

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
OFFICE OF THE INSPECTOR GENERAL**

**REPORT OF SPECIAL EVALUATION:**

**INTERACTIONS BETWEEN  
AN AT-RISK FAMILY,  
DISTRICT AGENCIES, AND  
OTHER SERVICE PROVIDERS (2005 – 2008)**

**APRIL 2009**



**CHARLES J. WILLOUGHBY  
INSPECTOR GENERAL**

**PUBLIC VERSION**

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The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness, and economy in operations and programs. I&E goals are to help ensure compliance with applicable laws, regulations, and policies, to identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

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## ACRONYMS

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ACEDS	Automated Client Eligibility Determination System
APRA	Addiction Prevention and Recovery Administration (DOH)
BTW	Booker T. Washington Public Charter School for Technical Arts
CCCPS	Charles County (MD) Child Protective Services
CFSA	D.C. Child and Family Services Agency
CHGM	Capitol Hill Group Ministry
CSED	Child Support Enforcement Division (Office of the Attorney General)
CSSD	Court Social Services Division (D.C. Superior Court)
DCHA	D.C. Housing Authority
DCMR	District of Columbia Municipal Regulations
DCPS	D.C. Public Schools
DHCD	Department of Housing and Community Development
DHS	D.C. Department of Human Services
DMH	D.C. Department of Mental Health
DOH	D.C. Department of Health
DSI	Diligent Search Investigator
DSSSS	Division of Student and School Support Services (DCPS)
DSU	Diligent Search Unit
EBT	Electronic Benefit Transfer
FS	Food Stamps
GWUMFA	George Washington University Medical Faculty Associates
HCYP	Homeless Children and Youths Program
HMIS	Homeless Management Information System
HS	Hotline Supervisor
HUD	U.S. Department of Housing and Urban Development
HW	Hotline Worker
IMA	Income Maintenance Administration (DHS)
I&R	Information & Referral
IW	Investigations Worker
MOU	Memorandum of Understanding
MPD	Metropolitan Police Department
MRT	Medical Review Team
OCME	Office of the Chief Medical Examiner
OIG	Office of the Inspector General
OSSE	Office of the State Superintendent of Education
OUC	Office of Unified Communications
PCSB	Public Charter School Board
POWER	Program on Work, Employment and Responsibility
S+C	Shelter Plus Care
SWWR	South Washington/West of the River Family Strengthening Collaborative
SY	School Year
TANF	Temporary Assistance for Needy Families
TCP	The Community Partnership for the Prevention of Homelessness
USMS	United States Marshals Service
VWFRC	Virginia Williams Family Resource Center

**ORGANIZATIONS SERVICING [REDACTED] \* [REDACTED] \* FAMILY**

The following is a list of District government and community-based organizations that played a significant role in the provision of services and benefits to the [REDACTED] \* [REDACTED] \* family during the period from November 2005 to January 2008. The list is presented essentially in the order in which the [REDACTED] \* [REDACTED] \* family came into contact with each entity.

**D.C. Housing Authority (DCHA)** – The D.C. Housing Authority is an independent District government agency that provides rental housing assistance to eligible low-income families.

**Coalition for the Homeless (Coalition)** – The Coalition for the Homeless is a non-profit organization that provides transitional and permanent housing, emergency shelter, employment assistance, substance abuse counseling, and social services to individuals and families who are homeless or vulnerable to becoming homeless. Under a contract with The Community Partnership for the Prevention of Homelessness, the Coalition operates and manages the Virginia Williams Family Resource Center (FRC), which is considered the District’s gateway to homeless services.

**Families Forward** – Families Forward is a non-profit organization that provides homeless and low-income families in the District with housing, individualized support, and training so that they can achieve their highest level of self-sufficiency. The organization provides housing assistance, case management, and job skills training and placement. Through a contract with The Community Partnership for the Prevention of Homelessness, Families Forward operates the D.C. General Hypothermia Shelter, a seasonal shelter for families.

**Department of Human Services, Income Maintenance Administration (IMA)** – The Department of Human Services is a District agency under the Mayor’s authority that manages federal and District-funded assistance programs. IMA administers and provides customer service for public benefits programs such as Temporary Assistance to Needy Families (TANF), Medicaid, and food stamps.

**Office of the Chief Financial Officer – Electronic Benefit Transfer (OCFO-EBT) Program Office** – OCFO is an independent District government agency that oversees financial and budgetary functions of the District government. A division of the OCFO administers the District’s EBT program, which uses debit card technology to deliver monetary benefits (e.g., TANF).

**D.C. Public Schools (Eastern Senior High School and Watkins Elementary School)** – Eastern Senior High School (Eastern) and Watkins Elementary School (Watkins) are public schools in the District of Columbia Public Schools (DCPS) system. The DCPS chancellor oversees all D.C. public schools and reports directly to the Mayor of the District of Columbia.

**Unity Health Care, Inc.** – The Student Health Center at Eastern is operated by Unity Health Care, a healthcare network that provides medical and social services to low income individuals in all eight wards of the District. The clinic provides healthcare services for Eastern students, including annual physical examinations, sports physicals, immunizations, and social services.

**South Washington/West of the River Family Strengthening Collaborative (SWWR)** – SWWR is a non-profit organization that provides support services such as case management, crisis intervention, job training, and housing placement to clients within the Southwest quadrant of the District. SWWR is one of seven Collaboratives operating in the District. Each collaborative is an independent entity led by a board of directors, but the Collaboratives share a common mission and client data system (the Efforts to Outcomes data system, or, ETO), and work together under the leadership of The Healthy Families/Thriving Communities Collaborative Council.

**Capitol Hill Group Ministry (CHGM)** – Capitol Hill Group Ministry (CHGM) is an interfaith coalition of congregations and individuals that provides spiritual and support services. CHGM has a contract with SWWR under which CHGM is responsible for operating a Family Resource Center that provides support services to unstable families within close proximity to the Center.

**The Community Partnership for the Prevention of Homelessness (TCP)** – TCP is an independent, non-profit corporation that is responsible, through a contract with the D.C. Department of Human Services, for management oversight of the 60+ homeless services providers that constitute the District’s Continuum of Care. In this role, TCP also administers the federally sponsored Shelter Plus Care program on behalf of the District’s Department of Housing and Community Development.

**George Washington University Medical Faculty Associates** – The George Washington University Medical Faculty Associates (MFA) is a multi-specialty physician practice located in the District. MFA is a non-profit organization, governed by a physician and executive board of directors. It has more than 270 doctors covering 40 medical specialties, and treats over 1,500 patients per day.

**D.C. Chartered Health Plan (Chartered)** – Chartered is a privately owned managed care organization that administers the provision of comprehensive health services (e.g., annual physicals, visits to specialists, prescriptions, vision care, home health care, hospice care, transportation services) for over 60,000 Medicaid-eligible and uninsured individuals in the District.

**D.C. Child and Family Services Agency (CFSA)** – CSFA is a District government agency under the Mayor’s authority that, *inter alia*, protects child victims of abuse or neglect and children at risk of abuse or neglect. Within CSFA, the Child Protective Services division (CPS) examines and investigates reports of child abuse and neglect whenever such incidents occur in the District.

**D.C. Department of Mental Health (DMH)** – DMH is a D.C. government agency under the Mayor’s authority that provides comprehensive mental health services to adults, children, youths, and their families.

**D.C. Department of Health (DOH), Addiction Prevention and Recovery Administration (APRA)** – DOH’s APRA provides services to identify, treat, and rehabilitate persons with alcohol, tobacco, and other drug addictions.

**Food and Friends** – Food and Friends is a non-profit organization that prepares and delivers specialized meals and groceries, and provides nutrition counseling, to men, women, and children living with HIV/AIDS, cancer, and other life-challenging illnesses.

**Booker T. Washington Charter School for Technical Arts (BTW)** – BTW is a vocational school that educates students in grades 9-12 and adults. BTW and the District’s other charter schools are independently operated by a board of trustees and monitored by the D.C. Public Charter School Board (PCSB).

**Meridian Public Charter School (Meridian)** – Meridian serves students from age 3 through the eighth grade.

**Metropolitan Police Department (MPD)** – MPD is a District government agency under the Mayor’s authority and is the primary law enforcement agency for the District.

**Superior Court of the District of Columbia** – The Superior Court of the District of Columbia is an independent judicial body that handles local trial matters, including family court cases. The Court Social Services Division (CSSD) is the juvenile probation system for the District and provides supervision, alternatives to incarceration, and social services to youths whose problems bring them within the purview of the Court, including youths whom schools have referred for truancy. U.S. Marshals stationed at the Court conduct evictions in the District.

**CHRONOLOGY OF SIGNIFICANT EVENTS**

## CHRONOLOGY OF SIGNIFICANT EVENTS

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November 23, 2005 [REDACTED]\* and [REDACTED]\* meet with intake specialist at VWFRC and submit a *Family Application for Emergency Shelter and Support Services*.

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December 6, 2005 [REDACTED]\* and [REDACTED]\* apply for housing assistance programs at DCHA.

December 14, 2005 [REDACTED]\*/[REDACTED]\* family admitted to D.C. General Hypothermia Shelter.

December 21, 2005 [REDACTED]\* and [REDACTED]\* go to IMA; [REDACTED]  
[REDACTED]\*.

December 22, 2005 IMA [REDACTED] [REDACTED]\*<sup>√</sup>

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January 2006 [REDACTED]\* begins attending Eastern H.S. [REDACTED]\* begins attending Watkins E.S.

January 24, 2006 [REDACTED]\* and [REDACTED]\* have first meeting with Hypothermia Shelter case manager, complete application and assessment paperwork.

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March 2, 2006 Social worker at Eastern refers [REDACTED]\* to SWWR for “help with obtaining housing and other supportive services.”

March 7, 2006 SWWR intake worker meets with [REDACTED]\* and [REDACTED]\*, completes intake and needs assessment forms. SWWR assigns family to CHGM for case management.

March 17, 2006 CHGM worker meets with family at Hypothermia Shelter, identifies goals and documents them in a case plan.

March 29, 2006 Eastern [REDACTED]\*<sup>√</sup> [REDACTED]\* for [REDACTED]\*<sup>√</sup> for “[REDACTED]  
[REDACTED] [REDACTED]\*<sup>√</sup>” and “[REDACTED]\*<sup>√</sup>”

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April 5, 2006 [REDACTED]\*<sup>√</sup> certifies [REDACTED]\* as having a [REDACTED]\*<sup>√</sup> and considers him eligible for participation in the S+C program.

April 9, 2006 Family departs Hypothermia Shelter for unknown location.

## CHRONOLOGY OF SIGNIFICANT EVENTS

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May 31, 2006 SWWR/CHGM close family's case, in part because [REDACTED]\* and [REDACTED]\* do not respond to contacts.

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June 1, 2006 [REDACTED]\* visits IMA office [REDACTED]  
[REDACTED]\*

June 16, 2006 Phone conversation between Chartered behavioral health case manager and [REDACTED]\*; [REDACTED]\* states she is [REDACTED]\*, and that the family is living in a "[REDACTED]\*"

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July 11, 2006 [REDACTED]\* makes an unscheduled visit to the SWWR/CHGM Family Resource Center and requests assistance with finding housing.

July 12, 2006 Chartered behavioral health case manager speaks with [REDACTED]\*, who says that she is using [REDACTED]\* and the family is living out of their van; case manager telephones CFSA abuse and neglect hotline. CFSA does not assign call to an Investigations Worker; classifies call as an "Information & Referral" and takes no further action.

July 13, 2006 [REDACTED]\* attends medical appointment at GWUMFA. [REDACTED]\* visits the SWWR/CHGM Family Resource Center to further discuss housing needs, and informs caseworker that the family is living out of its van.

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August 16, 2006 TCP first informs DMH that [REDACTED]\* (along with 41 other S+C program participants) needs to be linked to a supportive services provider (receipt of supportive services is a S+C program requirement.)

August 25, 2006 [REDACTED]\*/[REDACTED]\* family attends S+C "lease up" meeting at TCP, signs lease, and receives keys to [REDACTED]\* (house).

August 31, 2006 Food and Friends begins 3 times-per-week meal deliveries to house.

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November 30, 2006 [REDACTED]  
[REDACTED]\* day, [REDACTED]\* visits an IMA office [REDACTED]\* [REDACTED]\* fails to provide all requested information. [REDACTED]  
[REDACTED]\*



## CHRONOLOGY OF SIGNIFICANT EVENTS

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- May 1, 2007 CFSA Investigations Worker and MPD Officer #1 go to house; no one answers door. Junk mail observed on April 28 visit still in front of door, as is letter Investigations Worker left for [REDACTED]\*.
- May 2, 2007 CFSA Investigations Worker goes to house; no one answers door.
- May 11, 2007 BTW mails truancy referral for [REDACTED]\* to D.C. Superior Court Social Services Division; CFSA Investigations Worker requests assistance from DSU because he was unable to make contact with the family.
- May 16, 2007 Investigations Worker erroneously believes that DSU has located the family in Charles County, MD, and therefore recommends to his supervisor that the investigation be closed. CFSA closes the case, and the Investigations Worker then sends a fax to Charles County Child Protective Services stating "[REDACTED] [REDACTED]\*".
- May 17, 2007 House at [REDACTED]\*, still occupied by [REDACTED]\* and daughters is sold at foreclosure; house's owner, who received TCP's monthly rental payments via a property management company, had apparently stopped paying the mortgage.
- May 31, 2007 Washington Gas disconnects service to house.
- June 14, 2007 CCCPS sends fax to CFSA Investigations Worker [REDACTED] [REDACTED]\*.
- June 29, 2007 Court Social Services Division probation officer sends truancy determination letter to DCPS in error.
- August 8, 2007 PEPCO field representatives go to house to inquire about delinquent account; no one answers door.
- August 25, 2007 D.C. Water and Sewer Authority disconnects service to house.
- August 28, 2007 TCP employee goes to house to conduct annual inspection; no one answers door.

## CHRONOLOGY OF SIGNIFICANT EVENTS

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- September 5, 2007 PEPCO field representatives go to house to inquire about delinquent account, no one answers door; PEPCO disconnects service to the house.
- September 17, 2007 [REDACTED]\* fails to attend [REDACTED] [REDACTED]\*<sup>√</sup> at IMA and does not contact the office to reschedule; therefore, [REDACTED]\*<sup>√</sup>
- September 20, 2007 TCP employee goes to house to conduct annual inspection; no one answers door.
- October 1, 2007 [REDACTED] [REDACTED]\*<sup>√</sup>
- January 9, 2008 U.S. Marshals begin eviction at house, discover bodies of [REDACTED]\* children.
- January 10, 2008 Critical event meeting convened at CFSA to discuss circumstances surrounding the girls' deaths, including the services provided to and agency interactions with the [REDACTED]\*/[REDACTED]\* family.
- January 13, 2008 MPD officer's memorandum regarding MPD's April 30, 2007, interactions with [REDACTED]\* and children.

### Conflicting and Questionable Statements/Information Reported to Team

#### Girls Withdrawn from Meridian Public Charter School

- Meridian's vice principal said that the girls' godmother was employed by Meridian at the time and informed school officials that the girls had been withdrawn to be home-schooled by [REDACTED]\*

Meridian's business manager informed the team that the godmother's employment at the school ended in October 2006, months before the girls stopped attending class.

Meridian's principal said that a school employee called the girls' godmother because she was listed as an emergency contact. The employee said the godmother reported that the children were being home-schooled. The principal felt the godmother was not withdrawing the girls, just informing Meridian that [REDACTED]\* intended to home-school them.

## CHRONOLOGY OF SIGNIFICANT EVENTS

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The school employee who reportedly telephoned the godmother told the team that the godmother said she had spoken to [REDACTED]\*, who stated she was going to home-school the girls and that they should be withdrawn.

The girls' godmother said (1) [REDACTED]\* never mentioned to her an intent to home-school the girls, and (2) she never directed school employees to withdraw them. The godmother said she told the staff that she had suggested to [REDACTED]\* that she enroll the girls in DCPS near their residence.

### BTW Call to CFSA Hotline and Resulting Investigation

- The CFSA Investigations Worker told the team that had he been given more time, he might have been able to make contact with the family. The CFSA Investigations Worker recommended to his supervisor closing the case 20 days after receipt of the hotline call to CFSA even though he had 30 days to complete the investigation.

### MPD Response to [REDACTED]\*

- CFSA's Child Fatality Case Review final report states that Officer #1 telephoned CFSA's Investigations Worker at 10:00 a.m. on April 30, and said that he had gone to the [REDACTED]\*, [REDACTED]\* home. According to the OUC event chronology, Officer #1 was dispatched to [REDACTED]\* at 11:53 a.m.
- The BTW social worker said that she first spoke with CFSA's Investigations Worker, then telephoned MPD to ask that they check on the welfare of the children. The Investigations Worker said that he first spoke with Officer #1 about MPD's visit to the house, then telephoned the BTW social worker and weighed her observations against those of Officer #1.
- Officer #1: April 30, 11:54-11:57 a.m. – Officer #1 arrives at the house and tells the OUC dispatcher that he is available for assignment because "There's an adult on the scene." After being reminded by the dispatcher that the mother has withdrawn the children from school and has "mental problems," and that he is there to check on their welfare, Officer #1 says, "The kids seem fine to me, ma'am."

MPD Internal Memorandum dated January 13, 2008: "When [Officer #2] and [Officer #1] arrived on the scene, they encountered [REDACTED]\* who would not allow them entry and would not allow them to see the children."

- According to the Memorandum, the MPD sergeant telephoned and spoke with the BTW social worker while the officers were interacting with [REDACTED]\* children. BTW social worker said she was not under the impression the sergeant was calling from the house; otherwise she would have asked him specific questions about conditions in the house, and the well-being of [REDACTED]\* and the other children.

## CHRONOLOGY OF SIGNIFICANT EVENTS

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# **PART I: OVERVIEW**



**EXECUTIVE SUMMARY**

## EXECUTIVE SUMMARY

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## Background and Perspective

On January 9, 2008, at approximately 10:00 a.m., members of the U.S. Marshals Service (USMS) arrived at [REDACTED]\* Washington, D.C., a rental row house occupied by [REDACTED]\* [REDACTED] ([REDACTED]\*), to execute an eviction ordered by the D.C. Superior Court. Upon arrival, a Deputy Marshal spoke with [REDACTED]\*, showed her the eviction notice, and requested that she get dressed and remain outside while the eviction took place. When USMS entered the house and went upstairs to the second floor, they discovered what appeared to be the remains of three children lying face down on the floor in one bedroom, and a decedent in another bedroom. USMS immediately secured [REDACTED]\* and eventually learned that the bodies were her four children: [REDACTED]\* (age 17), [REDACTED]\* (age 11), [REDACTED]\* (age 6), and [REDACTED]\* (age 5). USMS contacted their Communication Division, which then contacted the Metropolitan Police Department (MPD).

Members of MPD were dispatched to the scene and an investigator from the D.C. Office of the Chief Medical Examiner (OCME) arrived to examine the bodies. The OCME investigator pronounced the four children dead, and observed that the bodies were in advanced stages of decomposition.

[REDACTED]

## Scope, Purpose, and Methodology

Several days after the discovery of the bodies, city officials announced that [REDACTED]\*, her four daughters, and her partner, [REDACTED]\*, had resided in the District for over 2 years and obtained assistance from several District government agencies and community-based service organizations. Given the number of interactions that the [REDACTED]\*/[REDACTED]\* family had with government agencies, concerns were raised about the degree to which agencies were aware of the family's social services needs and the quality of services provided. Questions were also raised regarding the adequacy of agencies' existing internal controls and whether systemic changes were needed in order to help prevent a similar tragedy from happening again.

---

1 [REDACTED]\*<sup>v</sup>  
2 [REDACTED]\*

## EXECUTIVE SUMMARY

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Consequently, the Mayor and City Administrator requested that the Office of the Inspector General (OIG) conduct a systemic review and assessment of the services rendered to assist the [REDACTED]\*/[REDACTED]\* family and to make recommendations for corrective actions as appropriate. In response to this request, the Inspector General appointed a team of OIG inspectors and investigators to:

- establish an accurate chronology and understanding of all the interactions the family had with District agencies and social services organizations;
- review the regulatory requirements and procedures that should have applied to these interactions;
- determine individual employees' and organizations' compliance with these requirements and procedures;
- evaluate the adequacy of the services and benefits that the family received; and
- identify areas for improvement in the delivery of supportive services to individuals and families facing challenges with needs similar to those of the [REDACTED]\*/[REDACTED]\* family.

The timeframe of the special evaluation starts with the family's arrival into the District in November 2005 and concludes with the January 9, 2008, eviction proceedings. Fieldwork for the special evaluation was conducted between January and October 2008.

The OIG team interviewed 88 individuals, many of whom had interacted directly with one or more members of the [REDACTED]\*/[REDACTED]\* family. Interviewees included current and former employees of District agencies, including the Income Maintenance Administration (IMA) and the Child and Family Services Agency (CFSA); District of Columbia Public Schools and public charter school teachers and administrators; medical and social services providers; case managers at community-based service organizations; friends of the family; and neighbors. The team reviewed policies, procedures, and case files it requested from those District agencies and community-based organizations that interacted with the [REDACTED]\*/[REDACTED]\* family; District laws and municipal regulations; school records; and information from other jurisdictions.

### Narrative

The [REDACTED]\*/[REDACTED]\* family's "story" did not start when they arrived in the District in the fall of 2005. [REDACTED]\* and [REDACTED]\* brought with them a history of housing instability: subsidized housing, foreclosure, and periods when they lived in motels. As recently as May 2005, [REDACTED]\* [REDACTED]\*. She also received ongoing assistance from Maryland's Child Support Administration. [REDACTED]\* had applied for, but apparently did not receive, emergency rent payment assistance for an apartment that the family eventually abandoned in Prince George's County before moving into the District.

Once in the District, the family was referred by the VWFRC to the D.C. General Hypothermia Shelter (Shelter) in a timely fashion after they provided the necessary

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documentation. IMA handled their [REDACTED]\*<sup>√</sup> expeditiously. In early 2006, while living at the Shelter, [REDACTED]\* and [REDACTED]\* attended public school. Teachers at both of their schools said they were aware of their residency in the Shelter, but apparently neither [REDACTED]\* nor [REDACTED]\* received any type of assessment or supportive service through their schools in response to their residency status. Shortly before the family voluntarily left the Shelter, [REDACTED]\* [REDACTED]\*<sup>√</sup> she finished out the school year at Eastern, but her attendance continued to be a problem. [REDACTED]\* missed a significant amount of school during the final quarter of the school year; according to one teacher, she “just disappeared.”

From April until August 2006, the [REDACTED]\* [REDACTED]\* family apparently stayed with friends and lived in motels, and continued to obtain public benefits from the District. The family was active in seeking help and staying in contact with a number of entities: the charter schools that the girls would attend beginning in August 2006; a Family Strengthening Collaborative; IMA; The Community Partnership for the Prevention of Homelessness (TCP); and medical services providers. Yet, in July 2006, CFSA did not try to find them after receiving a call of concern about the family’s well-being.

In August 2006, TCP<sup>3</sup> succeeded in placing [REDACTED]\* and the family in a row house and paid the rent for the next 17 months through the Shelter Plus Care (S+C) program, but [REDACTED]\* was never assigned to an agency that would have coordinated the supportive services he should have received as a condition of his participation in the program. Monthly home visits that should have occurred never did. [REDACTED]\*, described by interviewees as more vocal and active than [REDACTED]\* in managing the family’s affairs, died in February 2007, but TCP was unaware of his death. The family’s [REDACTED]\*<sup>√</sup> had been terminated several months before and, due to his death, [REDACTED]\* and her daughters no longer received the thrice-weekly food deliveries provided by a District non-profit organization during his illness.

After [REDACTED]\* death, the utility bills went unpaid, and [REDACTED]\* daughters stopped attending school. Representatives from one of the charter schools visited the home in April 2007 and subsequently telephoned both CFSA and the Metropolitan Police Department (MPD). The CFSA Investigations Worker assigned to the case tried but failed to make contact with the family.

