

OCPO found that DCFS invited Ms. Bierly to meet with DCFS, the foster parent, and the medical professionals working with Jordan on several occasions to discuss the concerns about Jordan's glucose levels. According to the DCFS documentation, on several occasions, Ms. Bierly would refuse to discuss her concerns, was uncooperative, or did not attend the meetings.

OCPO did not find documentation that DCFS responded to Ms. Bierly's complaints by contacting Dr. Hardin directly to determine if there was a legitimate health concern considering Jordan's low levels. There is also no documentation that DCFS attempted to determine whether Jordan was being fed when hungry. There is some documentation to indicate that DCFS conferred with the foster parent regarding the low levels and how Jordan was doing; however, because the complaints were against the foster parent, consultation with the doctor appears to have been warranted. OCPO notes that in a DCFS meeting held in May of 2001, Ms. Bierly was still reporting concerns about Jordan's

low levels while in the foster home and questioning the qualifications of the foster parent. DCFS did not provide information to disprove or alleviate Ms. Bierly's concerns. OCPO is concerned as it appears that either Jordan was being adequately cared for in the home and DCFS should have documentation to support this or Jordan should not have remained in the placement. If DCFS had confirmation that Jordan was being adequately cared for by the foster parent, OCPO believes that it was a disservice to this foster parent to not have been given full support and backing by DCFS against the accusations. OCPO found that DCFS did not conduct interviews with Jordan to determine if he was being fed and to assess how he was doing in the home. According to the logs from September 2000, when Jordan was taken into custody, until May 4, 2001, there is no documentation that DCFS conducted private interviews with Jordan. OCPO believes that this contact is not only a requirement of policy but was essential in this case considering the ongoing complaints from Ms. Bierly that Jordan was not being appropriately cared for in the foster home.

An email from Abel Ortiz to Linda Wininger was copied to the foster care worker, Linda Harris, on July 23, 2001. Mr. Ortiz provides a recommendation in response to Ms. Bierly's concern about Jordan's low glucose levels. Mr. Oritz recommends that Ms. Bierly and the foster parent attend the doctor's appointment and develop a safety plan including what Jordan's levels should be, how often they should be checked, and when the foster parents should call the hospital. It was also recommended that a crisis plan be developed. This plan would establish who should call the doctor, who to contact if the doctor is out of town or if it is after hours, what if any action should be taken if the levels are determined to be a problem, and who should notify the worker. Mr. Ortiz further suggested that everyone sign the plan and that CPS intake and OCPO be made aware of the plan. OCPO believes that this provides an excellent remedy both to ensure Jordan's well being and address Ms. Bierly's ongoing concern for the safety of her child. OCPO found no documentation that this recommendation was implemented by DCFS.

Recommendation: Because OCPO is unable to verify that the foster mother did not provide Jordan with adequate care and Jordan's primary care physician reported that his medical needs were being met while in the care of the foster mother, OCPO makes no recommendations to this complaint.

OCPO recommends that the current foster care worker, Linda Harris, and the previous foster care worker, Kelly Lewis, receive training on the appropriate steps to follow when they receive concerns that foster children are not receiving adequate care. OCPO notes that this should include a referral to CPS intake to determine if an investigation is warranted. If the concerns do not meet the criteria for an investigation, OCPO recommends that the caseworker immediately conduct a private interview with the child regarding the specific concerns, explore the concerns with the foster parent, and interview any other party who may have pertinent information to ensure the child is receiving appropriate care.

OCPO recommends that Kelly Lewis receive training on the DCFS policy that outlines the requirements for visiting foster children regularly in the foster home in order to make ongoing assessments of their well being and any potential needs the children may have. OCPO further recommends that Ms. Lewis demonstrate knowledge of this policy that she is provided with the resources necessary to comply with this policy.

OCPO recommends that the foster care worker review and implement the recommendations made by Mr. Ortiz regarding the development of a safety and crisis plan. OCPO requests a copy of the safety and crisis plans.

