

Reports on abuse cases lack details, critics say

Oregon child welfare officials say inquiries prompted by two high-profile cases have resulted in more training and oversight

By EMILY TSAO
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Children in state custody will be better protected because of two groundbreaking investigations that have resulted in increased oversight, staff training and more than a dozen changes in protocol, according to state child welfare officials.

But experts outside the agency say the reports made public following those investigations shed little light on

how caseworkers failed to notice that a 5-year-old girl was starving in foster care or why a 15-month-old boy who later died from abuse was returned to parents with a history of drugs, alcohol, crime and domestic violence.

In both cases, investigators found that state child-protection employees made mistakes and violated state policy. But their reports do not disclose details of those mistakes, identify who made them

or recommend disciplinary action.

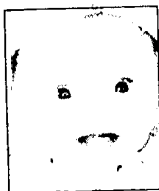
Vickie Knapp, grandmother of Jordan Knapp, the malnourished foster child, expected much more: "My granddaughter almost died, and this is what they got?"

Department of Human Services officials on Thursday issued a statement that said the agency has taken "appropriate personnel or disciplinary action with regard to four employees" in

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JORDAN KNAPP
Foster child injured, malnourished



ASHTON PARRIS
15-month-old died in parents' care

ON THE WEB

Reports from the Critical Incident Response Team are available at www.oregon.gov/DHS

What's next: A separate independent review of Oregon's child welfare system, focusing on statewide issues rather than specific cases, is due to be completed next month.

Jordan's case, but they declined to provide details.

Gov. Ted Kulongoski created the Critical Incident Response Team late last year to review high-profile cases of children who are abused or killed in state care.

"The goal is to make the system more accountable," Kulongoski said at the time, "both to the people of Oregon and — most importantly — to the children the system is charged to protect."

Child welfare officials call the investigations an unprecedented attempt to respond to child protection problems and devise prompt systemwide solutions.

"We accepted responsibility and accountability for the problems," said Gary Weeks, director of the Department of Human Services. "We have not done this in the past, in terms of having the agency say we will be accountable for the way this went."

The reports are brief, however, no longer than six pages, with findings often summarized in one or two sentences, such as: "The records in this foster case were incomplete and were not well-organized."

"I feel like I don't quite get what went on," said Tina Kotek of Children First for Oregon, a nonprofit organization that advocates for children's health, education and general welfare. The report finds that records were incomplete, but the reader doesn't know if it was because a caseworker was being lazy or because the caseworker had too much to do, she said.

Nancy Miller, state director of the citizen review board that examines foster care cases, questioned whether the investigators' recommendations and actions — training, new protocol and supervisory reviews — would lead to meaningful change.

"This is an agency with excellent policy in place. But somewhere between policy and implementation, there is a synapse break," Miller said. "One meeting isn't going to change practice. One training isn't going to change practice."

The harshest criticisms of the reports concerned the governor's

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goal of accountability.

"This is almost worse than no report at all, since it gives the impression of accountability without actually providing any," said Richard Wexler, executive director for the National Coalition for Child Protection Reform in Alexandria, Va. Wexler, a researcher and author consulted nationally for his expertise on state child welfare programs, reviewed the reports at the request of The Oregonian.

Kulongoski, however, is pleased with how the review process is proceeding, said Anna Richter Taylor, a spokeswoman for the governor.

"The public for the first time has more information about what happened, why it happened and what the state is doing about it," she said. "We will be making changes, and the system will become stronger, and it will be communicated to the public."

A new review process

The governor's initiative to publicly examine high-profile cases began to take shape in June.

DHS Director Weeks chaired a 15-member committee, which included top department officials and representatives from across the state — a judge, police chief, district attorney, union representative and several advocates for children's rights.

The committee established a core review team and called for members to be added for specific cases. The first two teams, both chaired by Una Swanson of state Child Protective Services, were dominated by Human Services officials and included an attorney, law enforcement representative and children's rights advocate.

In early December, Jordan, now 6, became the subject of the team's first investigation after emergency workers found her unconscious with a fractured skull and weighing just 28 pounds. Normal weight for a girl her age is 34 to 52 pounds. Her foster parents have since been charged with criminal mistreatment and are awaiting trial.

About a week later, a second investigation began when 15-month-old Ashton Parris died of head injuries after the state returned him to his parents on a trial basis. Ashton's father, Darrell Parris, has since been charged with murder and is in Clackamas County Jail.