MPD reportedly made contact on April 30, 2007, but the team’s review of the visit raised questions as to whether officers ever saw [REDACTED]\*, who was the primary subject of the “check on the welfare” call to which they responded.

TCP continued to submit monthly rent payments to a property management company that would then send the funds, less its management fee, to the owner of [REDACTED]\*. Unknown to both TCP and the management company, the house was sold at foreclosure auction in May 2007. That same month, Washington Gas disconnected service to the house. The house’s water service was disconnected in August; several weeks later, Pepco disconnected the electrical service.

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<sup>3</sup> TCP administers the federally-sponsored S+C program on behalf of the District.

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The team learned the story of a family that was not living in isolation, unknown to District agencies and non-profit organizations, but rather one which actively sought and received numerous services and benefits. However, there were also service failures. Two primary failures are evident. When someone should have been looking after the family (i.e., conducting the monthly home visits required as part of the program that placed ██████\* and his family in ██████\*), no one was. When it was imperative that the District locate the family in response to the July 2006 and April 2007 calls to the CFSA hotline, it did not.

A lot of support, often uncoordinated, was extended to the family: admittance to a District homeless shelter; prompt issuance of ██████\*<sup>v</sup>; acceptance into a federally-funded program that provided the family with \$1,580 monthly in rental assistance; the opportunity for each child to attend a public charter school; and weekly food deliveries from a District non-profit during the decline in ██████\* health. Throughout this chronology of assistance, however, are a number of mistakes and omissions, both on the part of service providers and ██████\* and ██████\* themselves: the failure on the part of the District's S+C program to link ██████\* with supportive services and conduct monthly home visits; ██████\* failure to seek supportive services; ██████\* misstep in November 2006, when she neglected to provide the information necessary for the family ██████\*<sup>v</sup>; TCP's unawareness that ██████\* had died; Meridian Public Charter School's decision to remove ██████\*, ██████\*, and ██████\* names from the school roster, despite the fact that the school never spoke with ██████\* or determined whether the children were being taken care of properly; and CFSA's inability to establish contact with ██████\* in May 2007 when, as information obtained by the team suggests, she never moved out of the District.

All of these events are meaningful, yet any attempt to define the effect of each and the degree to which each pushed the family closer to its tragic conclusion would be speculative.

### Conclusions

The ██████\*/█████\* family tried to navigate its way through the District's network of nonprofit agencies and government entities that has evolved for the purpose of providing assistance to individuals in need. As will become clear from the individual findings concerning the services provided to the family by each of the relevant organizations, errors of omission and commission, failures to communicate and coordinate, and deficient policies and procedures were evident. On the other hand, there were numerous occasions during their residency in the District when the family received prompt and appropriate services and benefits.

Errors specific to individuals or agencies are documented in this report, and our recommendations for remediation are set forth in detail. Multiple entities worked effectively, but largely obliviously to each other's efforts, to put in place many of the elements necessary for the ██████\*/█████\* family to sustain itself. Yet, no single organization seemingly had the full perspective necessary to see and follow the family's progress, and intervene when these elements of self-sufficiency began to destabilize. Our analysis of the totality of actions in this case results in a single overarching finding: segments of the District's loosely connected social help network function individually, often with significant success; however, when the segments act in isolation, unable to coordinate effectively with the efforts of other helping hands and unaware of

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the necessity to do so, the effects of errors and omissions are amplified. For example, it appears that at the time these organizations were working with the family:

- Chartered contacted CFSA in July 2006 out of concern for the children's well-being, but did not know that [REDACTED]\*<sup>v</sup> had certified [REDACTED]\* as having a [REDACTED]\* and that TCP had approved [REDACTED]\* for participation in the S+C program. Had this been known, Chartered could have provided CFSA with information that may have allowed CFSA to make contact with the family.
- TCP did not know that Chartered had alerted the CFSA hotline out of concern for the children's well-being in July 2006, the month before TCP placed the family in [REDACTED]\*. Had this been known, TCP could have provided CFSA with information about the family's location and status.
- BTW and Meridian did not know that 2 months prior to the children starting school, Chartered had alerted the CFSA hotline out of concern for the children's well-being and that CFSA never made contact with the family. Had this been known, BTW and Meridian could have provided: (1) CFSA with information about the family's location and status; and (2) the children with targeted needs assessments and, if necessary, supportive services.
- TCP, BTW, and Meridian did not know that [REDACTED]\*<sup>v</sup> due to [REDACTED]\* failure to properly recertify. Had this been known, any one of these organizations could have investigated the reason for the termination and worked with the family and [REDACTED]\*<sup>v</sup> to re-establish this vital benefit.
- TCP, IMA, CFSA, and SWWR did not know that [REDACTED]\* died in February 2007. Had these entities known of [REDACTED]\* death, they could have worked together to stabilize the family and identify a long-term housing solution for [REDACTED]\* and her children to take the place of [REDACTED]\* S+C monthly rental subsidy.
- CFSA's Investigations Worker did not know that the family was placed in [REDACTED]\* as a direct result of [REDACTED]\* acceptance into the S+C program. Had he known that TCP was paying the family's monthly rent, he might have: (1) solicited TCP's assistance in establishing contact with the family; (2) alerted TCP of his inability to establish contact with the family; and (3) been less likely to reach the erroneous conclusion that [REDACTED]\* and her children had moved out of the District.
- OUC and MPD, who coordinated on the response to a "check on the welfare" call on April 30, 2007, did not know that Chartered had alerted the CFSA hotline in July 2006 out of concern for the children's well-being. Had they known, OUC and MPD may have characterized and responded to the "check on the welfare" call and documented their actions with a heightened level of concern and focus.

Linking the various parts of this network will be difficult: a new environment of control and connectivity is needed in order to create within the system a safety net that could help prevent a single instance of human error or neglect from imperiling a person or family in need. Creating that connectivity will require an inter-organizational effort to collect, preserve, and share data in a coordinated manner; to create policies and procedures that reflect shared responsibilities; and to track and analyze individual cases to ensure accountability.

### Select Findings and Recommendations

Following are a number of the special evaluation team's key findings and related recommendations. A complete delineation of findings and recommendations is contained in Part II of this report.

#### Virginia Williams Family Resource Center (VWFRC)

- ***The VWFRC intake process was not thorough; the family's needs were not assessed*** – VWFRC is considered the District's gateway to services and shelter for homeless individuals and families, and [REDACTED]\* and [REDACTED]\* went there seeking shelter for their family. [REDACTED]\* and [REDACTED]\* provided all the documentation that was requested of them; however, much of the information on the *Basic Intake Form* for each family member was not recorded by the intake worker who completed the forms. Entire sections of the forms intended to capture information about housing history, income, insurance, benefits, and physical health were not completed. VWFRC also did not conduct any type of needs assessment, even though its primary mission is to "provide case management, emergency services, placement in emergency shelter, employment services, substance abuse assessment and counseling, mental health assessment and other services for families and children."<sup>4</sup> The team did not identify a specific, negative consequence to the family that resulted from incomplete intake and assessment, but it is reasonable to assume that similar omissions in procedure at VWFRC, if repeated, might prevent other individuals and families from receiving targeted services that address critical needs.

#### Recommendation

That TCP and the Coalition for the Homeless review and amend, in writing where necessary, the Coalition's VWFRC intake, needs assessment, and case management processes to ensure that they are consistent not only with the Coalition's contractual obligations to the District, but also the intent and provisions of the District's Homeless Services Reform Act of 2005.

#### D.C. General Hypothermia Shelter

- ***Families Forward, the non-profit organization that operated the Shelter, did not conduct a thorough needs assessment of [REDACTED]\* and [REDACTED]\**** – For reasons the evaluation team could not determine, the *Initial Interview Assessment Form* at the Shelter was neither completed nor dated. Entire sections of the form pertaining to *Medical History*,

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<sup>4</sup> Contract between VWFRC and TCP, art.1, Dec.1, 2005.

*Psychosocial/Family history, and Assessor's Subjective Observations* were not completed. The Shelter's Director of Supportive Services did conduct a "P[s]ychosocial Assessment" to identify the reasons (as reported by [REDACTED]\* and [REDACTED]\*) for the family's homelessness, and enumerate goals and a plan of action for meeting them. The assessment, however, does not capture [REDACTED]\* and [REDACTED]\* responses to a thorough set of probative questions akin to those contained in the incomplete *Assessment Form*, but rather appears to document a more casual conversation with [REDACTED]\* and [REDACTED]\*. A thorough assessment could have provided valuable insight into the family's needs and past challenges. Again, the team did not identify a specific, negative consequence to the family that resulted from the lack of thorough assessment, but it is reasonable to assume that such omissions in procedure might prevent other individuals residing in the Shelter from receiving targeted services that address critical needs.

- ***During their stay in the Shelter, the children's needs were never assessed*** – The National Center on Family Homelessness reports that children experiencing homelessness are sick four times more often than other children, have three times the rate of emotional and behavioral problems compared to non-homeless children, and are four times more likely to display delayed development.<sup>5</sup> These statistics demonstrate a strong need for assessing the physical and emotional needs of children who have recently experienced or are experiencing homelessness.

The inspection team found no documentation to indicate that the [REDACTED]\*/[REDACTED]\* children were either assessed during their nearly 4-month stay at the Shelter, or referred to any outside service provider for any type of health screening or needs assessment. The children's names are listed on the *Initial Interview Assessment Form*, but the form captures no information pertaining to their health, behavior, or needs. Pertinent questions on the form that should have been asked of [REDACTED]\* and [REDACTED]\* – such as "Has homelessness affected the children's progress in school?" and "What kind of help do you think the children need?" – were not addressed. The psychosocial assessment completed on February 16, 2006, does not mention any of the children. The team did not identify a specific, negative consequence to the children due to this lack of assessment, (i.e., a condition or need that went undiagnosed or unidentified) but given the profound physical and psychological stresses inflicted by homelessness, this is a void in procedure that must be addressed in order to promptly identify and address acute needs in homeless children.

### Recommendations

- That the D.C. Department of Human Services consider proposing to the Mayor a strategy (with funding requirements, milestone completion dates, and clearly assigned accountability) for providing physical, mental health, and developmental screenings to all children known to be homeless.
- That TCP and Families Forward review and amend, in writing where necessary, the Hypothermia Shelter's intake, needs assessment, and case management processes to

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<sup>5</sup> THE NATIONAL CENTER ON FAMILY HOMELESSNESS, *THE CHARACTERISTICS AND NEEDS OF FAMILIES EXPERIENCING HOMELESSNESS 4-5* (Apr. 2008).

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ensure that they are consistent not only with Families Forward's contractual obligations to the District, but also the intent and provisions of the District's Homeless Services Reform Act with respect to "low barrier"<sup>6</sup> shelters.

### **DHS Income Maintenance Administration (IMA)**

- *The [REDACTED]\*/[REDACTED]\* family received initial [REDACTED]\* benefits expeditiously – [REDACTED]\* and [REDACTED]\* went to IMA in order to complete applications for the following [REDACTED]\*, [REDACTED]\*, [REDACTED]\*, and [REDACTED]\*. Based on both a review of documentation and interviews with [REDACTED] employees, the team concluded that the family's initial applications were handled expeditiously and that the family was given prompt access to all three benefits.*

### **Recommendation**

That IMA explore the feasibility of establishing interfaces with benefits information systems in surrounding jurisdictions (i.e., Maryland, Delaware, Virginia, and North Carolina) so that those employees who need it can access information pertaining to applicants who are seeking benefits in the District. The intent of this recommendation is to provide IMA employees with a more complete understanding of an applicant's benefit history so that they can rely less on self-reported information, and make more informed decisions and recommendations.

### **D.C. Public Schools**

- *DCPS' responses to [REDACTED]\* and [REDACTED]\* absences were inadequate – According to The Institute for Children and Poverty, "12% [of children who are homeless] miss at least one month of classes and 33% miss at least two weeks in a single school year."<sup>7</sup> [REDACTED]\* and [REDACTED]\* were no exception to this statistic and were frequently absent from DCPS classes. Eastern High School, which [REDACTED]\* attended in spring 2006, had no documentation of any action taken by school personnel to address [REDACTED]\* absences and/or truancy. Similarly, the team was unable to identify any actions, other than one teacher's telephone calls, that Watkins Elementary School administrators took in order to address [REDACTED]\* absenteeism. Schools are commonly considered to be the first line of defense against child abuse and neglect; absenteeism is an obvious indicator of potential neglect or a physical or mental health issue in a child that should be addressed.*
- *There is no indication that the [REDACTED]\*/[REDACTED]\* family's apparent interactions with DCPS' Homeless Children and Youths Program were documented – Beginning in*

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<sup>6</sup> A "low barrier shelter," as defined in the District's Homeless Services Reform Act of 2005 (D.C. Law 16-0035, eff. Oct. 22, 2005), "means an overnight housing accommodation for individuals who are homeless, provided directly by, or through contract with or grant from, the District, for the purpose of providing shelter to individuals without imposition of identification, time limits, or other program requirements." *Id.* § 2(26).

<sup>7</sup> HOMES FOR THE HOMELESS, SHELTER-BASED AFTER-SCHOOL PROGRAMS BOOST LEARNING AMONG HOMELESS STUDENTS 1 (Jan. 29, 2002), <http://www.homesforthehomeless.com/index.asp?CID=1&PID=36&NID=47> (last visited Jul. 5, 2008).

January 2006 and until July 2006, someone in the [REDACTED]\*/[REDACTED]\* family was communicating with staff in the DCPS Office of Student and School Support Services' Homeless Children and Youths Program (HCYP). The team reviewed call records for the family's primary cell phone number and found a total of 10 calls to and from a phone number assigned to DCPS' Transitory Services and the homeless program. Eight of the calls occurred during January 2006, the month after which the family arrived at the Shelter. According to the records, the last two calls between the family and the program occurred on July 19, 2006,<sup>8</sup> and totaled approximately 15 minutes.

The team interviewed several DCPS employees but none was able to identify what services, if any, were provided to the family through this program. While it appears the family sought services or information on multiple occasions, these interactions were not documented. As a result, the team was unable to determine whether DCPS adequately addressed the [REDACTED]\*/[REDACTED]\* family's needs.

### **Recommendations**

- That DCPS provide annual training for all school employees to enhance the ability to identify and respond appropriately to the needs of homeless students.
- That DCPS ensure that all schools report data on homeless children to HCYP as required by the McKinney-Vento Homeless Assistance Act.<sup>9</sup>
- That DCPS promulgate uniform, written policies and procedures for referring students to internal and external social services agencies/offices, and disseminate the information to all principals, teachers, and counselors.
- That DCPS ensure that all DCPS mandated reporters receive annual training in detecting abuse and neglect, and develop uniform policies and procedures for reporting suspected cases of abuse or neglect.

### **South Washington/West of the River (SWWR) Family Strengthening Collaborative**

- *The family was not classified as "high risk"; however, none of the children was interviewed or received any physical or mental health evaluations* – After meeting with [REDACTED]\* and hearing her express concern about her family's "[REDACTED]\*/[REDACTED]\*", a social worker at Eastern High School's Student Health Center referred [REDACTED]\* to SWWR. On the referral form, [REDACTED]  
[REDACTED]\* One week after the referral, a SWWR intake worker met with [REDACTED]\* and [REDACTED]\* and, using a CFSA family assessment tool, concluded that the family's risk level was "Medium" or "Moderate."

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<sup>8</sup> The first of two calls to the CFSA hotline regarding the well-being of the [REDACTED]\*/[REDACTED]\* family occurred on July 12, 2006.

<sup>9</sup> The McKinney-Vento Education for Homeless Children and Youth program was originally authorized in 1987 and re-authorized by the No Child Left Behind Act of 2001.

The Collaboratives' *Practice Standards Manual* encourages social workers to “[e]ngage the family and the child fully in the change process” and “[c]onsider both the family and the child’s immediate needs for safety . . . .”<sup>10</sup> During the intake and case management process at SWWR, however, it appears that none of the children were ever interviewed, nor were their individual needs specifically addressed through physical, mental health, and/or developmental or educational screenings. In fact, the social worker who conducted the initial intake assessments could not recall whether any of the children were present; she assumes they were not because there were no notes pertaining to them on the intake forms.

The team could not identify a specific negative effect caused by the absence of interviews with or assessments of the girls. However, given that the District’s seven Collaboratives are responsible for keeping children safe from abuse and neglect and “[r]ecognizing that child maltreatment may be a symptom of other problems and underlying needs,”<sup>11</sup> it seems reasonable that it would have been important to obtain information directly from ██████\* and her sisters to (1) determine whether the health and safety of any of the children were at risk, and (2) more accurately define each child’s needs, especially because the intake worker noted “some challenges in thought and reasoning” in both ██████\* and ██████\*.

### Recommendation

That SWWR, along with the District’s other Collaboratives, explore ways to enhance the procedures and capabilities for assessing clients’ needs so that each individual family member, and the family as a unit, receives appropriate, targeted assessments and services.

#### S+C Program

- ██████\* *S+C program application lacked required documentation* – The U.S. Department of Housing and Urban Development (HUD) awards S+C program funds to state and local governments “to serve a population that has been traditionally hard to reach – homeless persons with disabilities such as serious mental illness, chronic substance abuse, and/or AIDS and related diseases.”<sup>12</sup> In March 2006, at the advice of a Families Forward housing counselor he met at the Shelter, ██████\* applied for the S+C program. ██████\*<sup>v</sup> certified ██████\* ██████\*<sup>v</sup> despite not having the required documentation. In fact, during an interview with the team, the ██████\*<sup>v</sup> employee who certified ██████\* ██████\*<sup>v</sup> believed he was only attesting that ██████\* should receive ██████\* treatment services once accepted into the S+C program.

During the intake process at SWWR, both ██████\* and ██████\* reported that they did not have problems related to alcohol or drugs, and had never been treated for substance abuse; concurrently, as part of the S+C application he completed with the Families

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<sup>10</sup> HEALTHY FAMILIES/THRIVING COMMUNITIES COLLABORATIVE COUNCIL, PRACTICE STANDARDS MANUAL 14-15 (Feb. 2002).

<sup>11</sup> *Id.* at 12.

<sup>12</sup> HUDHRE.info, <http://hudhre.info/index.cfm?do=viewSpcResourceManSec1-1> (last visited Oct. 14, 2008).

Forward housing consultant, ██████\* apparently spoke of his 20-year history of ██████ ██████\* . The team was unable to determine whether ██████\* was an appropriate candidate for the S+C program. ██████\* may have had a certifiable ██████ ██████\*<sup>13</sup>, but the team believes his application should not have been approved because it lacked the requisite documentation.<sup>13</sup> The ██████\* / ██████\* family's need for safe, stable housing was undeniable, and their moving into ██████\* , was clearly a positive development. However, the process through which ██████\* secured the housing benefit was improperly administered and the repetition of such mistakes could be financially costly and thus reduce program benefits available to qualified applicants.

- ***It appears that ██████\* was not assessed to determine whether he was prepared to transition into housing*** – According to S+C policies and procedures, a sponsoring agency should review a copy of the candidate's application package, meet with the candidate, and if the agency accepts the candidate, then begin to engage and prepare the candidate for housing placement. The sponsoring agency should also work with employees of the referring agency (in ██████\* case, Families Forward) to ensure that all of the candidate's supportive service and housing needs have been identified. ██████\* was never paired with a sponsoring agency and, therefore, did not receive the evaluation and guidance typically provided as part of the S+C engagement and placement process. The team did not identify a specific, negative consequence to ██████\* , but this omission represents a missed opportunity to determine whether placement in S+C program housing was appropriate for ██████\* and ██████\* and her daughters.

### **Recommendations**

- That TCP ensure that all candidates certified to participate in the S+C program are paired with a sponsoring agency and appropriately evaluated and counseled prior to being placed in housing.
- That TCP periodically audit the certification process and ensure that candidates are certified in accordance with S+C policies and procedures.

### **Chartered Health Plan**

- ***In June 2006, one month before placing a call to CFSA's hotline, a Chartered employee suggested ██████\* obtain a ██████\* evaluation; ██████\* never scheduled an appointment*** – On June 16, 2006, a Chartered behavioral health case manager spoke on the telephone with ██████\* . According to notes, ██████ ██████\* During the conversation with ██████\* , the behavioral health case manager suggested ██████ ██████\* . The case manager gave ██████\* the telephone number for a ██████\* services provider located in the District, and felt that ██████\* was

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<sup>13</sup> On June 17, 2008, the OIG issued a Management Alert Report (MAR) entitled "APRA Employee Improperly Certifying Substance Abuse Disabilities on Federally Funded 'Shelter + Care Program' Applications." (See oig.dc.gov.) According to information provided by TCP in response to the MAR, 96 APRA-certified applicants were still participating in the S+C program as of June 18, 2008.

capable of making her own appointment. [REDACTED]\* never acted on the suggestion; the case manager told the team she wasn't required to and therefore did not follow-up with the provider to determine whether [REDACTED]\* made an appointment.

### **Recommendation**

That Chartered, in consultation with its mental health services providers, strengthen its referral and reporting/follow-up procedures, in particular to better deal with instances when minor children are in the care of a person who would benefit from a mental health evaluation.

#### **Chartered Call to Child and Family Services Agency Hotline**

- ***Despite a clear allegation of child neglect, CFSA did not act upon any of the information provided by the July 12, 2006, hotline caller*** – On July 12, 2006, the Chartered behavioral health case manager telephoned the family's cell phone and spoke with [REDACTED]\*. [REDACTED]\* sounded "[REDACTED]\*," and soon after the call concluded, the case manager, out of concern for the [REDACTED]\* children, telephoned CFSA's Child Abuse and Neglect Hotline (hotline). She informed the hotline worker that [REDACTED]\* and [REDACTED]\*. [REDACTED]\*. The CFSA hotline worker noted in her summary report, and reiterated to the team during an interview, that "[REDACTED]\*" but it was not categorized as such because she did not have an address. The specifics communicated by the Chartered behavioral health case manager (i.e., [REDACTED]\*, [REDACTED]\*, and that [REDACTED]\* and [REDACTED]\* ) seemingly were muted by the hotline worker's perception that the [REDACTED]\* family could not be found.
- ***CFSA was working in isolation; the [REDACTED]\* family was known to multiple District entities*** – Given the seriousness of the allegations, CFSA should have acted to verify the information provided by the Chartered behavioral health case manager, and reached outside of the agency in an effort to locate the children. For example, on the same day the Chartered case manager called the CFSA hotline, someone used the [REDACTED]\* family's primary cell phone to talk with Families Forward, Meridian Public Charter School, TCP, and the Booker T. Washington Public Charter School. The day after the hotline call, [REDACTED]\* attended a medical appointment at George Washington University Medical Faculty Associates. [REDACTED]\* also visited the CHGM's Family Resource Center and told a caseworker that the family was living in their van, a disclosure that, ironically, did not prompt the caseworker to telephone the CFSA hotline.

In July 2006, the [REDACTED]\*, had worked with and was known to SWWR, was in collaboration with Families Forward and TCP in order to obtain permanent housing, was communicating with BTW and Meridian in preparation for the girls' upcoming school year, and had an active cell phone with a number that was on record at various District entities. At the time of the call to the CFSA hotline, the family was not living in isolation; CFSA was working in isolation.

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Information entered into *ServicePoint*, the District's Homeless Management Information System, might have helped CFSA locate the [REDACTED]\*/[REDACTED]\* family, but CFSA did not, and as of the writing of this report, still does not have access to this database.

- ***At the time of the July 12, 2006, call from Chartered to the CFSA hotline, there is evidence that the [REDACTED]\*/[REDACTED]\* family was residing in Maryland*** – Billing records from a Camp Springs, MD Motel 6 indicate that on July 12, 2006, the same day that CFSA received the hotline call, [REDACTED]\* rented a room for one night. For 13 of the remaining 19 days of the month, either [REDACTED]\* or [REDACTED]\* paid cash for a room at the motel. Every day in August, up until August 25, 2006, when the family moved into [REDACTED]\* Washington, D.C., [REDACTED]\* or [REDACTED]\* paid cash for a room at the motel. This information should not obscure the fact that CFSA made no attempt to locate the family.