Concern # 4 *OCPO received a complaint that Leigh, Jordan's sibling, should not have been removed from Ms. Bierly's care as the allegations were for medical neglect of Jordan and did not involve Leigh.*

Finding: On October 3, 2000, the CPS worker documented, "[Caseworker] has been in conference with AG-Paul Amann and GAL-Lisa who discussed the "sibling at risk" factor of the 2-year old and 15-year old siblings of PV. Amann and Lisa obliged [caseworker] to seek the immediate removal of siblings as noted. [Caseworker]-colleague (Barnes) assisted in this staffing procedure and concurred on the importance of having a 2-year old sibling removed." The caseworker documented going to the Days Inn with law enforcement's assistance and locating a man with a stroller in the hallway passing in front of Ms. Bierly's room. The CPS worker documented "[The man] had to be physically detained to interview. He immediately identified himself as 'Darrell...the father of the sibling-Leigh.' Shortly after this interview and some caseworker counseling with sibling/brother-Timothy, [Caseworker] took sibling-Leigh into custody and booked her into [shelter]." There is no documentation that Leigh's father was provided with any information about the shelter hearing, which according to the CPS worker's logs was scheduled for the following day. OCPO interviewed the CPS worker who stated that he did not recall whether he provided information to Mr. Taylor when he removed Leigh from his care. OCPO interviewed Mr. Taylor who reported that he was not provided with any information, verbal or written, regarding the removal of his daughter. The CPS case file contains a "Notice of Shelter Hearing." The notice is signed by Barry Richards and documents that he delivered an "accurate and complete copy of the forgoing notice to the parent (s) named above." The name of the parent to whom the notice was delivered is blank. Ms. Bierly informed OCPO that the first time that she has seen a copy of this document was when she received a GRAMA copy of her file. OCPO notes that DCFS policy requires that both parents (including putative father) be notified of the child's removal.

On October 10, 2000, the caseworker documented, "Substantiation of sibling/sister (Leigh) for 'sibling at risk' is supported via multitude of factors relevant to the highly probably 'bad-to-worse' potential of circumstances facing the child." The caseworker lists 14 items in support of the sibling at risk substantiation, which he states are based on Ms. Bierly's lack of care for Jordan's medical condition. The list is as follows:

> *"1) The child's FA is (reportedly) a convicted felon; 2) DV has occurred in the presence of sibling-Leigh to the extent that her FA was hospitalized via extensive brain damage because sibling-Leigh's brother beat MO-Leesa's paramour (FA) in the head with a ballbat in the presence of sibling-Leigh; 3) there is constant transiency in sibling-Leigh's current circumstances; 4) two people who have intimate knowledge of MO-Leesa's [life-style circumstances] have voluntarily provided information to CW that describe their grave concerns for the welfare and safety of sibling-Leigh; 5) MO-Leesa absented herself from an arranged supervised visitation with sibling-Leigh (after loudly proclaiming the need for immediate MO-Daughter interaction to prevent neglective consequences); 6) the alleged and strongly suspicioned "drug abuse" reported by those who know MO-Leesa most [intimately] AND because of sibling-Leigh's appearance at the time of removal from FA's custody (i.e. lethargic, flat affect and un-emotionally responsive when removed from FA's custody and transported to the CBH-Shelter Home); 7) the documented history/observations of MO-Leesa's cooperation with medical authorities regarding appropriate child care; 8) the absence of a stable home-environment; 9) the documented record of deception and dishonesty on the part of MO-Leesa during the course of this investigation (i.e. lying about whereabout of PV when initial removal was made; lying about time spent with attorney after shelter hearing, etc. etc.); 10) MO-Leesa's unwillingness to forthrightly disclose location/identity and how to contact any next-of-kin; 11) MO-Leesa's failure to complete as*

necessary medical education required for the care and treatment of sibling-Leigh's diabetic brother; 12) MO-Leesa's marginal-to-zip responsiveness to the casework counseling provided to her as to how to best (most effectively) demonstrate her ability to adequately care for the wellbeing and safety of sibling-Leigh and her diabetic brother; 13) the collective observations of CW and their concurrance by other associate CW's, the AG's representative and the GAL, and 14) because of the physician's expressed concerns about the adequacy of MO-Leesa's (consistent and adequate) maternal abilities and the observed behavior of her under stressful circumstances (which are the past- current and likely life-circumstances that PV and sibling/sister are currently enduring."

Based on this information, it appears to OCPO that there is a significant amount of information indicating that Leigh may have been at risk for several reasons unrelated to Jordan's lack of medical care. OCPO believes that these allegations and "suspicions" should have been thoroughly investigated and assessed by the CPS worker to determine the need for removal as it is unclear why Leigh would be considered at risk solely because of the medical neglect of her sibling. OCPO is also concerned, as there is no documentation that the CPS worker assessed whether there were any potential risks to the 15-year-old sibling. OCPO found the CPS referral does not list Leigh or Peter as siblings or show that Leigh was substantiated as a sibling at risk. OCPO notes that the CPS worker's activity logs are ambiguous, which makes it difficult to determine what assessments were made and what actions were taken on the case. OCPO is concerned that Mr. Richard's supervisor did not identify and address the oversights in this case.

Although the SAFE logs do not document when Leigh when returned to Ms. Bierly's home, on December 20, 2000, the foster care caseworker documents conducting an unannounced home visit with Leigh and Ms. Bierly. At the next court hearing held on January 11, 2001, the caseworker documented, "[Assistant Attorney General] informed court that he was taking physical custody of Leigh back today…[Assistant Attorney General] told [Ms.Bierly] that she was not complying with the safety plan she had signed, which stated she would have a working phone so caseworker could contact her, and having proof of residence." The caseworker took custody of Leigh who had been outside the court waiting in a cab for her mother. On January 12, 2001, the DCFS worker documented having a conference with her supervisor, Dan Reid and Patti VanWagner about the removal of Leigh. The caseworker provided a list of her concerns regarding Leigh remaining at home. The caseworker documented, "Patti told caseworker that she was justified in her concerns in taking Leigh back into custody." There is no documentation from Ms. VanWagner or Mr. Reid regarding their involvement and perspective on this staffing. OCPO interviewed Ms. VanWagner who reported that this was not how she recalls the conversation. Ms. VanWagner stated that she recalls discussing with the worker that non-compliance is generally not a reason for taking custody of a child. Ms. VanWagner reported that the worker was relatively new and thought that was how the system worked. She stated that this was the first court hearing in which the worker's supervisor was not in attendance. Taking into consideration that the caseworker was relatively new, OCPO is hopeful that this staffing was an opportunity for DCFS to provide guidance and training to the caseworker regarding DCFS policy and other activities related to taking children into custody.

The SAFE logs do not document at what point Leigh again returned to Ms. Bierly's care; however, according to the payment screen, Leigh returned to Ms. Bierly on March 30, 2001. On April 21, 2001, the caseworker attempted an unannounced home visit and saw Mr. Taylor, Leigh's father, walking down the street towards Ms. Bierly's house. Ms. Bierly was seen by the caseworker walking across the bridge towards her house with Leigh. The caseworker documented that Ms. Bierly and Mr. Taylor met and walked into the house with Leigh. This was in violation of a court

order, which stated that Mr. Taylor would not have visitation with Leigh until he makes an appearance before the court. The caseworker documented knocking on Ms. Bierly's door three times and rang the doorbell with no answer. The caseworker staffed the case with her supervisors and was told to wait until Monday to staff what had happened. OCPO believes that it would have been appropriate for the caseworker to contact law enforcement for assistance as the DCFS worker was aware of the court order and is obligated to determine whether the child was at risk. This also would have provided the worker with an opportunity to explain the court order to Mr. Taylor as Mr. Taylor had not been in court when the order was made. It also would have been an opportunity to explore and clarify Ms. Bierly's understanding of the court order. On Monday it was determined that DCFS would have the AAG file an order to show cause. On May 10, 2001, a hearing was held on the order to show cause. It was set over until June 14, 2001, as Ms. Bierly had not received notice of the hearing. In the interim, on May 17, 2001 the SAFE logs document that Ms. Bierly was in jail. Again, although there is no documentation in the SAFE logs, OCPO was informed that at the hearing, the Judge ordered that Leigh be returned to DCFS custody.