### Recommendations

- That CFSA update its policies and procedures so that hotline workers and Investigations Workers have sufficient guidance for dealing with calls and cases for which there is no current or fixed address.
- That CFSA work with the District's Healthy Families/Thriving Communities Collaboratives on improving their data capture procedures and their ability to share real-time information with CFSA, TCP, and other service providers regarding their interactions with clients.
- That CFSA hotline workers and Investigations Workers be given access to the Homeless Management Information System in an effort to improve their ability to locate individuals and families.

### The Community Partnership and Shelter Plus Care Housing Placement

- [REDACTED]\* ***was never assigned a sponsoring agency; as a result, he never received once-per-month home visits*** – [REDACTED]\* was certified as having a [REDACTED]\*<sup>v</sup> and was accepted into the S+C program, which was administered by TCP. TCP paid the \$1,580 monthly rent on [REDACTED]\*, and [REDACTED]\* should have been paired with a sponsoring agency so that he could receive supportive services.<sup>14</sup> His sponsoring agency, had he been assigned one, would have been required to conduct a monthly home visit, complete a report, and send it to TCP. TCP's own program guidelines underscore the importance of the home visit and the completion of the report. TCP should not issue a monthly rent payment if a sponsoring agency fails to conduct the visit or submit a report that describes the visit. [REDACTED]\* was never assigned a sponsoring agency, and monthly home visits were never conducted. Compounding the problem, [REDACTED]\* failed to seek supportive services as required by a S+C program contract he signed.

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<sup>14</sup> Examples of S+C program supportive services include: health care; mental health treatment; alcohol and other substance abuse services; childcare services; case management; counseling; education and/or job training; and other services essential for achieving and maintaining independent living, such as courses on household budgeting.

- ***TCP and the D.C. Department of Mental Health communicated regularly about the need to link individuals with supportive services, but S+C “expansion” participants were not matched with sponsoring agencies in a timely fashion*** – In August 2006, TCP faxed to DMH a list of 42 S+C families that had not been linked with supportive services. [REDACTED]\* name appears on the list and he is identified as having a [REDACTED]\* disability, even though he was certified by [REDACTED] as having a [REDACTED].\*<sup>v</sup> TCP and DMH officials met on March 26, 2007, and again on April 23, 2007, in part to discuss the need to link S+C program participants with services.

In June 2007, TCP emailed DMH and wrote “[R]emember we have another urgent issue and that’s linking those families who are in our S+C Expansion program .... We engaged DMH last August to aid these families in need of services and 10 months later only have ¼ of them being served.”

In November 2007, 9 months after [REDACTED]\* death, TCP faxed another list of S+C families to DMH. Twenty-one families had yet to be linked; [REDACTED]\* name still appeared on the list.

- ***After placing [REDACTED]\* and his family in [REDACTED]\* in August 2006, TCP never saw the family again*** – In December 2006, TCP’s Director of Federal Programs left a voicemail for [REDACTED]\* asking that he provide an update on his case management, and the following month, she drove to the family’s house in an effort to make contact. No one answered the door, so she left him a note. In April 2007, two months after [REDACTED]\* died, TCP mailed him a letter regarding the need to enroll with [REDACTED]\*<sup>v</sup> for [REDACTED]\*<sup>v</sup> treatment services and DMH for [REDACTED]\* services. TCP reiterated that “the payment of [his] rental subsidy is contingent upon [his] receiving supportive services.” In fact, TCP had lost touch with [REDACTED]\* and disregarded its own program requirements; nonetheless, it continued to pay his S+C rent subsidy through January 2008 unaware that he had died in February 2007.

## Recommendations

- That TCP implement new procedures to ensure that (1) S+C program participants are promptly assigned a sponsoring agency and receive appropriate supportive services, and (2) appropriate actions are taken when a sponsoring agency fails to submit a thorough and timely *Home Visit Report*.
- That TCP revise the S+C *Home Visit Report* template so that sponsoring agency representatives are required to document (1) the date and time of the home visit and the names of the family members with whom they interacted, and (2) their observations and assessments of the health and well-being of the program participants and family members who reside in the S+C unit with them.

**D.C Public Charter Schools**

- ***District public charter schools lacked standard procedures for addressing absences, truancy*** – During school year 2006-07, the D.C. Public Charter School Board (PCSB) had not promulgated policies and procedures regarding attendance and how to address absences. As a result, Meridian and BTW appear to have followed informal, internal policies and procedures for responding to students’ absences.
- ***Meridian personnel did not aggressively address [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* absences; BTW’s efforts on behalf of [REDACTED]\* were more exhaustive*** – Meridian mailed several letters to [REDACTED]\* regarding [REDACTED]\*, [REDACTED]\* and [REDACTED]\* absences and, in January 2007, two teachers telephoned [REDACTED]\*. One spoke with her; one was unable to reach her. Apart from those efforts, it appears Meridian took no additional action. BTW’s attempts to contact the family appear more exhaustive. The BTW attendance counselor and several teachers tried to reach [REDACTED]\* by telephone in order to discuss [REDACTED]\* unexcused absences. The attendance counselor also sent a letter to the family’s home. The lack of response from [REDACTED]\* prompted BTW’s attendance counselor to discuss the issue at a meeting of the school’s student support team, and BTW’s principal requested that school personnel conduct a home visit. Immediately following an April 27, 2007, home visit, BTW’s social worker was concerned by her inability to see [REDACTED]\*, so much so that she called CSFA and eventually the Metropolitan Police Department (MPD). In addition, after the school communicated its concerns to CSFA and MPD in May 2007, BTW’s attendance counselor referred [REDACTED]\* case to the D.C. Superior Court for further action.
- ***Meridian never communicated directly with [REDACTED]\*, yet removed [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* names from the school’s roster*** – The team received conflicting accounts of how [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* were withdrawn from Meridian. The school’s attendance clerk and vice principal said the girls were withdrawn after the girls’ godmother told the clerk that [REDACTED]\* was home-schooling them. The godmother told the team that she never directed school employees to withdraw the girls, and that [REDACTED]\* never mentioned home-schooling to her. One thing is clear, however: Meridian withdrew [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* without written authorization from [REDACTED]\*, and took no further action.
- ***Recently enacted legislation still does not clearly assign and define responsibilities with regard to monitoring student withdrawals*** – The District of Columbia Public Schools Agency Establishment Act of 2007 designated DCPS as a cabinet-level agency subordinate to the mayor and a new State Board of Education. The team reviewed the Act and concluded that it does not clearly delineate a single District entity that is responsible for tracking all student withdrawals. Moreover, Office of the State Superintendent of Education and State Board of Education employees were unable to tell the team which agency is responsible for such tracking. The potential for losing track of a student apparently still exists.

**Recommendations**

- That the PCSB take steps to help ensure that students who are homeless are promptly referred to the HCYP so that they may receive assessments to determine if they need educational assistance.
- That the PCSB promulgate written policies and procedures for the formal withdrawal of students from schools, to include a requirement that a charter school must provide OSSE with written notification when a student is withdrawn to be home-schooled.
- That legislation be proposed that allocates to a single District entity responsibility for tracking every District student’s education status and history (i.e., enrollments, withdrawals, and transfers) regardless of the educational setting (e.g., public, independent, private, charter, and parochial schools and home-schooling).

**BTW Call to Child and Family Services Agency**

- ***CFSA hotline worker’s written narrative failed to capture vital language used by the BTW social worker during the telephone call*** – On April 27, 2007, having just interacted with [REDACTED]\* in an attempt to make contact with [REDACTED]\*, the BTW social worker telephoned the CFSA hotline while sitting in an MPD cruiser in front of [REDACTED]. [REDACTED]\* During the call, the hotline worker used hand-written notes to record information. The team found that the call summary created in CFSA’s database by the hotline worker failed to capture important comments the BTW social worker made, comments such as:  
[REDACTED]  
[REDACTED]\*
- ***The hotline worker’s written summary of the call was not reviewed for accuracy*** – No one at CFSA listened to a recording of the call. The Investigations Worker who was assigned to the call told the team that it was not routine practice for Investigations Workers to listen to calls that had been assigned to them. When asked whether he thought it should be standard practice, he replied, “I trust that they [the hotline workers] took the call right” and asked the necessary questions.
- ***CFSA’s Investigations Worker failed to document all actions he took, failed to accurately conclude that the family [REDACTED]\*<sup>v</sup> and made an erroneous assumption about information communicated to him by the Diligent Search Unit*** – The CFSA Investigations Worker tasked with making contact with and assessing the family did not document conversations he had with the BTW social worker, [REDACTED]\* “aunt,” and an investigator from Charles County Child Protective Services. He also failed to “interview neighbors, resident managers, or landlords to confirm the address or determine the whereabouts of the family,” per CFSA procedure. The Investigations Worker neglected to follow-up on information provided to him in a report

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15 [REDACTED]  
[REDACTED]\*

## EXECUTIVE SUMMARY

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by CFSA's Diligent Search Unit (DSU). Even though the report clearly provided him with [REDACTED]\* mother's address in Waldorf, MD, he assumed the information pertained to [REDACTED]\*, and that the reference in the DSU report to [REDACTED]\* mother was "a typo."

The team also identified the following as areas where the Investigations Worker (IW) either could have fulfilled his duties more accurately and more effectively, or where he made a mistake:

1. IW could have called the Collaborative (SWWR) cited on the July 2006 Information and Referral report to determine whether someone there knew the family's whereabouts.
2. IW could have called the Collaborative (Far Southeast) cited on the April 2007 *Referral Acceptance Snapshot* to determine whether someone there knew the family's whereabouts.<sup>16</sup>
3. IW either was told or erroneously concluded that [REDACTED]\* and the children were not receiving [REDACTED].\*<sup>√</sup>
4. Unable to reach an [REDACTED] [REDACTED]\*<sup>√</sup> during his first call, IW could have followed up continuously with [REDACTED]\*<sup>√</sup> until he was able to confirm whether his understanding of the [REDACTED] [REDACTED]\*<sup>√</sup> was correct. Presumably, he would have learned that [REDACTED]\* was in fact [REDACTED] [REDACTED]\*<sup>√</sup>, and could have obtained information regarding [REDACTED] [REDACTED]\* that strongly suggested the family had not moved from the District. Specifically, someone (presumably [REDACTED]\*) used [REDACTED] [REDACTED]\* (two transactions), [REDACTED]\* (two transactions), and [REDACTED] [REDACTED]\*<sup>√</sup>. All of these transactions occurred at businesses located less than 3 miles from the [REDACTED]\* [REDACTED]\* house at [REDACTED]\*.
5. IW neglected to confirm the information provided to him by CFSA's DSU and simply assumed that the address information pertained to [REDACTED]\*, instead of [REDACTED]\* mother, as was clearly noted on the report.

IW told the team he was required to complete his investigation within 30 days, and speculated that had he been given more time, he might have been able to make contact with the family. It is important to note, however, that 20 days after the call came in to the CFSA hotline, he recommended to his supervisor that the case be closed.

### Recommendations

- That CFSA implement a policy requiring Investigations Workers to listen to the recording of every hotline call that has been assigned to them for investigation.

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<sup>16</sup> At the team's request, Far Southeast searched its records and found no documentation regarding any interactions with the family. Therefore, it appears the family had no contact with the collaborative.

## EXECUTIVE SUMMARY

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- That CFSA update and enhance DSU policies and procedures in order to standardize search procedures and improve the quality and thoroughness of its written work products by, among other things, requiring corroborative evidence (where possible) to support findings and prevent such erroneous inferences or assumptions as occurred here with respect to the location of individuals.
- That CFSA amend its procedures and information systems (if needed) so that Investigations Workers are required to promptly, accurately, and thoroughly record the dates and times of all investigative actions they take and information received.
- That CFSA examine, and clarify if necessary, its procedures regarding Investigations Workers' interaction with neighbors and family members so that the need to gather information during an investigation is appropriately balanced with the need to maintain the proper level of confidentiality.

### Metropolitan Police Department

- ***No clear indication that any MPD officer saw ██████, \* the subject of the April 30, 2007, "check on the welfare" call*** – In response to a telephone call the BTW social worker placed to the District's non-emergency "311" telephone number, the Office of Unified Communications (OUC) dispatched MPD officers to ██████\* to "check on the welfare" of ██████\* and two other children. In a memorandum dated January 13, 2008, and provided to us by the OAG on January 17, 2008, the MPD sergeant who responded along with two other officers on April 30, 2007, wrote: "The ones I clearly remember are the three youngest. I believe the oldest, ██████\* was on the scene as well after I thought about it some more because that is the one we were there to check on." Apart from this statement, the team found no documentation or any reference on recorded radio transmissions provided by OUC that indicate the MPD officers saw or interacted with ██████\* on that date, which is the last known date anyone outside of the family has accounted for any of the children.

On May 1, 2007, one of the MPD officers who went to the house on April 30 returned with CFSA's Investigations Worker in an attempt to make contact with ██████\* and her children. No one answered the door.

- ***MPD radio transmissions do not support the MPD sergeant's written recollection of the "check on the welfare" call*** – The team noted a significant incongruity between the primary events as documented by an audio recording of April 30, 2007, radio transmissions and the sequence of events presented in the January 13, 2008, memorandum. Based on the audio recording, approximately 3 minutes after he informs the OUC dispatcher that he is pulling onto the block of ██████\*, the first officer (Officer #1) who responded clears the call and states, "There is an adult on the scene .... The kids seem fine to me, ma'am ...." After being reminded by the dispatcher that the children are supposed to be in school, Officer #1 requests a "truant car." After being told none was available, Officer #1 asks the dispatcher to send an official to his location.

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This sequence of events differs from the sequence of events put forth in the memorandum. The sergeant who visited the house wrote in the January 13, 2008, memorandum that when the first two officers arrived at the house, they encountered “[REDACTED]” who would not allow them entry and not allow them to see the children. The officers then called for a supervisor. I responded to their call for assistance.”

Furthermore, there are no indications on the radio transmissions provided by OUC that any of the officers positively identified or spoke with [REDACTED]\*, [REDACTED]\*, or [REDACTED]\* three other children. The OUC dispatcher never provided the MPD officers with [REDACTED]\* name. On the recording, the only family member mentioned by name is [REDACTED]\*, when the dispatcher informs one of the officers that she is the subject of the “check on the welfare” call. Early in the recording, the officer indicates that there is an adult on the scene, but he does not identify that adult.

- ***The team was told that none of the MPD officers who went to the house on April 30, 2007, took notes or completed a report regarding their interactions with the family –*** While MPD General Orders provide no specific guidance on how officers should respond to and document a “check on the welfare” call, MPD’s *Field Reporting System* General Order articulates a policy that its members “shall file a report for all reported crimes and incidents brought to his/her attention. Self-initiated police action taken and calls for police service shall be accurately and thoroughly documented to ensure that a follow-up investigation can be conducted for potential adjudication.” It seems reasonable to infer that a “check on the welfare” call is an incident that should be documented in line with the General Order.

When asked to provide all notes and reports used to produce the January 13, 2008, internal memorandum, the MPD sergeant who participated in the “check on the welfare” call informed the team that “there were no handwritten notes or 251<sup>17</sup> prepared in reference to the contact we (meaning all 7<sup>th</sup> District personnel) had on April 30 and May 1, 2007.” If the sergeant’s statement is correct, then the officers’ failure to document their actions would appear to constitute a violation of the *Field Reporting System* General Order.

Due to the lack of criteria for how an MPD officer should respond to and document a “check on the welfare” call, the absence of notes and reports taken by the officers who responded, and a D.C. Superior Court “gag order,” the team was unable to fully understand and assess the interactions between the officers and the family. For example:

- Why, after the sergeant told the BTW social worker during an April 30, 2007, telephone call he placed from [REDACTED]\* that “the kids were okay and appeared to be in good condition,” did he instruct Officer #1 and Officer #2 “to be sure to follow up with the family services office and try to get them help and get their attention towards the case ...”?

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<sup>17</sup> A PD Form 251 is an event report that is used for “documenting reported incidents or offenses that indicate a violation of the laws and ordinances established in the District of Columbia and the United States, as well as for documenting miscellaneous reports.”

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- Why did MPD Officer #1 return to the house, reportedly out of uniform, on May 1, 2007, with CFSA's Investigations Worker?

In response to a request for applicable policies and procedures, an MPD Assistant Chief informed the team that after discovery of the girls' bodies in January 2008, MPD issued a teletype to its officers regarding "a protocol." However, members of MPD's Policy Development Division were unable to locate this protocol.

### **Recommendation**

That the Chief of the Metropolitan Police Department ensure that MPD General Orders are revised to provide clear guidance on how its officers should respond to and document "check on the welfare" calls.

### **D.C. Superior Court – Court Social Services Division**

- ***Court Social Services Division mishandled BTW's truancy referral and erroneously sent its response to the referral to DCPS instead of BTW*** – On May 11, 2007, BTW's attendance counselor mailed a truancy referral to the Court Social Services Division of the D.C. Superior Court (CSSD). A CSSD manager acknowledged that CSSD exceeded the 5-day timeframe for follow-up, that a determination letter was never sent to BTW in response to the referral, and that there was no conference between the probation officer and her unit supervisor to determine an appropriate course of action. Thirty-eight days elapsed between the date the BTW referral was submitted to CSSD, and the date a request for additional information was erroneously sent from CSSD to DCPS. There is no indication that DCPS took any action after receiving the letter from CSSD.

### **Recommendations**

- That PCSB and DCPS promulgate policies that (1) prevent schools from closing out a truancy referral without receipt of documentation or a determination letter from D.C. Superior Court, and (2) require the referring school to contact the Court in the event it has not received a response to its referral within 5 business days.
- That PCSB and DCPS ensure all schools are provided with CSSD truancy policies and procedures.

### **U.S. Marshals Service**

- ***TCP was unaware that the house it was renting on the family's behalf had been foreclosed on and the family was being evicted*** – The owner of the property management company, which received the rent payments from TCP on behalf of the owner, told the team that he was unaware the property had been sold at foreclosure until he saw the news of the discovery of the girls' bodies during an eviction proceeding. Similarly, TCP staff members did not learn of the foreclosure and resulting eviction until news of the

discovery of the girls' bodies prompted them to contact the owner of the management company.

- ***Marshals' procedures provide no guidance on referring evicted families to supportive services*** – Standard operating procedures provided by the Marshals Service offer brief guidance on dealing with unattended minor children and sick individuals. There is nothing in the procedures, however, that indicates [REDACTED]\* and her children would have been referred to a supportive services agency such as a Collaborative or the District's Department of Human Services following eviction from their home.

### **Recommendation**

That the U.S. Marshals Service collaborate with the District's Department of Human Services to develop and document procedures through which (1) all persons who are evicted from their home are given contact information for a specific support services agency, and (2) the support services agency is provided with the name and contact information for each person evicted from the home.

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## **PART II: DETAIL**



**FAMILY HISTORY PRIOR TO ARRIVAL IN THE DISTRICT  
(2000-2005)**

**██████████\* Rental subsidy, foreclosure in Charles County, MD**

Prior to the family’s residency at the D.C. General Hypothermia Shelter, and dating back at least to the year 2000, the lives of ██████████\* and her daughters were characterized by housing instability.

██████████\* once lived in an apartment in Waldorf, MD (Charles County) that was subsidized by the U.S. Department of Housing and Urban Development (HUD). According to the lease agreement, from November 2000 to November 2001, ██████████\* paid \$90 per month for an apartment on ██████████\*, in which she presumably lived with then 10 year-old ██████████\* and 4 year-old ██████████\*.

██████████\* was born in April 2001, and later that year, ██████████\* moved her family from the HUD-subsidized apartment into a townhome nearby. On November 8, 2001, ██████████\* borrowed just over \$75,000 and bought a house solely in her name<sup>18</sup> located about a mile away from the apartment, on ██████████\* in Waldorf, MD. In October 2002, ██████████\* was born, and ██████████\* and her four daughters were presumably all together in the 1,000 square-foot, two-story townhouse. Two years later, however, there was another episode of housing instability. In April 2004, foreclosure proceedings were initiated against ██████████\* and, according to court documents, ownership of the house transferred back to the mortgage company in September 2004.

Prior to the 2004-05 school year, records suggest that ██████████\* and her children moved into her mother’s home in Waldorf, MD, and that ██████████\* and ██████████\* attended Charles County Public Schools.<sup>19</sup> In November 2004, it appears that the family relocated, or was preparing to relocate, to Prince George’s County. ██████████\* completed a Prince George’s County school system *Request for Information* form, asking that ██████████\* Charles County elementary school send her records to an elementary school in Prince George’s County. On the form, ██████████\* listed the address of a Camp Springs, MD Motel 6 as the family’s address.

On November 29, 2004, ██████████\* was withdrawn from school in Charles County; according to school documents, she had missed only ██████████\*<sup>√</sup> days of school that year, and her grades for the marking period consisted of ██████████\*<sup>√</sup>. On December 6, 2004, ██████████\* withdrew ██████████\*, indicating that the family was moving, and stated that ██████████\* would attend middle school in Prince George’s County.

**Prince George’s County, MD rental apartment; the family “skips”**

██████████\*, the father of ██████████\* two youngest daughters, signed a lease on December 27, 2004, for an apartment located on ██████████\* in Oxon Hill, MD. On the application, ██████████\* indicated he had recently started work as a mover, and had been living for the last 4 months at an address on ██████████\* in Camp Springs, MD. The address was that of the Motel 6.

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<sup>18</sup> The team was unable to determine the circumstances, such as source of income or employment, under which ██████████\* was able to purchase this property.

In August 2004, on a statement of residence verification for Charles County Public Schools ██████████\* certified that she and ██████████\* would reside on a full-time basis at the residence of ██████████\*, ██████████\* mother.

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**FAMILY HISTORY PRIOR TO ARRIVAL IN THE DISTRICT (2000 – 2005)**

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For \$1,070 per month, the family rented a two-bedroom apartment that also contained a den.<sup>20</sup> In January 2005, [REDACTED]\* completed enrollment paperwork so that [REDACTED]\* and [REDACTED]\* could attend school in the Prince George’s County public school system. Soon after moving into the apartment, [REDACTED]\* fell behind in the rent. In February 2005, [REDACTED]\* received his first of several *Failure to Pay Rent* notices. Management described the family as consistently late payers. [REDACTED]\* [REDACTED]\*<sup>v</sup>, according to Maryland’s Department of Human Resources, ended on May 31, 2005. Around this time, [REDACTED]\* appears to have applied for rental assistance with the state.<sup>21</sup> During an interview with the team, friends of [REDACTED]\* said they gave him money for the June, July, and August 2005 rent payments.

The two oldest girls finished the 2004-05 school year in Oxon Hill, MD; [REDACTED]\* completed the eighth grade at Shugart Middle School. [REDACTED]\* completed the third grade at Valley View Elementary, where, according to her report card, she was “[REDACTED]” [REDACTED]\* [REDACTED]\* began the 2005-06 school year at Potomac High School in Oxon Hill, MD, but her grades fell during the first half of the year as she was “[REDACTED]”<sup>\*</sup> absent. [REDACTED]\* returned to Valley View, but was behaving differently. Her first report card of the year stated that “[REDACTED]” [REDACTED]\*

The family stopped paying rent altogether on the apartment and by November 1, 2005, [REDACTED]\* owed nearly \$2,300 in rent, late fees, and other charges. [REDACTED]\* began renting a room at the Camp Springs, MD Motel 6, paying cash for a room on November 9, 10, 11, 13, and 20, 2005. The management company left notices for the family warning that if they failed to make contact, “[management] will assume the apartment is abandoned.” At the end of the month, a representative of the management company entered the apartment and encountered that very scenario: clothing; pots on the stove and unwashed dishes in the kitchen sink; food in the refrigerator; children’s toys and bags of garbage on the floor. In rental management parlance, the family had “skipped” the apartment.

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<sup>20</sup> [REDACTED]\* and the four children were listed on the lease as occupants; [REDACTED]\* was not. According to the management company, maximum occupancy for a two-bedroom with den apartment was five persons and, legally, a sixth person could not be on the lease.

<sup>21</sup> Maryland’s Department of Human Resources denied the special evaluation team’s request for information regarding rental assistance provided to the family.