Ms. Bierly reported to OCPO that DCFS, Linda Wininger and LaRay Brown, has stated that DCFS should not have placed Ms. Bierly's children in foster care. Ms. Bierly questions why, if DCFS made a mistake and should not have removed the children, her children have not been returned to her care. OCPO spoke to Linda Wininger and LaRay Brown who confirmed that they did inform Ms. Bierly that Leigh should not have been removed and should be returned to Ms. Bierly's care. OCPO questioned that if this was the belief, why DCFS has not taken action to pursue having Leigh returned home. Ms. Wininger reported that DCFS did ask Paul Amann, AAG to request a hearing, but that Mr. Amann refused. OCPO was unable to locate documentation of this request. Ms. Wininger further explained the court order requires that any change in visits be made with the approval of both DCFS and the GAL. OCPO noted that there is no indication in the file that since Ms. Bierly was released from jail that DCFS had discussed a return home or increase in visitation with the GAL. The foster care worker reported to OCPO that before consulting with the GAL for an increase in visitation that she was attempting to get support for this from Ms. Bierly's and Jordan's therapist.

On September 5, 2001, the foster care worker reported to OCPO that DCFS' position on recommending that Leigh return home has since changed. Reportedly the concerns arose during Ms. Bierly's visit on August 31, 2001. Reportedly Ms. Bierly had upset Jordan to the point where the visit was terminated. The foster care worker reported that she also confronted Ms. Bierly on some issues and that Ms. Bierly was reportedly upset. Although the events that occurred at this point are unclear, Ms. Bierly reportedly went to the bathroom and a DCFS staff person heard the door slam a bit hard. The DCFS staff heard Ms. Bierly scream that she was locked in the bathroom and her son Peter went down the hall to assist. The door to the bathroom was broken and Peter stated that he picked up the pieces to put it back together. It is unclear whether Ms. Bierly broke the door by slamming it shut or whether she was locked inside as described. Based on the problems during the visit, the foster care worker informed OCPO that she no longer supports a return home for Jordan and Leigh at this time and requested Ms. Bierly to complete at least two individual therapy sessions before extended visits would be considered by DCFS.

because of a door being slammed Leigh couldn't come home?

In a DCFS Quarterly Report/Progress Summary dated August 9, 2001, the foster care worker documents the following:

> "The current DCFS worker, Linda Harris, has been on this case approximately two months. Following investigation and/or review of the files and current situation involving the

children in this family, it is this workers opinion that DCFS should have provided in home services as opposed to foster care services. However, other concerns on this case have also complicated the matters before the court."

The foster care worker does not document what the specific concerns are which have complicated matters before the court. The progress summary indicates that Ms. Bierly has made no progress on her objectives on the service plan stating only that "Lisa is incarcerated..." The DCFS summary is dated August 9, 2001 and according to the SAFE logs, Ms. Bierly was released from jail on or about June 22, 2001.

The foster care worker reported to OCPO that she has been very specific with Ms. Bierly from the time she received the case regarding why the children were not being returned home and what Ms. Bierly needed to do to have them returned. According to the activity logs, Ms. Bierly has agreed to the service plan and then refused to sign it. The foster care worker reported that she has informed Ms. Bierly of the court orders, the need for DCFS to consult with the GAL, and that she has been specific about what compliance with the service plan is necessary before this can occur. There is a document in the case file which states that Ms. Bierly met with the foster care worker on June 26, 2001, to discuss the service plan, health care needs, visitation, support system and the possibility of Mr. Taylor's involvement. The document lists specific goals for Ms. Bierly and is signed by the foster care worker and Ms. Bierly. There is a second document in the case file dated July 3, 2001, which outlines "Goals for Lisa" and "Things Lisa Needs to do." The list is very specific in documenting what DCFS expects from Ms. Bierly. The document notes that the list was given to Ms. Bierly on July 31, 2001. The foster care worker reported to OCPO that Ms. Bierly has not attended therapy since being released from jail. DCFS also documents that Lisa reports looking for employment but refuses to share information about job contacts or the type of job she is seeking. DCFS also reports that Ms. Bierly has to work on her issues with domestic violence and that they have informed Ms. Bierly that this can be done through her therapist, Ted Harris.

OCPO was informed that DCFS and Ms. Bierly have mediation scheduled for September 6, 2001. DCFS reports being hopeful that some of these issues will be resolved at that time.

Recommendation: OCPO recommends that State Administration implement a statewide practice in which DCFS supervisors and administrators independently document their involvement in case staffings and their understanding of the agreed upon outcome in the SAFE activity logs. OCPO recommends that DCFS State Administration notify DCFS regarding this practice and provide OCPO with a copy of the notification.

OCPO recommends that Mr. Richards be able to demonstrate a knowledge of CPS policy, the ability to adequately assess risk and the ability to write clear and specific activity logs which accurately represent the action taken on the case. The Ombudsman believes the appropriate way to document DCFS' expectations of Mr. Richards and his attempts to comply with the expectations is through a plan of corrective action. OCPO requests a copy of the DCFS action plan to implement this recommendation.

OCPO recommends the supervisor, Carolyn Thomas, receive Human Resource Supervisor Training and training on CPS policy. OCPO further recommends that the Community Services Manager support Ms. Thomas by developing an action plan that provides mentoring, training and supervision of Ms. Thomas to assist in strengthening her supervisory skills and understanding of policy.

OCPO recommends that Kelly Lewis receive training on appropriate documentation in SAFE activity logs and demonstrate the ability to document casework activities including all relevant information that is used in decision making on cases.

OCPO recommends that Linda Harris receive training on how to document and prepare meaningful, clear, and concise Progress Summary/Court Reports and be able to demonstrate this ability.

OCPO recommends that the foster care worker continue to consult with both Jordan and Ms. Bierly's therapists and request a recommendation from the therapists regarding whether increased visitation and/or a trial home placement for Leigh and Jordan is appropriate.

Concern #5 *A complainant is concerned that DCFS allowed Leigh to travel out of state with her foster parents without Ms. Bierly or her attorney's consent. The complainant also reported that DCFS made a request to the court for Leigh to leave the state before the state had custody of Leigh.*

Finding: On June 12, 2001, the caseworker documented that she asked Paul Amann, Assistant Attorney General, and Liz Knight, Guardian ad Litem, "to get the courts approval for out of state travel for Leigh." The caseworker documented, "[Paul Amman and Liz Knight] indicated Judge Johanson did not want to be bothered with the issue and they both approve [Leigh] going. After further discussion, Supervisor, Dan Reid agreed we would document as is." OCPO interviewed the caseworker who recalled that Ms. Bierly's attorney was also present for this discussion; however, she did not personally speak with Ms. Bierly about the travel at that time, but spoke to her about the travel at a subsequent meeting. The caseworker was unable to recall the exact date of the meeting and indicated that she now recognizes it would have been appropriate for her to speak with Ms. Bierly at the court hearing. Ms. Bierly also reported to OCPO that she was not informed of Leigh's plans to travel out of state until shortly before Leigh left.

DCFS policy #315.9 requires that if the whereabouts of the parent is known, DCFS should request the parents to sign a written release for travel on agency letterhead. DCFS policy provides a format for this release and requires that documentation showing the parents were notified shall be in the child's case record. DCFS policy also states that the Juvenile Court shall be given written notice of the out-of-state travel including the location the child is going to and documentation that the parents have been given notice of their child's travel out-of-state.

The complainant reported that DCFS made a request to the court regarding out of state travel for Leigh, before Leigh was in custody. OCPO contacted Dominica Nelson, Sandy Juvenile Court, who reported that the only request DCFS has made to the court for Leigh to leave the state was made on May 15, 2001. The SAFE foster care logs do not document when or why Leigh was taken into custody, but the payment screen shows that DCFS began making payments on May 14, 2001 to foster parent for the placement of Leigh. Based on this information it appears that Leigh was in custody when the notification to the Juvenile Court for out of state travel was made.

Recommendation: OCPO recommends that Linda Harris and her supervisor, Dan Reid, review DCFS policy #315.9 regarding foster children vacationing out-of-state with their foster parents.

OCPO makes no recommendations regarding the complaint that DCFS requested out-of-state travel prior to Leigh entering custody.