**VIRGINIA WILLIAMS FAMILY RESOURCE CENTER**  
(NOVEMBER – DECEMBER 2005)  
FAMILY'S RESIDENCE UNKNOWN

Key Findings:

- The VWFRC intake process was not thorough.
- The [REDACTED]\*/[REDACTED]\* family's needs were not assessed and case management services were not provided.



Whether the family ever resided at these locations would have had no impact on their eligibility to reside in a District shelter or obtain District benefits. However, self-reported contact information and recent addresses, if accurate, could prove useful in locating individuals and families when the District has lost contact, and every effort should be made by agencies collecting such information to verify its veracity. There is no indication that any District agency tried to establish contact with the [REDACTED]\*/[REDACTED]\* family through either of these addresses, but the family did provide Chartered with one of them as a mailing address, and the information was entered into Chartered's member database.

**Client information is not verified before admittance to low barrier shelters.**

Intake workers at VWFRC are not required to verify the information that clients report on the intake form. According to TCP, the Hypothermia Shelter is classified as a "low barrier" shelter<sup>24</sup> and residents are not required to disclose personal information in order to be admitted. The amount of information obtained depends solely on what the client is willing to divulge. Residents are approved for placement in a low barrier shelter without verification of information. However, if and when a resident seeks assistance from a program that offers a higher level of assistance, such as a transitional housing or permanent supportive housing program,<sup>25</sup> additional information must be provided and self-reported information should be verified.

**The VWFRC intake process was not thorough and complete.**

[REDACTED]\* and [REDACTED]\* provided all the documentation that was requested of them; however, much of the information on the *Basic Intake Form* for each family member was not recorded by the intake worker who completed the forms. Entire sections of the forms intended to capture information about an individual's housing history, income, insurance, benefits, and physical health were not completed. The *Basic Intake Form* also asks for additional "profile information," including the name, address, and telephone numbers for an emergency/alternate contact person. This type of information is crucial to obtain when working with a transient, at risk population.

**The [REDACTED]\*/[REDACTED]\* family's needs were not assessed at VWFRC.**

According to its contract with TCP,<sup>26</sup> the Coalition is to provide "case management, emergency services, placement in emergency shelter, employment services, substance abuse

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<sup>24</sup> A "low barrier shelter," as defined in the District's Homeless Services Reform Act of 2005 (D.C. Law 16-0035, eff. Oct. 22, 2005), "means an overnight housing accommodation for individuals who are homeless, provided directly by, or through contract with or grant from, the District, for the purpose of providing shelter to individuals without imposition of identification, time limits, or other program requirements." *Id.* § 2(26).

<sup>25</sup> "Transitional housing" is a 24-hour housing accommodation that also provides individuals and families with a "structured program of supportive services for up to 2 years" and case management services. *Id.* at § 2(41). "Permanent supportive housing means supportive housing for an unrestricted period of time for individuals and families who were once homeless and continue to be at imminent risk of becoming homeless . . ." *Id.* at § 2(28).

<sup>26</sup> TCP is an independent, non-profit corporation that is responsible, through a contract with the D.C. Department of Human Services, for management oversight of the 60+ homeless services providers that constitute the District's Continuum of Care. Through a contract with TCP, the Coalition is one of the service providers and operates the VWFRC.

assessment and counseling, mental health assessment and other services for families and children.” The contract goes on to state:

[The Coalition] must collaborate with other social service agencies and homeless service program (sic) participating in the continuum of care system----to provide comprehensive services to persons who may have a variety of problems and special needs including behavioral, emotional, developmental, mental health and addiction treatment and recovery needs.

During interviews with the team, employees said that when a family goes from the VWFRC directly to a shelter, case management services are provided at the shelter. According to the intake specialist who worked with the family, VWFRC did not provide any case management services. He added that if the [REDACTED]\*/[REDACTED]\* family had not been placed immediately in the Hypothermia Shelter, they would have been assigned a VWFRC case manager. However, the family was not immediately referred to the Hypothermia Shelter. [REDACTED]\* and [REDACTED]\* first contact with the VWFRC came on November 23, 2005. Their application for shelter was “approved” that day, but they needed to submit additional documents before they could be placed in the Hypothermia Shelter. Their file was considered complete on December 12, 2005, and they received their referral to the Hypothermia Shelter on December 14.

The team noted a disconnect between VWFRC’s role as defined in its contract and what it actually did in helping the [REDACTED]\*/[REDACTED]\* family. According to the contract, the VWFRC should play a lead role in providing and/or coordinating the supportive services needed by individuals and families who are homeless. However, the VWFRC did not conduct any type of needs assessment; *Basic Intake Forms* were not completed for the family. The lack of a needs assessment is problematic given the VWFRC’s responsibility to coordinate the provision of supportive services. The team did not identify a specific, negative consequence to the family that resulted from incomplete intake and assessment, but it is reasonable to assume that similar omissions in procedure at VWFRC, if repeated, might prevent other individuals and families from receiving targeted services that address critical needs.

In part, this disconnect may be due to opposing goals: the VWFRC is obligated to provide a family case management services and, if necessary, place them in emergency shelter (i.e., low barrier shelter), which by definition is an accommodation “without imposition of identification, time limits, or other program requirements[.]”

#### RECOMMENDATIONS

- That TCP and the Coalition for the Homeless review, and amend in writing where necessary, the Coalition’s VWFRC intake, needs assessment, and case management processes to ensure that they are consistent not only with the Coalition’s contractual obligations to the District, but also the intent and provisions of the District’s Homeless Services Reform Act of 2005.

- That the District's Homeless Management Information System be enhanced so that homeless services providers are prompted to capture and regularly update homeless clients' contact information (e.g., cell phone numbers, contact information for family members) with the goal of improving the District's ability to communicate more quickly and effectively with this vulnerable and typically difficult-to-reach population.



**DISTRICT OF COLUMBIA HOUSING AUTHORITY**  
(DECEMBER 2005)  
FAMILY'S RESIDENCE UNKNOWN

Key Findings:

None

On December 6, 2005, 8 days before the family was placed in the D.C. General Hypothermia Shelter, ██████\* and ██████\* completed an *Application for Housing Assistance* at the D.C. Housing Authority (DCHA). The application identifies ██████\* as the applicant, ██████\* as the co-applicant, and all four girls as children who would live with ██████\* and ██████\* should housing become available through DCHA. ██████\* and ██████\* cited ██████\* as their home address, but did not provide a contact telephone number, even though the form asks for work telephone and home telephone numbers.

██████\* and ██████\* requested assistance from DCHA through three housing programs: Public Housing, the Housing Choice Voucher program, and the Moderate Rehabilitation program.<sup>27</sup>

After ██████\* completed the DCHA application, she was placed on the waiting list for each housing program.<sup>28</sup> The word “Homeless” is written on her application and “Preference” is checked. In specific instances, DCHA applies waiting list selection preferences. Indicating a preference affects where an individual or family seeking housing is placed on the waiting list. The condition of being homeless is considered a selection preference, according to DCHA.

There is no record of the family having any further interaction with DCHA after December 6, 2005.

### **RECOMMENDATION**

That DCHA capture at the time of application clients’ contact information (e.g., cell phone numbers, contact information for family members and/or friends) in order for the District to improve its ability to communicate with this vulnerable and typically difficult-to-reach population.

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<sup>27</sup> The Public Housing program consists of 52 apartment communities in the District that are managed and maintained by DCHA. The Housing Choice Voucher Program (HCVP, formerly known as the Section 8 Voucher Program) provides rental assistance so that eligible families can obtain housing from private landlords. The voucher allows the tenant to choose where he/she would like to live. The Moderate Rehabilitation program (formerly known as the Section 8 Moderate Rehabilitation program) includes apartment communities throughout the District that are managed by individual landlords. The assistance provided is called “Project-Based” or “Unit-Based.” This means that the assistance provided to pay rent is only for the unit in which a family lives. Unlike the “Tenant Based” voucher, the assistance provided through the Moderate Rehabilitation program cannot be transferred to another unit.

<sup>28</sup> DCHA provided the team with screen prints from its waiting list data system. For the “Public Housing” waiting list, ██████\* is shown in “position: 2383” and “Over All 16544.” According to DCHA, however, the information in the system is not accurate. DCHA said it had to disable elements of the data system over time, actions which, along with human error, corrupted the accuracy of the wait list information. DCHA’s practice is to place applicants in housing on a first-applied, first-placed basis using the year in which they applied and any preferences. As of the writing of this report, DCHA told the team that the agency was in the process of placing people who had applied for housing assistance in 2003.



(D.C. General Hypothermia Shelter. Family stayed in building on far right of photograph.)

**D.C. GENERAL HYPOTHERMIA SHELTER**  
(DECEMBER 2005 – APRIL 2006)

Key Findings:

- [REDACTED]\* and [REDACTED]\* did not receive a thorough needs assessment.
- Their children were never interviewed nor were their needs ever assessed.
- The family did not receive a required case review after being in the Shelter 90 days.

On December 14, 2005, [REDACTED]\*, [REDACTED]\*, and the four children checked into the D.C. General Hypothermia Shelter (Shelter), a 24-hour “emergency shelter” that is operated by Families Forward. According to the terms of its contract with TCP, Families Forward<sup>29</sup> was to provide “temporary shelter, comprehensive case management services, housing relocation assistance, and other services . . . . A case management component must begin with all due diligence immediately upon a family’s arrival at the shelter.”<sup>30</sup> It appears the family lived in the Shelter for nearly a month before they were assigned a case manager. On January 10, 2006, a Families Forward case manager informed the family in writing that she would serve as their case manager, and scheduled a meeting for January 17, 2006.

On January 11, 2006, 4 weeks after being admitted into the Shelter, [REDACTED]\* met with a Shelter shift supervisor to complete and sign a Families Forward *Intake Form*, acknowledge receipt of the Shelter’s *Client Responsibilities*, and sign a *Resident Contract Agreement*. [REDACTED]\* cited [REDACTED]\* as the address where the family became homeless; on their DCHA housing application, the family cited [REDACTED]\* as their “home address.”

For unknown reasons, [REDACTED]\* and [REDACTED]\* did not meet with their case manager until January 24, 2006, nearly 6 weeks after being admitted to the Shelter. During this meeting, the case manager completed a two-page general application form, and only the first two pages of a nine-page *Initial Interview Assessment Form*.

The following week, [REDACTED]\* met with Families Forward’s Director of Supportive Services/Shelter site manager to discuss his case management goals. According to the progress notes, [REDACTED]\* identified the following priorities: (1) stabilizing the family’s monthly income; (2) obtaining affordable housing; (3) receiving medical treatment [REDACTED]\*; and (4) locating childcare for the two youngest girls. During this meeting, [REDACTED]\* expressed concern about a rental arrearage the family had incurred from an apartment in Maryland.

[REDACTED]\* and [REDACTED]\* met again with the site manager on February 16, 2006, during which the site manager completed a brief “p[s]ychosocial assessment.”

This writer had the majority of contact with [REDACTED]\*. He appeared to be the spokesperson for the family . . . . He was open and expressed a desire to provide for his family. [REDACTED]\* was not engaging and often allowed [REDACTED]\* to articulate the needs and/or concerns of the family . . . . While residents in the facility, the [REDACTED]\*/[REDACTED]\* family kept to themselves and had minimal interactions with other families . . . . The family needs assistance with identifying and obtaining housing that they can sustain. They

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<sup>29</sup> The mission of Families Forward, Inc., is to provide homeless and low-income families in the greater Washington-Baltimore area with quality housing, individualized support, and marketable training so they can obtain the skills and motivation to achieve their highest level of self-sufficiency. Families Forward case managers work with families to execute a case plan, and make referrals to community-based organizations and District agencies for services. The family exercises its own discretion in following through on a referral.

<sup>30</sup> *Id.* at 1 and 4.

will be referred to housing resources with in-house subsidies as well as exploring (sic) the option of the Shelter plus Care Program.

Based on interviews with the team and a review of the family's Shelter case file, there is no indication that Families Forward made any referrals related to the physical or mental health needs of any [REDACTED]\*/[REDACTED]\* family member.

## ISSUES AND FINDINGS

### **Families Forward failed to conduct a thorough needs assessment of [REDACTED]\* and [REDACTED]\*.**

For reasons the evaluation team could not determine, the *Initial Interview Assessment Form (Assessment Form)* was neither completed nor dated. Entire sections of the form pertaining to "Medical History," "Psychosocial/Family" history, and "Assessor's Subjective Observations" were not completed. These sections of the form are intended to capture vital information on topics including:

- physical illness or disability;
- mental/emotional problems;
- medications;
- drug abuse and past drug treatment;
- past interactions with Child Protective Services; and
- criminal record.

As stated above, the Director of Supportive Services did conduct a "P[s]ychosocial Assessment" to identify the reasons (as reported by the family) for their homelessness, and enumerate goals and a plan of action for meeting them. The assessment, however, does not capture [REDACTED]\* and [REDACTED]\* responses to a thorough set of probative questions akin to those contained in the incomplete *Assessment Form*, but rather appears to document a more casual conversation with [REDACTED]\* and [REDACTED]\*.

A thorough assessment of both [REDACTED]\* and [REDACTED]\* could have provided valuable insight into the family's needs and past challenges they faced, and that could have resulted in their being referred for further evaluation, treatment, or services. The team did not identify a specific, negative consequence (i.e., a condition or particular need that went undiagnosed or unidentified) to [REDACTED]\* or [REDACTED]\* that resulted from their not being thoroughly assessed while living at the Shelter, but it is reasonable to assume that such omissions in procedure might prevent other individuals residing in the Shelter from receiving targeted services that address critical needs.

As similarly noted in the section of this report regarding the VWFRC, Families Forward's contractual requirements to provide emergency shelter to families as well as comprehensive case management services may be somewhat contradictory. Case managers are expected to provide residents with referrals to services such as public assistance programs, substance abuse treatment, legal assistance, and medical and mental health treatment. Yet, by definition, "low barrier" shelter is to be provided "without imposition of identification, time limits, or other program requirements," such as a mandatory needs assessment tool. Therefore, it

is reasonable to assume that Shelter case managers can be expected to respond to only those needs that residents themselves identify.

**During their stay in the Shelter, the children’s needs were never assessed.**

Research shows that children experience high rates of chronic and acute health problems, mental health issues, and developmental delays due to homelessness. The National Center on Family Homelessness reports that children experiencing homelessness are sick four times more often than other children; have three times the rate of emotional and behavioral problems compared to non-homeless children; and are four times more likely to show delayed development. These statistics demonstrate a strong need for assessing the physical and emotional needs of children who have recently experienced or are experiencing homelessness.

Families Forward’s contract with TCP provides very little criteria regarding the assessment or provision of services to children living at the Shelter. The contract calls for Families Forward to provide “appropriate overnight shelter and supportive services,” and to “engage the parents or guardians of child[ren] in support services that will assist with moving them into greater stabilization.”

The evaluation team found no documentation, however, to indicate that the [REDACTED] \* [REDACTED] \* children were either assessed by Families Forward personnel at the Shelter, or referred to any outside service providers for any type of health screening or needs assessment. The children’s names are listed on the *Initial Interview Assessment Form*, but the form captures no information pertaining to their health or behavior. Pertinent questions on the form that should have been asked of [REDACTED] \* and [REDACTED] \* – such as “Has homelessness affected the children’s progress in school?” and “What kind of help do you think the children need?” – were not addressed. The psychosocial assessment completed on February 16, 2006, does not mention any of the children.

The team did not identify a specific, negative consequence to the children due to this lack of assessment (i.e., a condition or need that went undiagnosed or unidentified,) but given the profound physical and psychological stresses inflicted by homelessness, this is a void in Shelter procedure that must be addressed in order to better identify acute needs in homeless children.

**The [REDACTED] \* [REDACTED] \* family did not receive a 90-day case review as required by Families Forward’s contract with TCP.**

It appears that Families Forward neglected to: (1) complete a 90-day case review for the family as required by the terms of its contract with TCP; and (2) enter data for each family member into the Homeless Management Information System (HMIS).

Families Forward was required to conduct a Case Review for any family that stayed more than 90 days consecutively; each case review was to be completed within 2 weeks after the family reached the 90-day stay mark. According to the contract:

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<sup>31</sup> Under the Families Forward “Client Rights and Responsibilities,” a client who receives a referral has the right to refuse treatment or service.

The Case Review(s) shall be entered into the case notes of the client's HMIS record and the Partnership will consider the client's record to be incomplete if there is no Case Review in the HMIS for any client who resided in the shelter for more than 90 days ....

Based on this contract provision, the [REDACTED]\*/[REDACTED]\* family should have received a case review on or before March 15, 2006. The team found no record, either in the Families Forward file or in the HMIS, that the case review was conducted. Again, the team did not identify a specific, negative consequence to [REDACTED]\* or [REDACTED]\* that resulted from their not receiving a case review while living at the Shelter, but it is reasonable to believe that such an omission might negatively impact other families residing in the Shelter from receiving timely, targeted services that address critical needs.

As defined in its contract with TCP, Families Forward was also required to “document the relationship between the adults and the children within the *Service Point* HMIS,” and collect from each family their last home address before entering the Shelter. The team found no evidence that Families Forward entered any of the family's information into the HMIS.

#### **RECOMMENDATIONS**

- That the D.C. Department of Human Services consider proposing to the Mayor a strategy (with funding requirements, milestone completion dates, and clearly assigned accountability) for providing physical, mental health, and developmental screenings to all children known to be homeless.
- That TCP and Families Forward review, and amend in writing where necessary, the Hypothermia Shelter's intake, needs assessment, and case management processes to ensure that they are consistent not only with Families Forward's contractual obligations to the District, but also the intent and provisions of the District's Homeless Services Reform Act with respect to “low barrier” shelter.
- That TCP lead an effort to improve the accuracy and thoroughness of information captured in *ServicePoint*, the District's Homeless Management Information System.



**DHS INCOME MAINTENANCE ADMINISTRATION**  
(DECEMBER 2005 – FEBRUARY 2006)  
FAMILY RESIDING IN D.C. GENERAL HYPOTHERMIA SHELTER

Key Findings:

- The [REDACTED]\*/[REDACTED]\* family received [REDACTED]\*<sup>v</sup> expeditiously.
- IMA workers lack complete information regarding applicants; the District could duplicate benefits provided by other jurisdictions.

(full page redacted) \*<sup>v</sup>

(full page redacted) \*<sup>v</sup>

have to submit additional documentation in May 2006 for further consideration. Additionally, as a result of [REDACTED]\* exemption, [REDACTED]\* was granted an exemption from the TANF work activity requirement so that she could take care of [REDACTED]\*.

ISSUES AND FINDINGS

**No period of D.C. residency is required before an applicant can receive benefits through IMA.**

An applicant must only profess an intention to live in the District. IMA policy 2.3 states, “A person is generally considered a resident if s/he is presently living in DC voluntarily and not for a temporary purpose and has no current intention of moving out of DC.”

**The [REDACTED]\*/[REDACTED]\* family received initial IMA benefits expeditiously.**

Based on both a review of documentation and interviews with IMA employees, the team concluded that the family’s initial applications were handled expeditiously and that the family was given access to monetary benefits promptly. IMA’s policy manual states: “It is IMA’s goal that eligibility determinations should be made within ten days from the date that all information necessary to determine eligibility has been submitted. IMA is not legally obligated to meet this timeframe, though it is generally expected that [social services representatives] do so.”<sup>41</sup> [REDACTED] [REDACTED]\*<sup>√</sup> and [REDACTED]\*<sup>√</sup> benefits were available to the family the same day they applied. [REDACTED]

**IMA is not required to check applicants’ benefits status in other jurisdictions.**

IMA employees told the inspection team they are not required to contact surrounding jurisdictions to request information about benefits currently or previously received by an applicant. Employees said such a practice would be too time-consuming given their case loads. Under a Memorandum of Understanding (MOU) with the state of Maryland, IMA has very limited access to Maryland’s benefits information system. According to IMA, computer networking obstacles are the reason very few IMA computers have connection that grants access to Maryland information. IMA’s social services representatives who interact with applicants do not have access; only IMA investigators and several managers have access to Maryland information.

[REDACTED]\*

**IMA workers lack accurate, complete client information; the District may duplicate benefits provided to an applicant in another jurisdiction.**

Despite having the releases authorizing them to do so, there was no indication that IMA requested information from surrounding jurisdictions. Had they contacted officials in Maryland, IMA employees could have determined that both [REDACTED]\* and [REDACTED]\* were past FS benefit recipients; [REDACTED]\* had once applied for emergency rental assistance in Prince George's County; and [REDACTED]\* had received/was receiving child support through Maryland's Department of Human Resources.

Though this information likely would not have impacted the benefits extended to the family at the time, this situation underscores the reality that social service representatives are expected to make sound, compassionate decisions based on imperfect (i.e., incomplete or inaccurate, self-reported) information.

The evaluation team did not identify any specific effect that this void in procedure caused with respect to the [REDACTED]\*/[REDACTED]\* family.<sup>42</sup> However, when considering IMA operations in their entirety and the safeguarding of District resources, it appears that in failing to obtain information from surrounding jurisdictions, IMA is not doing everything it could to minimize the possibility that applicants receive benefits from the District and from another jurisdiction concurrently.<sup>43</sup>

**RECOMMENDATION**

That IMA explore the feasibility of establishing interfaces with benefits information systems in surrounding jurisdictions (i.e., Maryland, Delaware, Virginia, and North Carolina) so that those employees who need it can access information pertaining to applicants who are seeking benefits in the District. The intent of this recommendation is to provide IMA employees with a more complete understanding of an applicant's benefit history so that they can rely less on self-reported information and make more informed decisions and recommendations.

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<sup>42</sup> According to Part V, Chapter 2.8 of IMA's Policy Manual, a person receiving TANF from the District must forward any child support payments he/she receives from other jurisdictions to the District's Child Support Enforcement Division (CSED) of the Office of the Attorney General. If the amount of the child support payment is less than the TANF benefit being received, it is retained by CSED to defray the costs of providing assistance. After 2 consecutive months of support payments that are greater than the TANF benefit, the TANF case is closed, and the child support is sent directly to the family. The team was unable to determine the amounts and frequency of child support payments made to [REDACTED]\*, and whether any payments were forwarded to the CSED.

<sup>43</sup> There is a process, the PARIS interstate match program, by which the District participates with other jurisdictions in an effort to detect instances where an individual is receiving benefits from multiple jurisdictions. It is not a preventative measure but rather a method for detecting fraud that is already occurring.



**D.C. PUBLIC SCHOOLS**

(JANUARY 2006 – JUNE 2006)

FAMILY RESIDES IN HYPOTHERMIA SHELTER UNTIL APRIL 10, 2006,  
THEN DEPARTS FOR UNKNOWN LOCATION

Key Findings:

- DCPS' responses to [REDACTED]\* and [REDACTED]\* absences from school were inadequate.
- There is no indication that the family's interactions with DCPS' Homeless Children and Youths Program were documented.
- DCPS mandated reporters, which include teachers, of suspected and known child abuse and neglect are not uniformly trained.

**\* Attends Eastern Senior High School (1700 E. Capitol St., N.E.)**

On January 10, 2006, \* was withdrawn from Potomac High School in Oxon Hill, MD, “per parent request via phone conversation.” The Prince George’s County Withdrawal/Transfer Record notes that \* The next day \* was enrolled in Eastern, citing the D.C. General Hypothermia Shelter as her address, and providing the family’s primary cell phone number.

Shortly after her enrollment, \* appears to have presented a *Consent Form* to the Student Health Center at Eastern, which authorized Unity Health Care to provide her with healthcare services.<sup>44</sup> In February 2006, \* visited with a family nurse practitioner (FNP) at the clinic on several occasions for immunizations and medicine. The Unity FNP referred \* to the clinic’s counselor, who \* met with on March 1, 2006.

During this meeting, \* “ \* ” The counselor encouraged \* \* \* The two also discussed \* \* \*<sup>45</sup> \* met with the counselor the next day and said \* \* \*<sup>46</sup> The Unity counselor faxed a referral to the South Washington/West of the River Family Strengthening Collaborative that day. (See page 61.)