Finding: Ms. Bierly contacted OCPO on November 22, 2000. As per an agreement with DCFS ,OCPO first referred Ms. Bierly's complaint to DCFS for a response. OCPO also sent an OCPO request for investigation form to Ms. Bierly to complete if she was not satisfied with DCFS' response. On December 11, 2000, OCPO received a second call from Ms. Bierly who expressed ongoing concerns regarding the care her son Jordan was receiving in foster care. OCPO sent Ms. Bierly a second request for investigation form and referred the concerns to DCFS for a response. On December 20, 2000, the OCPO letter sent in November was returned undeliverable. At that time, OCPO did not make an attempt to locate Ms. Bierly to ensure that she had received the second request for investigation form. On February 20, 2001, OCPO received a third call from Ms. Bierly indicating that DCFS had not responded to her complaint filed in November 2000. OCPO contacted DCFS to request a copy of their response to Ms. Bierly. On February 13, 2001, OCPO received a phone call from the foster care worker who responded to the concerns expressed by Ms. Bierly. On March 30, 2001, OCPO spoke with DCFS who indicated that the caseworker and DCFS Regional Administration met and that Ms. Bierly's youngest child would be returning home. OCPO noted that Ms. Bierly had not contacted OCPO again and that OCPO had not received a request for investigation form and the inquiry was closed.

In April of 2001, DCFS administration requested OCPO to investigate a complaint by a potential foster family who had been interested in providing foster care to Jordan. OCPO also received a complaint from another party in the case who expressed concern about how DCFS was handling the case. OCPO opened an investigation on April 13, 2001.

In reviewing this complaint, OCPO identified areas in the OCPO process that needed to be strengthened. OCPO appreciates the opportunity to review the complaint process and make changes to improve customer service.

Recommendation: In response to this complaint, the Ombudsman implemented a new process in which immediate action will be taken to locate complainants when mail is returned undeliverable. OCPO also has a current process in place in which a more immediate response will be made to assist clients when DCFS has been unable to resolve their complaints.

OCPO Concerns:

Concern #9: OCPO is concerned that DCFS did not attempt to notify Jordan's biological father that they he had been taken into state's custody.

Finding: There is no documentation in the CPS logs that DCFS attempted to locate and notify Jordan's natural father that Jordan had been placed in custody. OCPO interviewed the CPS worker who reported that Ms. Bierly was "guarded about kin" and reported that she did not know who the father of Jordan was. The DCFS case logs do not indicate that any other effort to locate kin or Jordan's natural father was conducted.

Based on the information received by OCPO, Jordan's father, Mohammad Safarpour, had been paying child support for Jordan and was notified that Jordan was taken into custody when there was a change regarding his payments to ORS. The CPS logs document that on December 13, 2000, the caseworker received a telephone call from Mr. Safarpour, who informed the caseworker that he was concerned about Jordan being in custody and wanted to know how he was doing. At that time,

were in the licensing process. The foster care worker was informed that, "Everything is back and in the file on the . They just need to be licensed. They will call caseworker back." The caseworker documented that she contacted Mrs. to "set up an activity for Saturday with Jordan and Leigh so that they can meet."

Mrs. letter documented that on February 10, 2001, the contacted the foster mother to see if they would mind if the took the children to their home for the afternoon. Jordan and Leigh spent the afternoon at the home and played with the son for six hours. At that time, the were not a licensed foster home.

On Monday, February 12, 2001, the foster mother and Mr. and Mrs. took Jordan to his medical appointment. At the appointment, Mr. and Mrs. were introduced to Ms. Bierly. Mr. and Mrs. were invited into the examining room and introduced to the foster care worker at that time. The staff at the hospital was reportedly informed that the were going to be Jordan's foster parents, which is how they were addressed during the visit. According to Mrs. , during this visit Jordan was asked if Jordan would like to go home with the that day. Jordan was told about the soccer team that their son was on and he asked if he could go home with the day. The foster care worker informed him he could go in just a couple of days. That evening, the foster care worker informed Mrs. that the paperwork from licensing had not gone through and that everything had to be put on hold. Mrs. reported that they were never told they should not go to the appointment and that they had spent three hours there and even took their son so that he would understand what Jordan needed. The caseworker's logs document that the "potential foster parents" were in attendance at Jordan's medical appointment. The caseworker informed Ms. Bierly that they were there to meet with Dr. Hardin because Jordan's current foster parent wanted the kids moved.