\* \* \* \* \*

\* \* \* \* \*

\* was eligible to return to school on April 21, 2006.<sup>46</sup>

On May 2, the Unity counselor met with \* after seeing her in the school hall “ \* \* \*<sup>47</sup> \* confided in the counselor that \* had been diagnosed with \* , and

<sup>44</sup> The name “ \* ”\* appears in the signature block for both the DCPS enrollment form and the Unity Health Care consent form. However, \* signature on the enrollment and consent forms appears differently than her signature on other forms. According to the consent, “confidentiality between the student and the medical team [would] be ensured . . . . Information [would] not be discussed with the parent or guardian unless the student agrees.”

<sup>45</sup> A total of seven Collaboratives operate within the District, each serving families in their respective neighborhoods. According to the HFTC *Collaborative Practice Manual*, “Collaboratives are a community-based, neighborhood-owned model for child and family service delivery that respects and cherishes the integrity of families and taps into the capacity of their neighborhoods for socially responsible action.” *Id.* at 7.

<sup>46</sup> The \* \* \*<sup>47</sup> was not completed properly; there is no indication of where \* served the \* \* \* (i.e., in school, at an “alternative educational placement,” or at home). Spring vacation during school year (SY) 2005-06 lasted 6 days: Monday, April 10 through Monday, April 17.



had mentioned that possibility. At the end of the school year, however, her attendance was cited as an issue on her final report card:



\*

\* “graduated” from the fourth grade but did not participate in the ceremony with her classmates according to her teacher. DCPS attendance records reviewed by the team showed different figures, but it appears that \* missed between \*<sup>v</sup> and \*<sup>v</sup> days of school during the final two advisory periods of the 2005-06 school year, or, approximately 1 out of every 3 days.

#### **Family’s Interaction with DCPS’ Homeless Program**

Beginning in January 2006 and until July 2006, someone in the \* family was communicating with staff in the DCPS Office of Student and School Support Services’ Homeless Children and Youths Program.<sup>50</sup> The team reviewed call records for the family’s primary cell phone number<sup>51</sup> and found a total of 10 calls to and from a phone number assigned to DCPS’ Transitory Services and the homeless program. Eight of the calls occurred during January 2006, the month after which the family arrived at the Shelter. According to the records, the last calls between the family and the program occurred on July 19, 2006,<sup>52</sup> and totaled approximately 15 minutes.

The team interviewed several DCPS employees but none was able to determine what services, if any, were provided to the family through this program.

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<sup>50</sup> In October 2007, the Homeless Children and Youths Program (HCYP) was transferred from DCPS to the Office of the State Superintendent of Education (OSSE). The program is now called the Education of Homeless Children and Youth Program. According to its website, the program offers transportation assistance (e.g., bus tokens for transportation to and from school); dispute resolution (e.g., if there is a dispute between a family and a school regarding which school a child should attend); emergency school enrollment assistance; and DCPS staff development. The program also collaborates with District social services agencies in order to raise awareness and understanding of issues facing homeless children.

<sup>51</sup> \* and \* did not appear to have had hardwired telephone service in their house. They shared one cell phone with “pay as you go” service, meaning they would periodically purchase minutes for their phone, as opposed to receiving a monthly bill for minutes used. The number for this cell phone is the only “home” phone number that \* and \* appear to have ever used when completing intake forms, applications, etc. during their District residency. As far as the team could determine, this phone was active with no apparent interruptions in service from January 5, 2006, until April 27, 2007. Other numbers may have existed, but the team found only one additional cell phone number, for which \* appeared to be the primary user. This number was active from October 21, 2006, to March 25, 2007.

<sup>52</sup> The first of two calls to the CFSA hotline regarding the \* family occurred on July 12, 2006.

ISSUES AND FINDINGS

**DCPS' responses to [REDACTED]\* and [REDACTED]\* absences were inadequate.**

According to The Institute for Children and Poverty, “12% [of children who are homeless] miss at least one month of classes and 33% miss at least two weeks in a single school year.”<sup>53</sup> [REDACTED]\* and [REDACTED]\* were no exception to this statistic and were frequently absent from school.

DCPS Directive 522.4 (Jun. 20, 2005) outlines a number of steps for “attendance intervention” to include the following:

- a. Parents **must** be notified within twenty-four (24) hours of their child(ren)'s unexcused absence from class/school by phone and/or in writing, inclusive of automated calling or DC STARS<sup>54</sup> form letters. (Emphasis in original.)
- b. All teachers must maintain contact with parents of students who are in jeopardy of failure due to poor attendance and other issues and document said contacts.

\* \* \*

- d. Teachers must refer students who have five (5) unexcused absences to the local school attendance committee for the development of an attendance intervention plan. The parents should be encouraged to attend the truancy conference. If all efforts to contact the family fail, a home visit is recommended to document the student's attendance status.

\* \* \*

- f. Elementary, middle and junior high school students who have accumulated ten (10) unexcused absences must be referred to the guidance counselor/attendance counselor/designee who will refer the student to the Child and Family Services Agency (CFSA) Hotline (671-SAFE) for suspected educational neglect ....<sup>55</sup>

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<sup>53</sup> Available at <http://www.homesforthehomeless.com/index.asp?CID=1&PID=36&NID=47> (last visited July 5, 2008).

<sup>54</sup> D.C. STARS, which stands for Student Tracking and Reporting System, is the data system used by DCPS to manage and store students' grades, attendance records, schedules, transfers, and family information. It was introduced at the beginning of the 2005-06 school year.

<sup>55</sup> *Id.* at 7.

Eastern

██████████\* attendance summary from Eastern enumerates numerous unexcused absences from individual classes, but not the number of full days when ██████████\* was considered absent from school. Therefore, the team could not determine whether ██████████\* was absent from school on a particular day, or had a habit of skipping certain classes. Consequently, the team did not have enough information to determine whether Eastern should have followed the various intervention steps articulated in DCPS Directive 522.4. In an interview with the team, the vice principal who, according to notes from the Unity counselor, met with ██████████\* and ██████████\* on May 2, 2006, to discuss her attendance, stated that he could not recall the meeting or any outcomes. Eastern had no documentation of any action taken by school personnel to address ██████████\* absences and/or truancy.

Watkins

██████████\* missed a “██████████\*<sup>v</sup>” and her absences impacted her academics. On ██████████\* attendance record card, someone wrote in large letters and underlined “██████████\*<sup>v>56</sup>” By the end of the school year, ██████████\* had missed roughly the equivalent of ██████████\* weeks of school.

During an interview with the team, Watkins’ principal said that ██████████\* was not a student “who stood out.” He stated that after he learned of her death, he asked his teachers about her and only then learned that she had attended the fourth grade at Watkins. In the course of several interviews with staff and numerous requests for documentation from DCPS, the team could not identify any actions by Watkins personnel, other than one teacher’s telephone calls and notes sent home, to address ██████████\* absences. The team found no documentation to indicate that Watkins personnel completed any of the attendance intervention steps enumerated in DCPS Directive 522.4.

██████████\* cited her father’s illness as the reason for her absences and had mentioned the possibility of the family moving, but her teacher was unable to reach ██████████\* or ██████████\* to discuss the absences. When ██████████\* “disappeared” during the final quarter of the school year and her parents were unreachable, it appears that a home visit, as recommended by DCPS Directive 522.4, would not have been possible because the family apparently had no fixed address after leaving the Shelter. Given the number of absences that ██████████\* had accumulated, Watkins’ guidance counselor should have called the CFSA hotline, per DCPS Directive 522.4, to report suspected educational neglect.

**There is no indication that the ██████████\*/██████████\* family’s apparent interactions with DCPS’ Homeless Children and Youths Program were documented.**

DCPS was unable to provide any substantive information regarding interactions between the Program (when it was under its purview) and the family. An Office of the State Superintendent of Education (OSSE) manager furnished a document dated July 2006 that listed

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<sup>56</sup> The notation is not dated. According to DCMR, “illness or other family emergency which requires the presence of the student in the home” is considered a valid reason for a student’s absence.

the names of “Doubled Up”<sup>57</sup> DCPS students. The names of [REDACTED]\*, [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* were on this list, and “[REDACTED]”\* is identified as their parent. [REDACTED]\* is identified as being enrolled in Eastern; despite the fact that [REDACTED]\* attended Watkins Elementary that spring, the list identifies her “current school” as “n/a.”

No one at DCPS or OSSE stated that they knew how this information was collected, and what action, if any, DCPS took in response to it. The OSSE manager could not provide the team with case file(s) or a referral form for the family. This manager could not determine whether the family was referred to the program or contacted the program on its own volition, or specify why there was no other documentation regarding the family.

The manager further stated that during the period that HCYP personnel appear to have been in telephone contact with the family (January-June 2006), an antiquated data system was in place. Currently, when HCYP opens a case for a student who is homeless, an HCYP employee creates an electronic file and all services are tracked in a database.

The HCYP manager also told the team that some school employees do not think homelessness is an important issue, while others do not understand that students who are “doubled up” or “couch surfing”<sup>58</sup> should be considered homeless. As a result, these students are not reported to HCYP and often go “under the radar.” Moreover, there are 165 DCPS schools that should report data on students who are homeless to HCYP, but during the most recently completed reporting period, only 47 furnished the required data. Schools that do not report data on students who are homeless to HCYP may not receive services that will help meet the needs of homeless students.<sup>59</sup>

### **DCPS lacks social services referral procedures.**

Neither Eastern nor Watkins could provide the team with written policies and procedures that their teachers must follow when they perceive a student’s need for social services. Employees at both schools said in interviews they were not aware of any policies and procedures for referring students to a social services agency or counselor. The lack of clear written guidance may cause confusion among teachers and staff regarding when and how to refer students for social services, and ultimately prevent children from receiving the services they need.

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<sup>57</sup> “Doubled Up” is a descriptor used commonly when referring to children and youths who share the housing of others because they lost their homes due to economic hardship or other like reasons. As stated elsewhere in this report, the team was unable to determine exactly where the family lived between the Hypothermia Shelter and [REDACTED] [REDACTED]\*, although it appears the family stayed with friends, lived in a vehicle, and rented motel rooms during this period.

<sup>58</sup> The program manager explained that “couch surfing” is when students “bounce” from house to house, living temporarily with friends, cousins, grandparents, or other family members.

<sup>59</sup> HCYP must “(1) gather reliable, valid and comprehensive information on the nature and extent of the problems homeless children and youths have in gaining access to public preschool programs and to public elementary schools and secondary schools, the difficulties in identifying the special needs of such children and youth, any progress made by the State educational agency and local educational agencies in the State in addressing such problems and difficulties, and the success of the programs under this subtitle in allowing homeless children and youth to enroll in, attend and succeed in school ....” Title X of No Child Left Behind Public Law 107-110 Sec. 722 (G)(f)(1)

**DCPS' mandated reporters<sup>60</sup> are neither uniformly trained to detect signs of abuse and neglect, nor informed about procedures for referring a child to CFSA.**

The Child Welfare Information Gateway<sup>61</sup> writes:

The first area of defense against the problem of child maltreatment is one of awareness. Each individual who is involved with children has the obligation of knowing the basics of how to protect children from harm .... Educators are an integral part of the community and, as such, can lead and be involved in community efforts to combat child maltreatment.

\* \* \*

Since the early 1980s, school systems ... have enacted school policies and procedures on child abuse and neglect .... A protocol clearly delineates duties and responsibilities for all staff. Equally important, it provides administrative backup for educators who do most of the reporting .... If no such policy or procedure exists, one should be developed .... Policies should be reviewed periodically with school staff (possibly during in-service training) so that everyone is reminded of the local school protocol, system procedures and policies, and State statutes.<sup>62</sup>

Several DCPS teachers interviewed by the team indicated that they had not received training from DCPS on how to detect signs of possible abuse or neglect in their students, or how to report suspected abuse or neglect. The team also learned that some teachers (i.e., mandated reporters) are reluctant to make referrals to CSFA for fear of reprisal from a parent or guardian, while others prefer to refer cases to a school social worker or guidance counselor for him/her to handle in their stead.

**DCPS records for [REDACTED]\* and [REDACTED]\* were incomplete.**

According to DCPS officials we interviewed, there are no standard criteria regarding information and documents that should be maintained in a student's record, and many schools maintain student records differently. The team found that Title 5 of the DCMR provides the following general guidance regarding student records:

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<sup>60</sup> A mandated reporter is a professional who is obligated by law to report known or suspected incidents of child abuse or neglect to CFSA. Such professionals include: mental health professionals; physicians; registered nurses; school officials; social services workers; and teachers.

<sup>61</sup> The Child Welfare Information Gateway is a service of the U.S. Department of Health and Human Services' Administration for Children and Families and provides access to information on topics including child welfare, abuse, and neglect.

<sup>62</sup> The Role of Educators in Preventing and Responding to Child Abuse and Neglect. User Manual Series (2003) Author(s): Office on Child Abuse and Neglect, Caliber Associates. Crosson-Tower., 2003. <http://www.childwelfare.gov/pubs/usermanuals/educator/educatora.cfm>. (last visited July 28, 2008).

2601.1 Official records that are open to inspection and review shall include, but are not necessarily limited to, the following:

- (a) A student's cumulative record folder;
- (b) Any data collected or intended for use within the D.C. Public Schools or intended for distribution outside the school system;
- (c) Identifying data or information;
- (d) Academic work completed;
- (e) Grades and scores and results from achievement tests, criterion referenced tests, standardized tests, norm referenced tests, aptitude tests, and other tests given to students;
- (f) Health data and accident reports;
- (g) Observations and ratings by teachers, counselors, and other D.C. Public School personnel; and
- (h) Reports of behavior or discipline problems or incidents.

2606.1 The student's cumulative record folder shall be maintained by the D.C. Public Schools and may only be destroyed seventy-five (75) years following the student's graduation, transfer, or withdrawal from the school system.

\* \* \*

2606.3 Document(s) other than those in the cumulative record folder, shall be destroyed five (5) years after the student transfers, graduates, or withdraws from the school system. However, documents related to suspensions shall be destroyed at the end of the school year immediately following the conclusion of the suspension period, as required by § 2504.7 of this title.

**██████████ \* Student Record at Eastern**

When reviewing ██████████ \* student record, the team noted missing documents. For example, the file did not have information on the following:

- whether ██████████ \* withdrew or transferred from the school;
- attendance information;
- documentation of ██████████ \* referral to SWWR;

- documentation of the behavior that resulted in her [REDACTED]\*<sup>v</sup>; and
- any record of telephone calls or follow up actions taken by the school with respect to her absences.

A review of call records for the family's primary cell phone found that someone in the family communicated regularly with Eastern from March 2006 until July 2006. Multiple calls between Eastern and a family member occurred on July 19, 2006.<sup>63</sup> However, DCPS was unable to provide any information or documentation regarding Eastern's interaction with the family and any actions the school took to address [REDACTED]\* absences and needs.

[REDACTED]\* Student Record at Watkins

When reviewing [REDACTED]\* student record, the team noted missing documents. For example, the record did not have information on the following:

- enrollment information or forms;
- withdrawal information or forms; and
- a record of any telephone calls or follow-up regarding [REDACTED]\* absences.

The team was unable to determine the exact date on which [REDACTED]\* began attending Watkins or any action taken by school personnel in response to her absences.

#### RECOMMENDATIONS

- That DCPS provide annual training for all school employees to enhance the ability to identify and respond appropriately to the needs of homeless students.
- That DCPS ensure that all schools report data on homeless children to HCYP as required by the McKinney-Vento Homeless Assistance Act.
- That DCPS promulgate uniform, written policies and procedures for referring students to internal and external social services agencies/offices, and disseminate the information to all principals, teachers, and counselors.
- That DCPS ensure that all DCPS mandated reporters receive annual training regarding how to detect abuse and neglect, and develop uniform policies and procedures for reporting suspected cases of abuse or neglect.
- That DCPS implement and promulgate written policies and procedures, based on 5 DCMR §2601.0, that outline what documents and information should be maintained in a student's record.
- That DCPS consider establishing a quality assurance program in each school to ensure that, when implemented, the above recommendations are integral aspects of day-to-day school operations.

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<sup>63</sup> The first call to the CFSA hotline regarding the [REDACTED]\*, [REDACTED]\* family occurred on July 12, 2006.

**SOUTH WASHINGTON/WEST OF THE RIVER  
FAMILY STRENGTHENING COLLABORATIVE (SWWR)**

(MARCH 2006 – MAY 2006)

FAMILY RESIDES IN HYPOTHERMIA SHELTER UNTIL APRIL 10, 2006, THEN DEPARTS  
FOR UNKNOWN LOCATION

Key Findings:

- The family was not classified as “high risk,” however, none of the children were interviewed or received any physical or mental health evaluations, which may have resulted in their being put in a “high risk” category.
- The case manager tried to maintain regular contact with [REDACTED]\* and [REDACTED]\*, however, at times, they were difficult to reach.

After meeting with [REDACTED]\* on March 2, 2006, at Eastern High School, a Unity Health Care social worker stationed at Eastern faxed a *Social Services Referral* form and an *Interagency Client Referral Form* to the South Washington/West of the River Family Strengthening Collaborative (SWWR).<sup>64</sup> On the *Client Referral Form*,<sup>65</sup> the social worker indicated that [REDACTED]\* was homeless and living with her family at the Shelter, and cited the following needs: housing; rental assistance; medical health; family problems; financial training/budgeting; and a Section 8 housing voucher. The social worker classified the family's risk level as "High." The next day, an SWWR employee created an electronic case file for [REDACTED]\* in the Efforts-to-Outcome (ETO) database system.<sup>66</sup> Information entered into ETO included the family's cellular phone number.

On March 7, 2006, an SWWR intake worker met with [REDACTED]\* and [REDACTED]\* for approximately 90 minutes at the SWWR office. Even though [REDACTED]\* was listed as the "client" being referred to SWWR, neither [REDACTED]\* nor any of her sisters appear to have attended this meeting. The intake worker conferred with [REDACTED]\* and [REDACTED]\* and completed an *Intake Form*, a *Family Assessment* questionnaire, and a *Comprehensive Needs Assessment Form*. These forms are intended to capture demographic information, identify the family's primary concerns and issues, and determine the family's risk level.

#### **Intake Form**

[REDACTED]\* and [REDACTED]\* indicated monthly income of [REDACTED] [REDACTED]\*<sup>v</sup> and [REDACTED] [REDACTED]\*<sup>v</sup>, and that the family was living in the Shelter. The only expense reported was a \$40 monthly telephone bill. The couple identified housing, medical health, and education as areas where they needed assistance. [REDACTED]\* and [REDACTED]\* reported that they did not have an active case with CFSA and that they had no prior cases with the agency.

#### **Family Assessment Questionnaire**

The SWWR intake worker completed the questionnaire to determine the family's risk level. This survey tool contained 13 psychosocial categories such as emotional stability, parenting skills, coping skills, and family interaction. The assessment tool rated the family at a

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<sup>64</sup> Created in 1996, SWWR is a non-profit organization that develops and coordinates resources and services within the community. Some of SWWR's services include case management, crisis intervention, job training, and housing placement. SWWR's goal is to conduct preventative work within the community that decreases removal of children from homes.

<sup>65</sup> SWWR distributes these forms within the community so that anyone (including family members, government agencies, and school officials) can refer individuals who need assistance to SWWR. Referrals can also be made in person or by telephone. The social worker told the team that she couldn't remember why she referred [REDACTED]\* to SWWR instead of another agency, but that she typically referred a family to an organization near a family's residence. The social worker said the family needed a "hands-on" social worker, and that SWWR was "good" and family oriented.

<sup>66</sup> Each Collaborative under the Healthy Families/Thriving Communities Collaborative Council enters information into the ETO database, but may only view the information that it entered. One Collaborative cannot view the information entered by another. Currently, the system tracks demographic information, service plans, contacts the social worker has made with the family, risk assessments, closing summaries, and supervisor notes. Select Collaborative Council staff members have access to all data. External entities, such as CFSA and TCP, do not have access to the ETO database.

“Medium” risk level due to problems with emotional stability, finances, employment, homelessness, health, support systems, and coping skills. The last question alone specifically addresses “Child(ren) Problems.” Based on [REDACTED]\* and [REDACTED]\* answer, this received the lowest risk assessment: “No Problem: child(ren) have no/minor emotional, behavioral, intellectual, or physical problems.”

**Intake/Initial Assessment Form, Comprehensive Needs Assessment**

The *Comprehensive Needs Assessment* form is designed to capture detailed client history information. The SWWR intake worker recorded information, as relayed by [REDACTED]\* and [REDACTED]\*, in a number of subject areas. A summary of relevant information reported by the couple is presented below.

***Physical Health Status/History:*** [REDACTED]\* reported that he was on medication for [REDACTED] [REDACTED]\* and that he was scheduled to have a [REDACTED]\* examined.

***Mental Health Status and History:*** [REDACTED]\* reported that she felt depressed “sometimes” and that she was “anxious to get a home of their own.” She also stated that her [REDACTED]\* was [REDACTED]\*. [REDACTED]\* reported that when he was [REDACTED] [REDACTED] but he could not recall the type of diagnosis. He also reported that he wanted to “get things back on track.”

***Substance Abuse History:*** [REDACTED]\* and [REDACTED]\* both reported that they did not have problems related to alcohol or drugs, and they had never been treated for substance abuse.<sup>67</sup>

***Housing History and Status:*** They reported that they had been living at the Shelter for the past 2 months, and that within the past 5 years, they had relocated twice. They said the first move occurred because a neighbor was harassing their daughter and in the most recent instance, they left their apartment due to housing code violations. The couple reported that they had never applied for Section 8 or public housing.

***Financial Status:*** [REDACTED]\* reported an outstanding debt of \$2,500 on an Oxon Hill, MD rental apartment. [REDACTED]\* reported that she had never filed for child support nor was she receiving any child support payments.<sup>68</sup>

***Social Support Status:*** The couple stated that they had family in the area, but that their relationship with them was “not good” and that they did not receive financial support from them.

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<sup>67</sup> One week later during an assessment completed by a housing counselor with Families Forward [REDACTED] [REDACTED] used [REDACTED]\* in the past 6 months.

Based on the frequency of calls (i.e., 10-12 times some months) placed from the family’s cell phone to the MD Department of Human Resources’ Child Support Enforcement Division, and the existence of checks dating back to 2005, the team surmised that [REDACTED]\* may have been receiving child support payments when she made these statements.

*Notes:* The SWWR intake worker included a summary assessment of the meeting:

The family reported having unstable housing for over 5 years. Currently the most pressing issues are [REDACTED]\* health, he has a [REDACTED]\* that they report having received conflicting diagnosis [sic] about .... [T]hey are having difficulties identifying which managed care provider they have been assigned to for health insurance. The other pressing issue is the Shelter is scheduled to close on March 31, 2006. The couple report they don't have a case manager and they believe the staff will not help them. This writer spent a lot of time challenging what seemed to be unrealistic expectations about being placed in housing w/o either of them having employment .... Although both parents denied having current mental health challenges this writer detected some challenges in thought and reasoning ....

Taking into consideration the information reported on the Family Assessment Form, the SWWR intake worker assigned [REDACTED]\* and [REDACTED]\* a Risk Level Assessment of "Moderate."

### **Case Management**

On March 9, 2006, SWWR transferred management of the [REDACTED]\*/[REDACTED]\* family's case to the Capitol Hill Group Ministry (CHGM).<sup>69</sup> A licensed Graduate Social Worker and Family Services Coordinator (coordinator) from CHGM was assigned to provide case management services to the family. The coordinator telephoned [REDACTED]\* and [REDACTED]\* on March 16, 2006. According to case management notes, during the call "[REDACTED]\*] reported some confusion regarding [the coordinator] and [CHGM] .... [REDACTED]\* explained confusion [that resulted from the] number of calls received promising help only to find help was not possible." The couple agreed to meet the coordinator at the Shelter.

The coordinator met with [REDACTED]\*, [REDACTED]\*, and their four daughters on the evening of March 17, 2006. During the meeting, [REDACTED]\* and [REDACTED]\* articulated three primary goals that were documented in a case plan. They reported that they wanted to: (1) find a three bedroom apartment or house; (2) address [REDACTED]\* medical issue; and (3) obtain assistance with issues regarding [REDACTED]\* education.

The following is a summary, compiled by the evaluation team through document review and interviews, of the extensive actions taken by the CHGM coordinator in an effort to help the family reach the goals enumerated in the case plan.