The were reportedly told that their home study was going to the committee on February 20, 2001. They assumed they would pass and bought toys, diapers, and other items for Jordan and Leigh. They had not heard anything until February 21, 2001, when the foster care worker left a message indicating that they had been put "on hold" and that a letter would follow. Ultimately Mr. and Mrs. were not approved by DCFS as a foster care placement.

OCPO interviewed the foster care worker who reported that it was her understanding that the license had been approved and she could move forward with the transition. The worker indicated that she did not understand the licensing and placement process in which the Office of Licensing may approve a home for a license; however, DCFS makes the determination as to whether foster children are placed in the home.

OCPO concurs with the complainant's concern that DCFS prematurely introduced a child to a family as a placement.

Recommendation: OCPO recommends that DCFS review with the foster care worker, Kelly Lewis, the foster care licensing process to ensure that in future cases, the appropriate steps have been taken prior to the introduction of a child to a foster family.

Concern #8 *Ms. Bierly was concerned that she contacted the Ombudsman's Office in November 2000 requesting assistance and that she did not receive a response to her concerns.*

Finding: Ms. Bierly contacted OCPO on November 22, 2000. As per an agreement with DCFS ,OCPO first referred Ms. Bierly's complaint to DCFS for a response. OCPO also sent an OCPO request for investigation form to Ms. Bierly to complete if she was not satisfied with DCFS' response. On December 11, 2000, OCPO received a second call from Ms. Bierly who expressed ongoing concerns regarding the care her son Jordan was receiving in foster care. OCPO sent Ms. Bierly a second request for investigation form and referred the concerns to DCFS for a response. On December 20, 2000, the OCPO letter sent in November was returned undeliverable. At that time, OCPO did not make an attempt to locate Ms. Bierly to ensure that she had received the second request for investigation form. On February 20, 2001, OCPO received a third call from Ms. Bierly indicating that DCFS had not responded to her complaint filed in November 2000. OCPO contacted DCFS to request a copy of their response to Ms. Bierly. On February 13, 2001, OCPO received a phone call from the foster care worker who responded to the concerns expressed by Ms. Bierly. On March 30, 2001, OCPO spoke with DCFS who indicated that the caseworker and DCFS Regional Administration met and that Ms. Bierly's youngest child would be returning home. OCPO noted that Ms. Bierly had not contacted OCPO again and that OCPO had not received a request for investigation form and the inquiry was closed.

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In reviewing this complaint, OCPO identified areas in the OCPO process that needed to be strengthened. OCPO appreciates the opportunity to review the complaint process and make changes to improve customer service.

Recommendation: In response to this complaint, the Ombudsman implemented a new process in which immediate action will be taken to locate complainants when mail is returned undeliverable. OCPO also has a current process in place in which a more immediate response will be made to assist clients when DCFS has been unable to resolve their complaints.

OCPO Concerns:

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Finding: There is no documentation in the CPS logs that DCFS attempted to locate and notify Jordan's natural father that Jordan had been placed in custody. OCPO interviewed the CPS worker who reported that Ms. Bierly was "guarded about kin" and reported that she did not know who the father of Jordan was. The DCFS case logs do not indicate that any other effort to locate kin or Jordan's natural father was conducted.

Based on the information received by OCPO, Jordan's father, Mohammad Safarpour, had been paying child support for Jordan and was notified that Jordan was taken into custody when there was a change regarding his payments to ORS. The CPS logs document that on December 13, 2000, the caseworker received a telephone call from Mr. Safarpour, who informed the caseworker that he was concerned about Jordan being in custody and wanted to know how he was doing. At that time,

DCFS did meet with Mr. Safarpour and inform him of the court process and reunification. The DCFS case file documents that Mr. Safarpour "had mixed feelings about the whole thing and that …He would make a decision and may be at court on the 19th." According to the DCFS case file, Mr. Safarpour did not attempt to get standing with the court regarding his son.