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<sup>69</sup> SWWR assigns cases to the CHGM. Under contract to SWWR, CHGM operates a Family Resource Center that provides services such as counseling, parenting skills, and employment readiness to unstable families within close proximity to the Center.

**Goal 1: Locate a three-bedroom apartment/house**

According to interviewees, The Community Partnership for the Prevention of Homelessness (TCP) approved<sup>70</sup> ██████ for the Community Care Grant 2 (CCG2) program on March 9, 2006.<sup>71</sup> In order to be eligible for the CCG2 program, an applicant must reside in a District shelter, be referred by a shelter staff representative, have sufficient income to maintain housing absent a temporary rent subsidy from TCP, and be able to retain a lease as the primary lease holder. Given the family's potential obstacles in meeting the minimum income requirements for CCG2, CHGM also attempted to locate housing for the family through the DCHA. The CHGM coordinator contacted DCHA on April 7, 2006, and determined that the family was on the DCHA waiting lists.

On April 11, 2006, the CHGM coordinator tried contacting the couple at the Shelter and learned that the family had left 2 days prior. A Families Forward employee at the Shelter told the CHGM coordinator that ██████\* decided the family should leave due to a confrontation ██████\* had with another resident. The Families Forward employee also told the CHGM coordinator that the family had been approved for the Shelter Plus Care (S+C) program, a grant program administered by TCP that provides permanent housing subsidies to homeless individuals with specific, certified disabilities. (See page 73.)

Families Forward, according to notes, was not aware that SWWR and CHGM were working to help the family obtain housing. The CHGM coordinator contacted TCP on April 12, 2006, to inquire about the S+C program and learned that only individuals who have a mental health condition, substance abuse problem, and/or are HIV-positive are eligible.

The CHGM coordinator reached out to the family on April 12, 2006, and spoke with ██████\* on the telephone. ██████\* said the family had left the Shelter, but did not indicate where the family was staying other than that the family was living with relatives. ██████\* also informed the CHGM coordinator that the family had been approved for another housing voucher, but ██████\* did not know which program. ██████\* came to the CHGM office on April 13, 2006, and after discussing the family's case with ██████\*, the coordinator accompanied her to the family's car. She saw ██████\* and the four girls, and later commented in her notes "children were neat and clean."

The CHGM coordinator made several attempts to contact ██████\* and ██████\* via telephone following the April 13, 2006, visit, but could not reach them. She eventually reached

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<sup>70</sup> The team found no signed application documents or correspondence to corroborate their approval into the program; furthermore, the team could not identify the referral/application/approval process that was administered.

<sup>71</sup> CCG2 is a federal program that was established to provide temporary assistance with a support services option to homeless families within the District of Columbia's shelter system. The goal of the program is "to provide families with an array of resources through the allocation of rent subsidies and support services that will ultimately result in housing stability and independence." If approved for the CCG2, TCP refers the applicant to a Family Support Center (FSC) within the District, which in turn assists the family with obtaining housing and learning how to live without a housing subsidy. The family support worker also conducts a psychosocial assessment of the applicant, establishes a financial spending plan to meet the housing and financial needs of the family, and selects one of the following subsidy terms:

- A. Short term subsidy with no support services (6 months or less);
- B. Intermediate subsidy with support services (1 year or less); or
- C. Long-term subsidy with support services (12 – 18 months).

the family via telephone on May 9, 2006, and [REDACTED]\* reported that he had identified three housing prospects. The CHGM coordinator called the family six times between May 9, 2006, and May 30, 2006, and left voice messages, but received no response. Consequently, CHGM sent the family a letter on May 31, 2006, stating that their case was closed “because [their] needs were being met through another agency.” The case closure letter was addressed to [REDACTED]\* and, in an obvious error, was mailed to “50 Massachusetts Avenue, N.E.” (Union Station).

[REDACTED]\* next contact with CHGM came on July 11, 2006, when he made an unscheduled visit to the office during which he informed the coordinator that the family still had not found housing. During another meeting 2 days later, [REDACTED]\* revealed that the family was living out of a van; CHGM did not report this information to the CFSA hotline. (See page 90.)

**Goal 2: Address [REDACTED]\* medical condition**

During the CHGM coordinator’s initial meeting with the couple on March 17, 2006, she learned that [REDACTED]\* and [REDACTED]\* were having difficulty switching from Amerigroup to Chartered Health Plan (Chartered). She also learned that [REDACTED]\* needed treatment for what he believed to be a [REDACTED]\*, and that he could not afford to refill his pain medication prescription. On March 20, the coordinator telephoned [REDACTED]\* and told her that the District’s Department of Health had prescription drug programs that would enable [REDACTED]\* to fill his prescription at a reduced price or for free.

[REDACTED]\* met with the coordinator at the CHGM office on April 4, 2006, and informed her that [REDACTED]\* had [REDACTED]\*. He was waiting for the [REDACTED]\*. Two days later, the CHGM coordinator contacted Chartered to confirm that the family was enrolled and that their health insurance cards were being sent to the Shelter. On April 12, the CHGM coordinator spoke with [REDACTED]\* and learned that a [REDACTED]\*. As noted above, there was a lapse in communication with the family for a period of about 3 weeks. On May 9, the CHGM coordinator finally spoke with [REDACTED]\*, who told her his [REDACTED]\*. Again, CHGM had no further contact with [REDACTED]\* until he visited their office (1227 G St., S.E.) on July 11, 2006.

**Goal 3: Educational Assistance**

During the CHGM coordinator’s initial meeting with the family, [REDACTED]\* asked for help in modifying [REDACTED]\* class schedule and updating her school record so that it would reflect the correct spelling of her name. [REDACTED]\* believed that Eastern had an incorrect spelling of [REDACTED]\* name on her record and, as a result, the school recorded her as absent on days when she was present.

When the CHGM coordinator spoke with the family on March 30, 2006, she learned that [REDACTED]\* name had been corrected on school records, but that she had been [REDACTED]\*<sup>√</sup> from school for [REDACTED]\*<sup>√</sup>. The [REDACTED]\*<sup>√</sup> notice<sup>72</sup> that [REDACTED]\* and [REDACTED]\* presented stated that [REDACTED]\* had not reported to her classroom after being instructed to do so by school officials, and that she had caused a disturbance. [REDACTED]\* and [REDACTED]\* explained that they made requests to

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<sup>72</sup> It is important to note that neither Eastern nor DCPS officials were able to provide the evaluation team with a copy of the suspension notice or any information regarding [REDACTED]\* [REDACTED]\*<sup>√</sup>.

meet with school staff but were unsuccessful in securing an appointment. The coordinator stated that she would contact the Unity Health Care social worker to discuss the situation.

The CHGM coordinator encouraged [REDACTED]\* to enroll [REDACTED]\* and [REDACTED]\* in childcare, a move that would afford [REDACTED]\* and [REDACTED]\* more time to focus on [REDACTED]\* medical care. The girls, however, needed an updated physical exam before they could be admitted into childcare. On March 20, 2006, the coordinator contacted the Children's National Medical Center Mobile Clinic and the Georgetown University Mobile clinic to gather information for [REDACTED]\*. No insurance was necessary, but [REDACTED]\* would have to pay for any lab work that needed to be done. The coordinator spoke with [REDACTED]\* that same day and relayed the information.

When the CHGM coordinator followed-up with the family on March 28, 2006, [REDACTED]\* reported that she had not taken the girls for their physicals because the family's focus was on "getting [REDACTED]\* health in order." On April 6, 2006, the CHGM coordinator called the family and spoke with [REDACTED]\*, who said she had begun the process of registering [REDACTED]\* and [REDACTED]\* at Meridian Public Charter School for the 2006-07 school year, but that she still had not scheduled medical appointments for the girls. As mentioned above, [REDACTED]\* and [REDACTED]\* came to the CHGM office on April 13, 2006. After that visit, [REDACTED]\* apparently fell out of contact with CHGM.

#### **ISSUES AND FINDINGS**

**The family was not classified as "high risk," however, had the children been interviewed or received physical and mental health evaluations, they may have been put into a "high risk" category.**

The SWWR intake worker used a CFSA family assessment tool and concluded that the family's case level was "Medium" or "Moderate." The *Healthy Families/Thriving Communities Collaborative Council Practice Standards Manual (Collaborative Manual)* enumerates the following criteria for "High Risk" cases:

- Walk-ins with little or no information independently provided by sources other than the family.
- Community Referrals with any of the following indicators[:]
  - Active substance use within the past 90 days[ ]
  - Emergency housing issues with minor children involved
  - Suicidal concerns
  - History of mental illness
  - Pregnancy with one of the above issues or pregnancy within the last trimester
  - CFSA involvement or recent history within the past 12 months

In addition, the manual provides that “face-to-face contact on Level 1 cases should occur a minimum of once weekly.”

When [REDACTED]\* and [REDACTED]\* met with the intake worker, they stated that they were homeless and had four minor children. [REDACTED]\* reported that he had been treated [REDACTED]\*, but was not sure of the diagnosis or the name of the facility. All of the information that was provided was self-reported, rather than independently provided or confirmed by sources other than the family. These factors would appear meet the criteria of “high-risk” rather than moderate risk, but as page 31 of the *Collaborative Manual* states, “[c]ase level assignment is part of the overall clinical/risk assessment provided the family. The case level is determined by objective and subjective criteria. Suggested guidelines are not to be used solely as determinants of case levels.”

The *Collaborative Manual* also cites the need to “[e]ngage the family and child fully in the change process,” and evaluate all members of a family.<sup>73</sup>

During the intake and assessment processes, the worker should focus on:

- Carefully assessing the risks to [the] safety of children and the family, particularly those risks that make maltreatment likely to occur, continue or reoccur; . . . .

Through the intervention process, the worker should be mindful to:

- Interview families and children with a focus on potential solutions rather than placing blame;
- Consider both the family and child[ren]’s immediate needs for safety, as well as the longer term needs for growth, healing, and permanency;
- Focus on nurturing families and children, rather than controlling their behaviors; [and]
- Develop specific services that help families and children to build new skills and change[.]

During the intake and case management processes at SWWR, it appears that none of the [REDACTED]\*/[REDACTED]\* children were ever interviewed nor were their needs specifically addressed through physical, mental health, and/or developmental/educational screenings. In fact, the social worker who conducted the initial intake could not recall whether any of the children were present; she told the team she assumed that they were not because there are no notes pertaining to them on the intake forms. During the case management process, the CHGM coordinator provided [REDACTED]\* with information about two mobile health care clinics, and on several

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<sup>73</sup> *Id.* at 14.

subsequent occasions asked [REDACTED]\* whether she had secured appointments for any of her children. Apart from this, there were no indications that the children's physical or mental health conditions were evaluated or even discussed.

The social worker at Eastern faxed the referral to SWWR because she was aware that [REDACTED]\* was living in the Shelter and that her family might need numerous supportive services. Yet, it appears that neither [REDACTED]\*, the impetus for the referral, nor any of her sisters was ever interviewed, either individually or as a group.

The team could not identify a specific negative effect caused by the fact that the girls were never interviewed or their individual needs assessed. However, given that a Collaborative is responsible for keeping children safe from abuse and neglect and "[r]ecognizing that child maltreatment may be a symptom of other problems and underlying needs,"<sup>74</sup> it seems reasonable that it would be important to obtain information directly from [REDACTED]\* and the other children, as practicable, to (1) determine whether the health and safety of any of the children were at risk, and (2) more accurately define each child's needs.

A SWWR employee explained that when they receive a referral, the primary goal is to empower the child's parents so that the parents can improve the entire family's well-being.

**The CHGM case manager attempted to maintain regular contact; at times the family was difficult to reach.**

According to the *Collaborative Manual*,<sup>75</sup> when a family is classified at a moderate risk level, the case manager is supposed to have face-to-face contact with the family twice per month, at a minimum.<sup>76</sup> The CHGM coordinator did not see the family twice per month as required. The CHGM coordinator maintained routine telephone contact with the family between March and May 2006; however, she only met with the family on three occasions during this period. According to her notes, she saw the family on March 17, April 4,<sup>77</sup> and April 13, 2006. Per the *Collaborative Manual*, it seems she should have met with the family a minimum of five times. However, it appears [REDACTED]\* and [REDACTED]\* did not always respond to telephone calls and voice messages.

The family moved out of the Shelter without notifying the CHGM coordinator or informing her of their new residence. [REDACTED]\* and [REDACTED]\* became less responsive to the CHGM coordinator's telephone calls and voicemail messages in mid-April and they were apparently non-responsive to calls and messages after May 9, 2006. Prior to closing the family's case, the coordinator contacted a Families Forward employee who informed her that the family was actively working with a case manager to secure housing.

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<sup>74</sup> *Id.* at 12.

<sup>75</sup> SWWR's Deputy Director assigns cases to CHGM and supervises their management. SWWR's Practice Standards Manual contains standard operating procedures that SWWR and CHGM employees should follow when providing case management services to clients.

<sup>76</sup> Practice Standards Manual Section 6.6B

<sup>77</sup> Case management notes stated that the coordinator was scheduled to see the family on April 3, 2006, but there are no notes documenting whether this visit took place. The CHGM coordinator could not recall whether this visit occurred.

**The Collaborative was thorough and detailed in its documentation of interactions with the family.**

SWWR provided the team with extensive, detailed case management notes, which contributed greatly to the team's understanding of the information and services provided to the family. From the team's perspective, it appears that SWWR and CHGM were diligent and thorough in their efforts to chronicle their efforts on behalf of the family. One SWWR employee noted, however, that there should have been additional documentation in the case file such as a copy of the S+C contract confirming the family's acceptance into the program, a family budget worksheet, and additional school enrollment information for [REDACTED]\*.

[REDACTED]\* and [REDACTED]\* authorized SWWR to request information from TCP, the Social Security Administration, Chartered, Eastern, Families Forward, and the DCHA, but the team found no documentation from any of these entities in the family's SWWR file. The CHGM coordinator documented telephone conversations that she had with individuals from these organizations, but it appears that none of them provided documentation pertaining to the family.

**Though approved, the family did not obtain housing through the Community Care Grant 2 Program.**

Between March and May 2006, the [REDACTED]\*/[REDACTED]\* family was concurrently working with case managers at both SWWR/CHGM and Families Forward in an effort to locate housing. SWWR/CHGM was attempting to locate housing under the CCG2 Program, while Families Forward was coordinating [REDACTED]\* application to the S+C Program. (For a period, the organizations were unaware that both were working on the family's behalf.) Although the family was approved for and could have used either housing subsidy, it was more advantageous for them to pursue the S+C subsidy. TCP's Executive Director speculated that once [REDACTED]\* had been approved for the S+C program, the family pursued that benefit more aggressively than the CCG2 grant because S+C is a permanent housing subsidy, while the CCG2 subsidy had a maximum term of 18 months.

**SWWR closed the case after the family became non-responsive to contacts.**

According to SWWR procedures, a worker preparing to close a case must:

review with his or her supervisor their work with the family, what has been done about the situation that first brought the family to the Collaborative, and what the current risk factors are. The worker should coordinate a family team meeting including other community supports and service providers that have been involved with the family, to jointly discuss what has been done and whether this case is stable enough for closure. All cases must go through Case Review before closure.

On May 3, the CHGM coordinator presented the [REDACTED]\*/[REDACTED]\* case to the SWWR Deputy Director for Case Review. The coordinator reported that the family had become non-

responsive and she had not had contact with them for approximately 3 weeks. She also noted that a Families Forward employee told her that [REDACTED]\* had been asked to leave the Shelter due to an act of violence.<sup>78</sup> The SWWR Deputy Director recommended that the coordinator send a letter to the last known address, contact [REDACTED]\* in writing through Eastern, and if there was no response, begin closing their case. Consequently, on May 9, the CHGM coordinator spoke with [REDACTED]\* on the telephone. She learned that he was undergoing [REDACTED]\* treatments and that he had identified three housing prospects. Following this conversation, the family became non-responsive to telephone calls and voicemail messages; according to the CHGM coordinator, she called the family on May 22, 23, 24, 25, 29, and 30, 2006. SWWR protocols state that if a family is non-responsive over a 30 day period, this constitutes case closure. The [REDACTED]\*/[REDACTED]\* case was closed on May 31, 2006, apparently as a result of their being non-responsive, and due to the fact that the family had been approved for participation in the S+C program.<sup>79</sup>

### **RECOMMENDATION**

That SWWR, along with the District's other Healthy Families/Thriving Communities Collaboratives, explore ways to enhance its procedures and capabilities for assessing clients' needs so that each individual family member (especially children) and the family as a unit, receive appropriate, targeted assessments and services.

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<sup>78</sup> According to Families Forward, [REDACTED]\* was not asked to leave the Shelter.

<sup>79</sup> SWWR invoiced TCP for a total of \$2,000 for case management services provided to the family in April 2006 and May 2006.



**██████████ \* SHELTER PLUS CARE (S+C)  
PROGRAM APPLICATION**

(APRIL 2006)

FAMILY RESIDES THE HYPOTHERMIA SHELTER, THEN  
DEPARTS FOR UNKNOWN LOCATION

Key Findings:

- ██████████ \* S+C Program application lacked required documentation, but he was still certified as having a ██████████\*<sup>v</sup> and was accepted into the program, which provides a permanent housing subsidy.

### **S+C Program Background**

The U.S. Department of Housing and Urban Development (HUD) awards S+C program funds to state and local governments “to serve a population that has been traditionally hard to reach – homeless persons with disabilities such as serious mental illness, chronic substance abuse, and/or AIDS and related diseases.”<sup>80</sup> The S+C program aims to provide participants with both financial assistance for rental housing (e.g., permanent monthly rent payments) and supportive services, such as counseling, treatment, and education to help participants maintain their housing and enhance their life skills. The program has a “matching requirement,” which requires grant recipients to match the amount of rental assistance with an equal amount of support services from other sources.<sup>81</sup>

The District’s Department of Housing and Community Development (DHCD) directly receives federal S+C program funds and is considered the grant recipient for the District, or the grantee.<sup>82</sup> Grantees are responsible for the grant, but may delegate program responsibilities to one or more sponsors. TCP is considered a S+C program sponsor and is responsible for applications to and the administration of the S+C program for the District.

In FY 2006, HUD awarded DHCD over \$3.4 million in S+C funds to place homeless individuals and families in approximately 250 units. According to TCP, it met this target and was able to secure many of the units at rental rates below fair market value. By doing so, TCP was able to “save” roughly \$1,300,000 in S+C grant funds. In December 2005, the D.C. Department of Human Services (DHS) hosted a “Homelessness No More” service fair with the goal of transitioning families from District homeless shelters into homes. TCP participated in the fair with the intent of using the \$1,300,000 in unspent S+C funds to house additional program participants. This funding was referred to as “the S+C Spend Down” initiative and participants who received housing subsidies through the S+C “Spend Down” were referred to as “expansion” or “spend down” families.

Ninety-eight families, including the ██████████ \* ██████████ \* family, eventually received housing subsidies through the spend down initiative. Some homeless individuals/families came to the December 2005 service fair and were referred to participating agencies that day. Others, such as the ██████████ \* ██████████ \* family, did not attend the fair but learned of the S+C program through other sources.

### **██████████ \* Applies for the S+C Program**

In January 2006, a Families Forward seasonal employee (FF counselor) who was employed part-time as a housing counselor during the hypothermia season, began working with ██████████ \* and ██████████ \* at the Hypothermia Shelter. The FF counselor first assisted them with completing applications for rental housing located in the community.

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<sup>80</sup> [Http://hudhre.info/index.cfm?do=viewSpResourceManSec1-1](http://hudhre.info/index.cfm?do=viewSpResourceManSec1-1) (last visited June 5, 2008).

<sup>81</sup> <http://hudhre.info/index.cfm?do=viewShelterPlusCare> “Requirements and Responsibilities” (last visited July 9, 2008)

<sup>82</sup> Sponsors are usually nonprofit organizations that provide housing and/or support services that enable participants to maintain their housing and address treatment needs. See <http://hudhre.info/index.cfm?do=viewSpResourceManSec1-4> (last visited June 5, 2008).

<sup>83</sup> TCP stated that a total of 98 families were housed between December 2005 and January 2007 (14 months).

According to the FF counselor, ██████████\* was “more aggressive than ██████████\*,” as he did all of the talking and handled the family’s affairs. The family was on housing program waiting lists at DCHA, but in talking about his personal history, ██████████\* told the FF counselor that in the past he had “██████████\*.” The FF counselor recalled that as ██████████\* talked “light bulbs went off” that he might be a candidate for the S+C Program.

In consultation with ██████████\*, the FF counselor completed TCP’s *Shelter Plus Care Permanent Housing Application* for ██████████\* signature. The application lists ██████████\* and the four children as other persons who would reside in the “Shelter Plus Care” unit with ██████████\*. The FF counselor indicated on the application that ██████████\* had “██████████\*” and that ██████████\* had ██████████\* within the past 6 months. In response to a question about whether the candidate has been diagnosed with mental illness, the FF counselor circled “N” for no.<sup>84</sup> Based on his assessment of ██████████\*, he indicated on the application form that ██████████\* needed “Case Management” and “██████████\* services.” The box recommending “Mental Health services” was not checked. Both ██████████\* and the FF counselor signed the application, and dated their signatures for March 31, 2006. As part of the application, ██████████\* also signed TCP’s *S+C Supportive Services Agreement*. The FF counselor faxed the application to TCP on March 17, 2006.

It appears that the application was not considered complete because in a letter to TCP dated April 2, 2006, the FF counselor provided additional information regarding ██████████\* “██████████\*” and noted the following:

██████████\* feels in patient or outpatient ██████████\* treatment is not needed at this interval of time. Currently he is being treated for ... ██████████\* condition .... ██████████\* further stated it was because of the excruciating pain he was experiencing the past 24 months from his illness that forced him back to ██████████\*. ██████████\* plans to enroll in an out patient treatment program ██████████\* after the operation and rehabilitative period for the fore-mentioned illness.

On April 5, 2006, an internal medicine physician with the District’s Addiction Prevention and Recovery Administration (APRA) ██████████\* had “██████████  
██████████  
██████████” \*

Several days later, ██████████\* decided to voluntarily leave the Shelter and said he was taking his family to live with relatives until a determination was made on his S+C application. Shortly

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<sup>84</sup> The team found two slightly different versions of ██████████\* S+C application. On the copy obtained from Families Forward, “N” is circled in response to the question regarding the diagnosis of mental illness. On a copy of the application obtained from TCP, the page that contains the same question is numbered differently from others around it, and “Y” is circled as the response. The application form states “Psychiatric Assesment [sic] Must Be Included,” but the team found no assessment on file at TCP with ██████████\* application.

thereafter, ██████████\* S+C application was approved,<sup>85</sup> and Families Forward continued working with the family to find them housing. According to cell phone call records, the family stayed in regular contact with the FF counselor after leaving the Shelter in April 2006 until they were ultimately placed in ██████████\* on August 25, 2006.

### ISSUES AND FINDINGS

#### ██████████ \* **S+C Program application lacked required documentation.**

The evaluation team did not have the information or medical expertise necessary to determine whether ██████████\* was an appropriate candidate (i.e., had one or more of the qualifying disabilities) for the S+C program. However, the team noted that ██████████\* ██████████\* despite not having the required documentation. In fact, during an interview with the team, ██████████\* believed he was only attesting that ██████████\* should receive ██████████\* services once accepted into the S+C program, not that he had a ██████████\* .

TCP's S+C application guidelines state that in order to certify a candidate's ██████████ abuse disability\*, the following documentation is required: (1) recent drug screen results; and (2) official documentation from the referring agency/treatment program that verifies the candidate's ██████████\* ██████████\* history. The team found no evidence that APRA's certifying agent reviewed ██████████\* results for ██████████\* , or even met with him. Furthermore, the April 2, 2006, letter from the FF housing counselor to TCP is not adequate documentation of a ██████████\* history.<sup>86</sup> The APRA employee who certified ██████████\* ██████████\* also admitted to the team that he had not maintained records or documentation of any of the S+C certifications he had completed. In short, it appears that the ██████████\* ██████████\* based solely on information reported by ██████████\* to the FF housing counselor.