Recommendation: OCPO recommends that the CPS worker, Barry Richards, and his supervisors demonstrate knowledge of DCFS policy regarding notification to natural parents.

OCPO recommends that CPS worker Barry Richards and his supervisors demonstrate the ability to query SAFE, ORISIS, PACMIS, and USSDS databases to conduct diligent searches for non-custodial natural parents of children who are placed in custody.

Concern #10: *OCPO is concerned that DCFS placed Jordan in a home that had not been authorized by DCFS to receive foster care placements.*

Finding: received a foster care license on July 16, 2001. Although DCFS had not approved the for placement, the foster care worker placed Jordan Bierly in the home on July 22, 2001. According to the SAFE activity logs, on August 10, 2001, the caseworker spoke with the foster parent who stated "she thought she was licensed when she received the paper indicating she had a license and she did not understand they could not take children at that time. I also explained to her my lack of understanding on the issue."

Kelly Powers is in charge of the Salt Lake Valley DCFS placement committee. This committee screens licensed foster homes to determine how DCFS will utilize the home and whether the home is authorized for placement. OCPO notes that this is not currently a statewide process and that each DCFS Region may vary in their approach to approving homes for placement. OCPO interviewed Ms. Powers who reported that the home was not authorized for placement as the committee felt they were in need of additional information about the medical status of Mr. . The committee was informed that DCFS had already placed a child in the home. As the committee was not comfortable providing authorization, the home would not be able to receive financial payment. The DCFS supervisor and caseworker maintained that continuing placement in the home was in the best interest of Jordan and that removal would not be appropriate. Ms. Powers reported that as the committee was not comfortable in giving approval to the home, she obtained signatures authorizing the placement from LaRay Brown, Regional Director, Patti VanWagner, Community Services Manager, and Dan Reid, DCFS supervisor. Ms. Powers informed OCPO that at this time, the authorization is specific to the placement of Jordan. According to the SAFE record, the home has a capacity of 2 with 1 opening. OCPO is concerned that the SAFE record is misleading and may contribute to further confusion regarding foster care openings in this home. Ms. Harris informed OCPO that it was her understanding that the family would have to be approved by the committee as a legal at risk placement, but that she was unaware the family had to be approved by the committee prior to any type of foster care placement.

OCPO notes that this is the second time in this case that confusion over the authorization process for foster parents has resulted in the introduction and/or placement of Jordan to foster parents who had not been approved for placement.

OCPO was informed that an "Initial Placement Committee" has recently been developed to review

the current process for approving licensed foster homes for placements. OCPO spoke with Linda Wininger who participates on this committee which will develop a statewide placement approval protocol to provide a guideline for this process. OCPO discussed the concerns identified in this case. These concerns will be forwarded to the committee for review so that these problem areas can be addressed as appropriate in the new protocol.

Recommendation: OCPO recommends that the Initial Placement Committee review the placement concerns identified in this case and address them in the new placement protocol to preclude this problem from occurring in the future.

OCPO recommends that DCFS coordinate with the Foster Care Foundation to ensure that all potential foster parents are given clear information regarding the licensing process. Specifically that although they may be approved for a license, there is an authorization process to determine how their home will be utilized by DCFS and that a license may not guarantee placement.

OCPO recommends that DCFS Administration in conjunction with SAFE, explore how to clearly delineate in SAFE the status of foster homes and whether the homes are licensed, authorized for placements, or have been placed on hold.

DCFS Response:

Upon receipt of an Investigative Report from OCPO, DCFS has ten (10) days to submit a written response to OCPO's recommendations. The response will state whether DCFS agrees or disagrees with each recommendation.

If DCFS does not agree with the OCPO recommendation(s), DCFS will submit a written explanation, specifically identifying the recommendation(s) that DCFS disagrees with and the reason for disagreement.

All responses to OCPO will be submitted to the DCFS Constituent Services Specialist for review. The DCFS Constituent Services Specialist will provide the approved response to OCPO.

Appeals Process:

If DCFS and OCPO cannot come to an agreement regarding the disputed recommendation, either party may file an appeal with the Executive Director of the Department of Human Services.