██████████\* may have had a certifiable ██████████\* , but the team believes that, in line with S+C program requirements, his application should not have been approved because it lacked the requisite documentation.<sup>87</sup>

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<sup>85</sup> The inspection team found no documentation to this effect, but according to CHGM case management notes, the CHGM coordinator spoke with Families Forward on April 11, 2006, and learned that the family had been approved. Given the lack of documentation of the approval, it is also unclear how this approval was communicated to ██████████\* .

<sup>86</sup> HUD guidelines state that “[k]ey to the definition [of disability] is determining that the impairment is of long-continued and indefinite duration AND **substantially impedes** the person’s ability to live independently .... Written documentation that a person’s disability meets the program definition must come from a credentialed psychiatric or medical professional trained to make such a determination. The possession of a title such as case manager or substance abuse counselor does not by itself qualify a person to make that determination. ‘Self-certification’ is also unacceptable.” HUDHRE, info, <http://hudhre.info/index.cfm?do=viewSpcResourceManSec2-2&printfriendly=true> (last visited Oct. 16, 2008) (emphasis in the original).

<sup>87</sup> On June 17, 2008, the OIG issued a Management Alert Report (MAR) titled “APRA Employee Improperly Certifying Substance Abuse Disabilities on Federally Funded ‘Shelter + Care Program’ Applications.” (See [oig.dc.gov](http://oig.dc.gov).) According to information provided by TCP in response to the MAR, 96 APRA-certified individuals were still participating in the S+C program as of June 18, 2008.

**██████████ \* did not receive services or counseling to help him transition into S+C program housing.**

The team found nothing to suggest that ██████████ \* participated in the S+C “engagement” process, the goal of which is to determine whether a program participant is prepared to transition into housing. According to S+C policies and procedures, the sponsoring agency should review a copy of the candidate’s application package, meet with the candidate, and if the agency accepts the candidate, then begin to engage and prepare the candidate for placement in housing. During the engagement process, the sponsoring agency is “expected to implement a team approach with member(s) from the referring agency” and “work together to ensure that all information regarding the candidate is discussed and understood.” The goal of the engagement process is to ensure that all of the candidate’s supportive service and housing needs have been identified prior to placement in housing.

It appears that because ██████████ \* was never paired with a sponsoring agency, he did not receive the evaluation and guidance typically provided as part of the S+C engagement and placement process.

**The family was not promptly placed in housing after ██████████ \* certification for the S+C program.**

Once the “expansion” candidates were certified, the family could begin looking for housing. ██████████ \* was certified on April 6, 2006, and he and the FF consultant began visiting potential units shortly thereafter. According to case management notes, ██████████ \* visited several units over the next 3 months but rejected them for various reasons (e.g., concern regarding the safety of a neighborhood.) It took 4 months for the family to locate suitable housing and complete the S+C placement process. There does not appear to have been any delay in placement caused by poor S+C program administration.

#### RECOMMENDATIONS

- That TCP ensure that all candidates certified to participate in the S+C program are paired with a sponsoring agency and appropriately evaluated and counseled prior to being placed in housing.
- That TCP periodically audit the certification process and ensure that candidates are certified in accordance with S+C policies and procedures.



**INCOME MAINTENANCE ADMINISTRATION (IMA)**  
**RECERTIFICATION**  
(JUNE 2006)  
FAMILY'S RESIDENCE UNKNOWN

Key Finding:

- The recertification process was handled efficiently and the family experienced no disruption in their [REDACTED]\*<sup>v</sup>

\*√

#### ISSUES AND FINDINGS

##### **The benefits recertification process was handled efficiently.**

According to IMA Medical Review Team documentation, the determination that [REDACTED]\* was “[REDACTED]\*” should have been reviewed again in May 2006. The team found no documentation that this review was ever conducted, but also did not identify a specific, negative consequence to [REDACTED]\*. Apart from this omission, it appears the recertification process was handled efficiently and that the family experienced no disruption in benefits.

##### **[REDACTED]\* used the Shelter address on the recertification form, even though the family had moved out several months earlier.**

IMA officials told the team that it is common for benefits recipients to have outdated addresses on file because they tend to be transient - staying with friends, relatives, etc. Similarly, a Families Forward employee said that any mail (i.e., IMA benefits correspondence) sent to the family after they had left the Shelter would have been held in the mailroom and the family could have picked it up if they returned to the facility.<sup>88</sup>

The *Record of Case Action* dated June 1, 2006, states the family’s residence at the Shelter was verified by a letter from the Shelter,<sup>89</sup> but as noted above, the family left the Shelter on April 9, 2006. The Shelter closed for the season on April 30, 2006.

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<sup>88</sup> Families Forward informed that team that it sent an employee to the main mail room at D.C. General to see whether any of the family’s mail was still at the facility; there was none.

<sup>89</sup> The team found no such letter.

CHARTERED HEALTH TELEPHONE CONVERSATION  
WITH [REDACTED]\*  
(JUNE 16, 2006)  
FAMILY'S RESIDENCE UNKNOWN

Key Findings:

- [REDACTED]\* admits [REDACTED]  
[REDACTED]\*
- Behavioral health case manager suggests [REDACTED]\* obtain a [REDACTED]\*  
evaluation and provides her with contact information for a [REDACTED]\* services  
provider, but [REDACTED]\* never scheduled an appointment.

[REDACTED]\* was enrolled in the D.C. Chartered Health Plan<sup>90</sup> on March 23, 2006.<sup>91</sup> Soon thereafter, he was diagnosed with [REDACTED]\* and began treatment through George Washington University Medical Faculty Associates (GWUMFA). He was admitted to George Washington University Hospital for treatment on May 24, 2006, and stayed until June 4, 2006, at which time he was discharged ‘ [REDACTED] [REDACTED].\*’<sup>92</sup> [REDACTED]\* was re-admitted to the hospital on June 8 with ‘ [REDACTED] [REDACTED]\*’ listed as symptoms attributing to his health condition and severe pain. During this hospital stay, [REDACTED] [REDACTED]\*. On June 13, 2006, [REDACTED]\*, against medical advice, left the hospital.

Two days later, according to case management comments reviewed by the team, [REDACTED] [REDACTED] [REDACTED].\* Chartered case management comments, time-stamped the afternoon of June 16, 2006, document the following telephone conversation between [REDACTED]\* and the case manager:

[REDACTED]

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<sup>90</sup> Established in 1987, D.C. Chartered Health Plan, Inc., (Chartered) is a privately owned company that participates in the District of Columbia Medicaid Managed Care Program.

<sup>91</sup> [REDACTED]\* and her daughters were enrolled several weeks later.

<sup>92</sup> GWUMFA Case Notes from June 8, 2006.

<sup>93</sup> The daily census report identifies the names of Chartered members recently admitted to medical facilities, their medical histories, and recent diagnoses. One job duty of a behavioral health case manager is to review the report, reach out to the member telephonically, determine whether the member needs/is amenable to being referred for behavioral health services; if so, the case manager refers the member to a behavioral health services provider.

<sup>94</sup> The team reviewed call records for the [REDACTED]\* [REDACTED]\* cell phone and found no record of a June 16, 2006, call from the cell phone to Chartered. However, on that same date, the family’s cell phone received a call from Chartered’s toll-free number that lasted approximately 9 minutes. The team also asked the Chartered case manager to review her notes from June 16, 2006; she stated they were accurate but could not remember any other details from that day.



In an interview with the team, Universal management contended that a referring agency should forward to them a referral document for the individual suspected of needing mental health services. Universal believed the referring entity should not rely upon an individual who is suspected of needing mental health services to voluntarily schedule and keep an appointment with the service provider. The Chartered behavioral health case manager said that she did not know whether [REDACTED]\* acted on the suggestion, as she was not required to follow-up with the client.

The evaluation team reviewed Universal's electronic records and found no information that would indicate Universal received any referrals and/or provided any services to any member of the [REDACTED]\*/[REDACTED]\* family.

#### **RECOMMENDATIONS**

- That Chartered ensure that all employees who are considered mandated reporters receive regular training and information regarding District statutes pertaining to and proper procedures for reporting known or suspected child abuse and neglect.
- That Chartered, in consultation with its mental health services providers, strengthen its referral and reporting/follow-up procedures, in particular to better deal with instances when minor children are in the care of a person who would benefit from a mental health evaluation.

**CHARTERED HEALTH CALL TO CFSA HOTLINE**  
(JULY 12, 2006)  
FAMILY'S RESIDENCE UNKNOWN,  
INDICATIONS THEY WERE RESIDING IN MD MOTEL

Key Findings:

- Despite a clear allegation of child neglect, CFSA did not act upon any of the information provided by the hotline caller.
- No one reviewed the CFSA hotline worker's decision to classify the call as an "Information and Referral," rather than one that merited investigation.
- CFSA was working in isolation. The [REDACTED]\* [REDACTED]\* family was known to multiple District entities.

On July 12, 2006, the Chartered behavioral health case manager called the family's primary cell phone at 12:09 p.m. in an attempt to reach [REDACTED]\*. She reached [REDACTED]\*, however, and the two spoke for approximately 6 minutes.<sup>97</sup> According to the case manager, [REDACTED]\* sounded "[REDACTED]\*" and as the conversation progressed, [REDACTED]\* became angrier. The case manager speculated to the team that [REDACTED]\* anger was due to the family's housing situation. At 12:43 p.m., the Chartered case manager telephoned (202) 671-SAFE, CFSA's Child Abuse and Neglect Hotline (hotline), and spoke with a CFSA hotline worker (HW#1). The case manager documented neither her call to [REDACTED]\* nor her call to CFSA; there is no reference to either in Chartered's case management comment system. Therefore, the only documentation of the call is the following summary of the conversation, which was written by HW#1.

[REDACTED]

Additional information captured in CFSA's documentation of the telephone call includes a work telephone number for the case manager, and a "[REDACTED]"<sup>v</sup> of an apartment at "[REDACTED]"<sup>v</sup> Washington, D.C. Based on the entry of this address, CFSA's FACES<sup>99</sup> system "auto-filled" into the *I&R Summary Report* form the name of the Collaborative corresponding to the address, "[REDACTED]"<sup>v</sup> Collaborative. For reasons the team was unable to determine, CFSA's documentation of the call does not include

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<sup>97</sup> There were no notes regarding this call in Chartered's case management comments, but call records for the family's cell phone show the incoming call from Chartered. Records also show two calls from the family's primary cell phone to Chartered later in the afternoon. One call lasted 11 seconds; the other lasted 7 seconds.

<sup>98</sup> Based on a review of call records for the family's cell phone, it appears that the Chartered case manager did initiate a call on July 12, and assuming that CFSA's documentation is correct, telephoned the hotline shortly after concluding the call with [REDACTED]\*. The team was unable to determine why, if the case manager spoke with [REDACTED]\* and the CFSA hotline on the same day, the CFSA narrative indicates the case manager had been "[REDACTED]" in trying to contact the family.

<sup>99</sup> FACES is CFSA's client information database.

the telephone number used by the Chartered behavioral case manager to contact [REDACTED]\* earlier in the day.

In an interview with the team, the case manager said she reported the family to CFSA because she was concerned they were living in a van in July. The case manager believed that the address included in the CFSA report of the call came from Chartered's member information database. She could not recall the phone number she used to telephone the family, or whether she provided that number to the CFSA hotline worker. She also told the team that the family's cellular telephone number was intermittently disconnected, and that she did not attempt to obtain a current address from George Washington University Hospital, where [REDACTED]\* was being treated for [REDACTED]\*, before she telephoned CFSA. HW#1 did not recall having any additional contact (i.e., a follow-up call) with the Chartered employee.

According to Chartered, one week later, on July 19, 2006, [REDACTED]\* telephoned Chartered to request the telephone number of [REDACTED]\* primary care practitioner and was provided the information.

### ISSUES AND FINDINGS

#### **CFSA procedures lack specifics for dealing with unusual circumstances, such as a call involving no current or fixed address.**

CFSA's "Hotline" policy provides very limited guidance for dealing with a caller who cannot provide a current or fixed address for the alleged abuse. The policy offers the following language:

3. A report of child maltreatment shall meet the following criteria:
  - a. sufficient identifying information to locate the victim or the family (e.g., last known address or where the child can be located); ....
4. Reports not meeting the criteria in #3 above shall be entered as I&Rs ....

A "last known address," especially in an instance where a family may be living in a vehicle or staying in a hotel, may not be "sufficient" to locate an individual or family. The hotline worker apparently is then faced with making an assessment of whether the information provided by the caller is considered "sufficient identifying information" and meets the threshold for accepting a case for investigation.

It is important to note that the address recorded in the *I&R Summary Report* would not have led a CFSA investigator to the [REDACTED]\*/[REDACTED]\* family. The family never lived at the address; the address merely resembles one that the family previously cited on documents, where they may or may not have lived.<sup>100</sup> This hindsight realization that the address was in no way tied to the

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<sup>100</sup> According to the Chartered case manager, she provided the address contained in the CFSA I&R report after consulting a Chartered database of member information. The address that is captured on the CFSA report, "[REDACTED] [REDACTED]\*" is very similar to one of the addresses that the family provided to the VWFRC and the



the family could not be found. In reality, the family was known to many District entities at this time, just not CFSA.

**It appears that no one reviewed the CFSA hotline worker's decision to classify the call as an "Information and Referral."**

HW#1 said she submitted her completed *I&R Summary Report* to the hotline supervisor (HS) and that the supervisor could have changed her assessment of the call (i.e., from I&R to warranting an investigation) if she had disagreed with her analysis and handling of the call.

HS refuted the claim that she could have changed the I&R to an accepted case. She asserted that in July 2006, I&Rs were not being forwarded via FACES to hotline supervisors.<sup>102</sup> As a result, she was not afforded the opportunity to review the information and could not have overridden the hotline worker's assessment. HS told the team that after the girls' bodies had been discovered, she reviewed HW#1's documentation of the call.<sup>103</sup> She believed that the call should not have been categorized as an I&R but rather accepted as a report and assigned for investigation.

**CFSA was working in isolation. The [REDACTED]\*/[REDACTED]\* family was known to multiple District entities.**

Given the seriousness of the specifics communicated, CFSA should have acted to verify the information provided by the Chartered case manager, and reached outside of the agency in an effort to locate the children. The team was struck by the fact that the family was interacting with multiple District entities at this time. For example, on the same day of the hotline call, someone used the family's primary cell phone to talk with Families Forward, Meridian Public Charter School, TCP, and Booker T. Washington Public Charter School. The day after the hotline call, [REDACTED]\* attended a medical appointment at GWMFA. According to SWWR/CHGM case notes, on July 13 he also visited with the CHGM coordinator and told her the family was living in their van.

At this time, the family was drawing [REDACTED]; had worked with and was known to SWWR; was in contact with Families Forward and TCP in order to obtain housing; was communicating with BTW and Meridian in preparation for the coming school year; and had an active cell phone with a number that was on record at various District entities.

Information entered into *ServicePoint*, the District's Homeless Management Information System, might have helped CFSA locate the [REDACTED]\*/[REDACTED]\* family, but CFSA did not, and as of the writing of this report, still does not have access to the database.

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<sup>102</sup> A representative in CFSA's information technology division said that FACES.NET was implemented toward the latter part of February 2006. Per the requirements of the Child Protective Services (CPS) workgroup for FACES.NET, only I&Rs categorized as "Runaway" would be routed for supervisory approval. All other types (General Information Request, Protective Services Alert, Abscondence and Abscondence Return) did not require an approval in the system. According to the interviewee, these requirements were identified and approved by the CPS workgroup.

<sup>103</sup> HS told the team that in July 2006, CFSA had the capability to record calls coming into the hotline, but for whatever reason, calls were not being recorded then.

**When told the family was living in a vehicle, the CHGM coordinator, who is a mandated reporter, decided not to contact CFSA.**

The CHGM coordinator told the team that she did not contact CFSA because she felt the family was only temporarily homeless and in the process of obtaining housing; she wanted to “keep the family engaged.” In addition, she noted it was during the summer, so the children were not missing any school as a result of their homelessness. She said that if this had been a situation where the family was content or complacent with living out of their van, she would have approached the situation differently.

**RECOMMENDATIONS**

- That CFSA update its policies and procedures so that hotline workers and Investigations Workers have clear and sufficient guidance for dealing with calls and cases for which there is no current or fixed address.
- That CFSA enhance its quality assurance processes so that a hotline supervisor reviews for accuracy and appropriateness the classification of all “Information and Referral” calls received by the CFSA hotline.
- That CFSA work with the District’s Healthy Families/Thriving Communities Collaboratives on improving their data capture procedures and their ability to share real-time information with CFSA, TCP, and other service providers regarding their interactions with clients.
- That CFSA hotline workers and Investigations Workers be given access to the District’s Homeless Management Information System in order to improve their ability to locate individuals and families.



( [REDACTED] \* Washington, D.C.)

**SHELTER PLUS CARE PROGRAM “LEASE UP” FOR**  
[REDACTED] \*  
(AUGUST 25, 2006)

Key Findings:

- [REDACTED] \* was never assigned a “sponsoring agency” as required; as a result, he never received the once-per-month home visits that he should have.
- TCP, the administrator of the program for the District, lost touch with [REDACTED] \* and continued to pay the rent on the family’s house until January 2008, unaware that he had died in February 2007.
- TCP and the D.C. Department of Mental Health communicated regularly about the need to link program participants, including [REDACTED] \*, with supportive services; for some individuals, it took over a year to match them with a services provider.

On April 5, 2006, APRA certified that [REDACTED]\* had a [REDACTED]\* [REDACTED]\*<sup>√</sup> and soon thereafter he was approved for participation in the S+C program. Under normal circumstances, according to interviewees, [REDACTED]\* would have been added to the S+C waiting list and would have waited for a vacancy within one of the sponsoring agencies.<sup>104</sup> [REDACTED]\*, however, was a part of the S+C “expansion” cohort (explained on page 74 of this report). According to TCP, the expansion families were not immediately paired with sponsoring agencies, and were allowed to immediately begin looking for housing. [REDACTED]\* eventually identified a three bedroom row house at [REDACTED]\* that he felt would be suitable for the family.

On August 2, 2006, the management company for [REDACTED]\* informed TCP that [REDACTED]\* could rent the property for \$1,580 per month, an expense that TCP would pay directly to the management company that represented the property owner. The next day, Families Forward’s housing consultant faxed a *Sponsoring Agency Placement Request* to TCP in order to continue the process of getting the family moved into the house.<sup>105</sup>

**August 16, 2006 – TCP Communication with the D.C. Department of Mental Health**

As [REDACTED]\* was nearing completion of the housing placement process, TCP contacted DMH to determine whether the agency could provide support services to S+C expansion families. On August 16, 2006, TCP’s Director of Federal Programs faxed to DMH’s Director of Housing a list of 42 S+C expansion families that needed support services. Ten of the 42 families were in the process of obtaining housing and TCP requested that they be prioritized so that the services were in place when they moved into their S+C-funded housing units. On August 17, 2006, TCP followed-up via email to ensure that DMH had received the list. TCP reiterated that most of the families were already housed.

I wanted to follow up to ensure you received the list ... regarding the 42 families who are currently in the Shelter Plus Care program (32 are already in housing) and need to be linked to DMH for mental health services. Upon receipt of the list, let’s strategize about the necessary steps to get these folks linked .... Also, let’s develop a clear process for families who are eligible for the program’s subsidy but will need the services from DMH in the future.

[REDACTED]\* name appears on this list and his S+C [REDACTED]\*<sup>√</sup> is listed as “[REDACTED]\*” – [REDACTED]  
[REDACTED]\*<sup>106</sup>

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<sup>104</sup> Once S+C candidates are certified with having one of the three qualifying disabilities, they are placed on a waiting list to be paired with a sponsoring agency. When a vacancy occurs within one of the sponsoring agencies, the next candidate in line on the waiting list who meets the eligibility criteria of the sponsoring agency with the vacancy fills the spot. Typically, S+C candidates must be linked with a sponsoring agency and agree to receive support services from the agency before they can be placed in housing.

<sup>105</sup> On this form, “Family Forward” is typed into the space that asks for the “Sponsoring Agency’s Name,” and the Families Forward housing consultant signed the form as the “Sponsoring Agency Representative.” Families Forward confirmed that it was never considered to be [REDACTED]\* sponsoring agency.

<sup>106</sup> [REDACTED]\* was certified as having a [REDACTED]\* [REDACTED]\*<sup>√</sup>; he was never certified as having a [REDACTED]  
[REDACTED]\* [REDACTED]\*<sup>√</sup>. Also, Families Forward is identified on this list as a “referring agency” not a sponsoring agency.

**August 25, 2006 – Family Attends “Lease Up” at TCP**

On August 23, 2006, TCP’s Property Administrator inspected [REDACTED]\* and approved it for occupancy.<sup>107</sup> The last phase of the housing placement process, the “lease up” meeting, was held on August 25, 2006.<sup>108</sup>

TCP’s Property Administrator facilitated the “lease up” meeting with [REDACTED]\* and his family. The Families Forward housing consultant, a representative from the company managing the row house, and TCP’s Director of Federal Programs also attended. [REDACTED]\* reviewed and signed a one-year lease for the row house and a S+C *Rental Assistance Contract*. TCP paid the rental deposit and first month’s rent, and [REDACTED]\* received the keys to the property.

**ISSUES AND FINDINGS**

**[REDACTED]\* was never assigned a sponsoring agency and as a result he never received the once-per-month home visits that he should have.**

An S+C program participant who moves into housing is supposed to receive supportive services (e.g., life skills, employment training, budgeting classes, alcohol and/or substance abuse treatment, parenting classes) from the sponsoring agency. In addition, the sponsoring agency is required to complete a monthly *Home Visit Report* (HVR). The submission of HVRs is the program’s mechanism for verifying and documenting, among other things, that:

- someone has visited the participant in the housing unit during the reporting month to assess support service needs;
- the program participant still resides in unit;
- the participant’s income source(s) and amount(s) have not changed;
- any maintenance issues are being addressed; and
- any landlord/program participant concerns are being handled appropriately.<sup>109</sup>

The importance of home visits by a representative of the sponsoring agency is underscored by the following language from the *Rental Assistance Contract*: “Rental subsidies will not be authorized without receipt of a completed Shelter Plus Care Home Visit Report.” The necessity and timeliness of the reports are further emphasized in the contract that TCP and a sponsoring agency typically enter into, although that was not done in [REDACTED]\* case.

Reports submitted after the **5<sup>th</sup> day of the month** will not receive authorization for rent subsidy payment and are therefore the responsibility of the Contractor [the sponsoring agency] to pay the program’s portion of the rent. In cases of tardy Home Visit

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<sup>107</sup> The Property Administrator conducts a housing inspection to ensure that the identified residence is in compliance with HUD’s housing quality standards, and District of Columbia housing codes.

<sup>108</sup> According to S+C policies and procedures, at “lease up” the TCP Property Administrator assists the candidate, sponsoring agency, as well as the candidate’s CMA [case management advocate] and/or guardian in reviewing the lease. The candidate is informed that he is fully responsible for the unit and that he must agree to abide by all additional lease provisions identified by S+C. The Property Administrator also explains the sponsoring agency’s responsibilities and all parties review applicable policies and procedures specifically related to the program.

<sup>109</sup> *TCP FY 2008 Shelter Plus Care Manual*, “Reporting Requirements.” (no page numbers)

Reports, The Partnership will notify the landlord and inform them that the Contractor is responsible for the participant’s rent subsidy

....

█████\* was never assigned to a sponsoring agency. He never received supportive services, and no one conducted the requisite monthly home visits.

It is ironic that TCP lost touch with █████\*, disregarded its own requirements, and as a result, continued to pay his S+C rent subsidy through January 2008, unaware that he had died in February 2007.

**The S+C Home Visit Report format fails to ask for valuable information regarding contact with program participants and their family members.**

The team reviewed the *S+C Home Visit Report* template (see Appendix 4) to assess whether the document, if it had been completed by a case management advocate from a sponsoring agency, would have captured information pertinent to the well-being of █████\* and the rest of the family. Given that the target population for the S+C program are individuals and families who were previously homeless and who are dealing with one or more serious issues (mental illness, substance abuse, and/or HIV/AIDS), the team was surprised to see that the *Home Visit Report* template captures no substantive information regarding the program participant. The report template asks several questions regarding changes in the participant’s income and rent. After these questions, the S+C representative is then required to note the physical condition of the apartment and whether it needs any maintenance or repairs. The final question is whether the smoke detectors work.

Notably absent are any questions regarding the health and well-being of the program participant; his/her interactions with family members living in the home; whether he/she is taking all required medications. Furthermore, the report template does not require the S+C program representative to record the date of the home visit.

Given the physical and/or mental health challenges faced by the target population of the S+C care program, the fact that participants were at one time homeless, and the reasonable assumption that participants may lack some of the life skills necessary to live independently, the need for more thorough documentation of each home visit is clear.

**After placing █████\*, █████\*, and the children in █████\* in August 2006, TCP never saw the family again.**

At the August 25 “lease up” meeting, TCP’s Director of Federal Programs asked █████\* to contact DMH in order to be assigned to a sponsoring agency and █████\* said he would provide TCP with the name of his case manager once he was linked. On October 3, 2006, TCP contacted █████\* to get his case manager information. █████\* said he had been busy, but that he would call. TCP reminded █████\* that he agreed in writing to get support services, and that the payment of his rent was predicated upon his receiving services. █████\* told TCP he would call back with the information.

In December 2006, TCP’s Director of Federal Programs left a voicemail for ██████\* asking that he provide an update on his case management, and in January 2007, she drove to the family’s house. She stated to the team that no one answered the door, so she left ██████\* a note. In April 2007, 2 months after ██████\* death, TCP mailed him a letter regarding the need to enroll with ██████\* services and DMH for ██████\* services. TCP’s April 9, 2007, letter reiterated that “the payment of [his] rental subsidy is contingent upon [his] receiving supportive services.”

TCP attempted to conduct a required annual inspection of the home, visiting once in August 2007 and once in September 2007. Both times, according to notes, there was no response at the door. It appears that after the second attempt to inspect the house, TCP took no additional action.

**TCP and DMH communicated regularly about the need to link individuals with supportive services, but S+C “expansion” participants were not matched with sponsoring agencies in a timely fashion.**

On January 11, 2007, 2 days after going to ██████\* house in an effort to speak with ██████\* and inquire about the status of his services, TCP’s Director of Federal Programs faxed DMH information about the S+C “expansion” participants:

[T]hese families ... all receive active S+C subsidies but need to be linked to DMH to ensure the SVC [service] match. As they are linked, please let me know so that I can follow up [with] the agency.

In this fax, ██████\* is still identified as having a ██████\*, rather than the ██████\* for which he was certified.

TCP and DMH officials met on March 26, 2007 (TCP’s Executive Director and the Director of DMH attended this meeting), and again on April 23, 2007, in part to discuss the need to link the S+C “expansion” participants with support services. On June 8, 2007, TCP’s Director of Federal Programs emailed her contact at DMH and wrote the following.

[R]emember we have another urgent issue and that’s linking those families who are in our S+C Expansion program .... Please give me an updated report of those who are linked from your list. We engaged DMH last August to aid these families in need of services and 10 months later only have ¼ of them being served.

In August 2007, TCP again faxed a list of S+C expansion families to DMH, indicated those in need of services, and reminded DMH that “the continued rental subsidies are contingent upon the receipt of services.” As of November 8, 2007, 21 of the 55 families still on the S+C “expansion” client list, including ██████\*, had not yet been linked with sponsoring agencies and therefore were not receiving the required supportive services.

**All S+C “expansion” participants who are still in the program are receiving supportive services.**

Most of the S+C “expansion” candidates moved into housing without being linked to a sponsoring agency. Many did not receive supportive services appropriate to their certified disability for a number of months. TCP told the team that it eventually paired all S+C expansion candidates with supportive services. Following the events of January 2008, TCP conducted a review to ensure that all S+C expansion participants had been assigned to a sponsoring agency.

**██████████\* name appeared on the list of S+C program participants as needing only ██████████  
██████████\* services but he was never certified as having a ██████████\*██████████\*.**

TCP believes this may have been a mistake. The team compared the S+C application that the Families Forward housing counselor submitted on ██████████\* behalf to the S+C application that TCP had on file and noticed a subtle but important difference. TCP’s copy of the application indicated that ██████████\* had been diagnosed ██████████\*; the application that Families Forward submitted did not. TCP stated that this discrepancy may have occurred because it was dealing with a high volume of applications and a page from another application form may have mistakenly been appended to ██████████\* application. Because ██████████\* application indicated that he had a ██████████\* condition, he was identified on the list of S+C expansion candidates as needing only ██████████\* supportive services.

**The District’s S+C “expansion” program failed to meet federal program matching requirements.**

The placement process for S+C “expansion” families deviated from HUD and TCP guidelines. The S+C program has a matching requirement that obligates the grant recipient (i.e., the District) to match the value of rental assistance with an equal dollar value of supportive services.<sup>110</sup> According to TCP, funds were available to meet the matching requirement for the initial cohort of S+C recipients, but the District did not have the funds necessary to meet the matching services requirement for the “expansion” families. As a result, the “expansion” participants could not be matched with sponsoring agencies prior to placement in housing. However, they were still placed in housing as it became available, and efforts were made after their placements to identify sponsoring agencies that could provide supportive services.

TCP told the team it believed that APRA and DMH would provide supportive services to families placed through the S+C Expansion program. However, they did not establish a memorandum of understanding (MOU) or contract with either agency to memorialize this agreement. One interviewee speculated that following the December 2005 Homelessness No More Service Fair, there was turnover in District agency leadership, and that the new administrators were not made aware of the commitments that prior agency leaders had made to this initiative.

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<sup>110</sup> <http://hudre.info/index.cfm?do=viewShelterPlusCare> “Requirements and Responsibilities” (last visited July 9, 2008)

**RECOMMENDATIONS**

- That TCP implement new procedures to ensure that (1) S+C program participants are promptly assigned a sponsoring agency and receive supportive services, and (2) appropriate actions are taken when a sponsoring agency fails to submit a thorough and timely *Home Visit Report*.
- That TCP periodically meet with APRA and DMH management to ensure that the S+C program regulations are properly executed.
- That TCP revise the S+C *Home Visit Report* template so that sponsoring agency representatives are required to document (1) the date and time of the home visit and the names of the family members with whom they interacted, and (2) their observations and assessments of the health and well-being of the program participants and family members who reside in the S+C unit with them.
- That TCP devise and implement a quality assurance procedure to ensure that the S+C *Home Visit Reports* are accurate, complete, and timely.



**CHARTERED HEALTH CALLS TO [REDACTED]\***  
(AUGUST 2006 AND DECEMBER 2006)  
FAMILY RESIDING AT [REDACTED]\*

Key Findings:

None

On August 31, 2006, the Chartered behavioral health (BH) case manager again reached out to [REDACTED]\* by telephone, and the two spoke for nearly 10 minutes. [REDACTED]\* informed the case manager that she had moved into a new house, but she refused to provide the address. [REDACTED]\* said that she had enrolled her children in school, but she refused to identify where. The case manager also noted the following in Chartered's electronic case management comment system.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]\*

The Chartered case manager told the team that she was “comforted” when [REDACTED]\* told her about the new house and the girls’ enrollment in school, but that in hindsight, she should have followed up with CFSA regarding her July 12, 2006, telephone conversation with [REDACTED].\*

[REDACTED]



**D.C. PUBLIC CHARTER SCHOOLS**  
(AUGUST 2006 – APRIL 2007)  
FAMILY RESIDING AT [REDACTED]\*

Key Findings:

- Meridian personnel did not aggressively address [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* absences; BTW's efforts on behalf of [REDACTED]\* were more exhaustive.
- Meridian never communicated with [REDACTED]\*, yet removed [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* names from the school roster.
- Recently enacted legislation still does not clearly assign responsibility for monitoring student withdrawals from schools.

In April 2006, [REDACTED]\* submitted applications for the 2006-07 school year to Meridian Public Charter School (Meridian; 1328 Florida Ave., N.W.) and Booker T. Washington Public Charter School for Technical Arts (BTW; 1346 Florida Ave., N.W.) [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* applications to Meridian all cite the Shelter address (i.e., 1900 Massachusetts Avenue, S.E.) as the family's home address. It is unclear from documents whether Meridian officials knew the children were homeless at the time of application. On [REDACTED]\* application to BTW, which is dated April 19, 2006,<sup>111</sup> there are two notations that the family was then living in the Shelter.

According to call records for the family's primary cell phone, someone was in regular contact with both Meridian and BTW during July and August 2006, presumably in order to finalize the details of the girls' applications and enrollments at the two schools. It is interesting to note that from July 10-12, 2006,<sup>112</sup> the family placed and received a number of calls to and from both schools. A note in [REDACTED]\* application materials from this time states, "[REDACTED]

[REDACTED]\*, [REDACTED]\* and [REDACTED]\* **Attend Meridian**

[REDACTED]\* began the 2006-07 school year as a 5<sup>th</sup> grader; [REDACTED]\* was in kindergarten, and [REDACTED]\* was in the Early Childcare Unit. [REDACTED]\* first progress report of the school year indicates that her attendance was already an issue.

[REDACTED]

On December 18, 2006, Meridian sent three form letters to [REDACTED]\* asking for her "support" in improving the girls' attendance. According to attendance records, [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* had missed [REDACTED]\*<sup>v</sup>, [REDACTED]\*<sup>v</sup>, and [REDACTED]\*<sup>v</sup> days of school, respectively. Several of the girls' absences were "excused" absences, but the majority of them were not. In January 2007, one of [REDACTED]\* teachers and one of [REDACTED]\* teachers each telephoned [REDACTED]\* following unexcused absences by the girls. On January 17, 2007, [REDACTED]\* informed one teacher that "[REDACTED]\*<sup>v</sup>" and that [REDACTED]\* [REDACTED]\*<sup>v</sup>; according to records, [REDACTED]\* missed an additional [REDACTED]\* days of school before returning.

At the end of January and again at the beginning of March 2007, Meridian mailed form letters regarding the girls' attendance to the family's home. As of March 16, 2007, [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* had missed [REDACTED]\*<sup>v</sup>, [REDACTED]\*<sup>v</sup>, and [REDACTED]\*<sup>v</sup> days of school, respectively, according to Meridian's records.

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<sup>111</sup> The family had already left the D.C. General Hypothermia Shelter by the time [REDACTED]\* submitted this application to BTW.

<sup>112</sup> Notes from BTW state that on July 12, 2006, the day the Chartered behavioral health case manager placed a call to the CFSA hotline, the school contacted [REDACTED]\* and noted that she would "come in to complete [REDACTED]\* application."

**██████████\*, ██████████\*, and ██████████\* Are Withdrawn from Meridian**

The team received conflicting accounts of how ██████████\*, ██████████\*, and ██████████\* were withdrawn from Meridian. Furthermore, we found no documentation that would substantiate any of the following descriptions of events.

Meridian's attendance clerk told the team she tried to reach the family via telephone to schedule a parent/teacher conference to discuss the girls' absences, but was unable to make contact.<sup>113</sup> According to her, "██████████ ██████████\*<sup>v</sup>" she contacted the godmother to two of the girls, a former employee at Meridian. According to the clerk, the godmother said that she was going over to the house that day and would call her back if she made contact with ██████████\*. The clerk told the team that the godmother called back: ██████████\* said she planned on home-schooling the girls, and the girls should be withdrawn. The clerk said she informed the girls' teachers that they would not return to school, and another employee removed the girls' names from the school's roster.

Meridian's vice principal told the team that the godmother was working at Meridian in March 2007, and said that she would go and check on the girls at home. He told the team that the godmother subsequently called the school, told them that the girls were withdrawn, and that ██████████\* planned to home-school them. Meridian's principal stated that the attendance clerk called the godmother because she was listed as an emergency contact for the children, and that the godmother told the attendance clerk the girls were being home-schooled by ██████████\*. The principal told the team that she did not believe that the godmother was withdrawing the girls, but merely informing the school of their mother's intention to home-school them.

In an interview with the team, the godmother said that she did not ask or instruct the school to withdraw the girls. She said that she informed several members of the school staff that she had advised ██████████\* to enroll ██████████\*, ██████████\*, and ██████████\* in a DCPS school that was within walking distance of the family's home. (██████████\* had commented to the godmother how difficult it was to get the girls from their home in Southeast to Meridian in Northwest.) The godmother said that she was still working at Meridian when the girls stopped coming to school (i.e., March 2007).<sup>115</sup> The godmother also said that ██████████\* never mentioned to her an intention to home-school the children. When the girls stopped going to Meridian, the godmother assumed ██████████\* had acted on her advice and enrolled the girls in the public school near their home.

Based on information provided by the school, it appears that ██████████\*, ██████████\*, and ██████████\* last attended school at Meridian on Tuesday, February 27, 2007. Beginning on Monday, March 19, 2007, through the end of the school year, their status in attendance records was no longer cited as absent but rather "██████████\*<sup>v</sup>"

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<sup>113</sup> Call records show that someone from Meridian left voice messages on the family's cell phone on February 22, March 1, and March 7, 2007.

<sup>114</sup> According to DCPS' website, Hendley Elementary School and Hart Middle School would have been the family's assigned schools. Both are located less than a mile from ██████████\*.

<sup>115</sup> When asked to confirm the dates of the godmother's employment, Meridian wrote that she stopped working at the school in October 2006, which contradicts the godmother's and the vice principal's respective accounts.



██████████\* numerous absences at a Student Support Team<sup>119</sup> (SST) meeting. One member of the team informed the group that students were saying that ██████████\* mom was not letting her out of the house.

In an interview with the team, BTW's former principal said that "red flags were raised" when he heard rumors about ██████████\*. As a result, he instructed the school's social worker to visit the family's home in an effort to determine how to categorize the issues surrounding ██████████\* absenteeism.

**April 27, 2007, Visit by BTW employees to ██████████\*/██████████\* Home**

On April 27, 2007, BTW's social worker and special education coordinator<sup>120</sup> went to the home with a school-based MPD officer<sup>121</sup> who was stationed at Cardozo High School. The social worker told the team that she asked the officer to accompany them because of general impressions she formed about ██████████\* through conversations with others and because she did not know what they would encounter at the home. She recalled "some conversation" about ██████████\* mom "being crazy," so she went to the house with the notion that ██████████\* may have mental health issues.

The MPD officer, social worker, and special education coordinator traveled to the house in the officer's marked MPD cruiser. The social worker knocked on the front door, but there was no response. The MPD officer then knocked on the door, and ██████████\* answered. BTW's social worker identified who they were and explained that they had come to see ██████████\*.

The school-based MPD officer asked ██████████\* for identification. At first she refused, but then instructed one of the children in the home to get her purse so that she could "get these [expletive] off [her] porch." ██████████\* provided the officer with identification.

The social worker told ██████████\* that she was concerned about ██████████\* because she had not attended school recently. ██████████\* said she was home-schooling her children. The social worker told ██████████\* that ██████████\* was a good student, and ██████████\* said, "I don't care."

The social worker told the team that she asked to see ██████████\* two or three times, but she never did see her. She said she also inquired about the well-being of the other children, but ██████████\* said that she did not have to answer any questions about the younger children because they did not attend BTW. The social worker replied that it was her business because she is a mandated reporter of suspected child abuse and neglect.

The special education coordinator described ██████████\* as "nasty and combative" and that she "ranted" about her daughters being subjected to cursing and "dirty pictures" at school. ██████████\* swore during the entire visit and was verbally abusive throughout the interaction, which

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<sup>119</sup> The SST was comprised of the following: the school's principal, guidance counselor, social worker, attendance counselor, Dean of Students, and psychologist. This team met weekly to discuss students' behavioral, family, and attendance issues.

<sup>120</sup> ██████████\* was not considered a special education student. The special education coordinator accompanied the social worker on the visit out of prudence.

<sup>121</sup> Due to a "gag order" imposed in ██████████\* criminal case, the evaluation team was unable to interview the MPD officer.

lasted 10 to 15 minutes. She said the home visit was different from others she had conducted during her career in that it was confrontational; usually parents are supportive during home visits.

Once the BTW employees returned to the MPD officer's cruiser, the social worker telephoned the CFSA hotline. (See page 113.)

### **ISSUES AND FINDINGS**

#### **During school year 2006-07, District charter schools lacked standard procedures for addressing absences and truancy.**

During school year 2006-07, the D.C. Public Charter School Board (PCSB) had not promulgated policies and procedures regarding attendance and how schools should address absences. As a result, Meridian and BTW appear to have followed informal, internal policies and procedures for responding to their students' absences.

During an interview with the team, Meridian's principal could not recall the attendance policies and procedures for the 2006-07 school year. Additionally, she was unable to provide the team with the 2006-07 Meridian Student/Parent Handbook, which outlined the schools attendance action plan.

BTW's attendance counselor told the team that during the 2006-07 school year, her practice was to send a certified letter to the student's home and call a parent if the student had five unexcused absences. If a student accumulated 10 unexcused absences, she would send a second certified letter home and attempt to arrange a truancy conference with a parent.

#### **Meridian personnel did not aggressively address the girls' absences; BTW's efforts on behalf of ██████\* were more exhaustive.**

Meridian mailed several letters to ██████\* regarding ██████\*, ██████\* and ██████\* absences, and in January 2007, two teachers telephoned ██████\*; one spoke with her, one was unable to reach her. Apart from those efforts, Meridian took no additional action.

BTW's attempts to contact the family were more exhaustive. The BTW attendance counselor and several teachers tried to reach ██████\* by telephone in order to discuss ██████\* unexcused absences. The attendance counselor also sent a letter to the family's home. The lack of response from ██████\* prompted BTW's attendance counselor to discuss the issue at a meeting of the school's student support team, and BTW's principal requested that school personnel conduct a home visit. BTW's social worker also called CSFA and, 3 days later, MPD (see page 125.) In addition, BTW's attendance counselor referred ██████\* to the D.C. Superior Court for truancy.

**During school year 2006-07, charter schools lacked standard procedures for withdrawing students.**

During the 2006-07 school year, the PCSB had not promulgated policies and procedures regarding how students should be withdrawn from school. As a result, Meridian and BTW followed internal policies and procedures for withdrawing students. The principal of Meridian said a parent/guardian needed to come to the school and fill out a withdrawal form in order to withdraw a student. According to the BTW attendance counselor, a parent/guardian was required to complete withdrawal paperwork in person and inform BTW which school the student will attend, and complete an exit form. BTW further stated that all of its students are automatically withdrawn at the end of the school year and must reapply and be accepted in order to attend the following year.

**Meridian never communicated with [REDACTED]\*, yet removed [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* names from the roster; BTW did not withdraw [REDACTED]\* until the end of the school year as part of the standard practice applied to all students.**

The team received conflicting accounts of how [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* were withdrawn from Meridian, but one thing is clear: Meridian withdrew [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* without verbal or written authorization from [REDACTED]\*. The school's attendance clerk and vice principal said the girls were withdrawn after the godmother told the clerk that [REDACTED]\* was home-schooling them. The godmother told the team that she never directed school employees to withdraw the girls, and that [REDACTED]\* never mentioned home-schooling to her. BTW withdrew [REDACTED]\* from school on June 13, 2007. According to the attendance counselor, she was withdrawn according to its standard end-of-school year practice.

**The PCSB did not have procedures for tracking and monitoring those students who were withdrawn from charter schools. Responsibility for monitoring charter schools' student withdrawals still does not appear to be clearly defined and understood.**

Title 5 DCMR provides the following guidance, which appears to have obligated charter schools to report withdrawals to the D.C. Board of Education:

2100.8 The individual in charge of each educational facility, not affiliated with the D.C. Public Schools, and each teacher who gives private instruction outside of a school setting, to school-aged children who reside permanently or temporarily in the District of Columbia shall report to the D.C. Board of Education, on forms provided by the Board, the name, address, sex, and date of birth of each child who meets one of the following requirements:

- (a) Transfers between facilities, from a facility to non-school private instruction, or from one non-school private instructional situation to another; or

(b) Enrolls in, or withdraws from, a facility or private instruction.

2100.9 The Superintendent of the D.C. Public Schools is authorized to select and appoint appropriate staff members to carry out the provisions of the compulsory school attendance law of the District of Columbia.

2100.10 For purposes of this section, “school-aged child” is defined as any child who is five (5) years old or older on December 31st of any school year but who has not yet reached his or her eighteenth (18th) birthday.

Therefore, despite the fact that Meridian withdrew [REDACTED]\*, [REDACTED]\*, and [REDACTED]\* from the school’s roster without an explicit instruction from [REDACTED]\*, it appears to the team that Meridian should have reported the withdrawals to the D.C Board of Education.

Furthermore, recently enacted legislation still does not clearly assign and define responsibilities with regard to monitoring student withdrawals from charter schools. The District of Columbia Public Schools Agency Establishment Act of 2007 (Act) designated DCPS as a cabinet-level agency subordinate to the mayor and a new State Board of Education. According to Title III § 302(d) of this Act, “all powers, duties, and functions delegated to the District of Columbia Board of Education concerning the establishment, development, and institution of state-level functions ... are transferred to the Office of the State Superintendent of Education ...” The Act also outlines the responsibilities of the new State Board of Education.

The team reviewed the Act and concluded that it does not clearly delineate a single District entity that is responsible for tracking all student withdrawals. The team contacted several OSSE and State Board of Education employees in order to clarify the issue, but no one was able to identify which District agency is responsible for such tracking.

### **RECOMMENDATIONS**

- That the PCSB and CSFA implement an MOU regarding truancy and reporting educational neglect.
- That the PCSB take steps to help ensure that students who are homeless are promptly referred to HCYP so that they may receive assessments to determine if they need educational assistance.
- That charter schools provide training for all teachers and counselors to ensure identification of and sensitivity to the needs of homeless children.
- That charter schools ensure that all schools report data on homeless children to HCYP as required by the McKinney-Vento Homeless Assistance Act.

- That the PCSB develop written policies and procedures for referring students to internal and external social services and disseminate such information to all teachers and counselors.
- That the PCSB ensure that all its mandated reporters receive annual training regarding how to detect abuse and neglect and develop policies and procedures for reporting abuse and neglect.
- That the PCSB promulgate written policies and procedures for the formal withdrawal of students from schools, to include a requirement that a charter school must provide OSSE with written notification when a student is withdrawn to be home-schooled.
- That legislation be proposed that allocates to a single District entity responsibility for tracking every District student's education status and history (i.e., enrollments, withdrawals, and transfers) regardless of the educational setting (e.g., public, independent, private, charter, and parochial schools and home-schooling).



**BTW CALL TO CFSA HOTLINE AND  
RESULTING INVESTIGATION**  
(APRIL 2007 – MAY 2007)

Key Findings:

- CFSA hotline worker's written narrative failed to capture vital language used by the BTW social worker.
- The CFSA Investigations Worker assigned to the call failed to document all of the actions he took, failed to accurately conclude that the family was receiving District [REDACTED]\*<sup>v</sup>, and made an erroneous assumption about information communicated to him by CFSA's Diligent Search Unit (DSU).
- The DSU's investigation was poorly documented.

On Friday, April 27, 2007, at approximately 12:30 p.m., CFSA hotline worker #2 (HW#2) answered a call from the BTW social worker, who was calling from an MPD cruiser in front of [REDACTED]\* to report her interaction with [REDACTED]\* and attempt to contact [REDACTED]\*.



Toward the conclusion of the call, HW#2 tells the social worker that [REDACTED]\* “[REDACTED]\*” and that CFSA would send an investigator to the home. (See Appendix 5 for a full transcript of this telephone call.)

During the telephone call, HW#2 used hand-written notes to capture information.<sup>123</sup> After the call ended, he entered the information into FACES, classified the call as one involving “[REDACTED]\*” and assigned a response time of “[REDACTED]\*.”<sup>124</sup> He then generated a *Referral Acceptance Snapshot* form and submitted it to a hotline supervisor (HS), who reviewed and approved it. The referral was then transmitted electronically to an Investigations Supervisor (IS), who assigned the case to an Investigations Worker (IW) in CFSA’s Intake and Investigation Unit.

IW told the team he began to work on the referral the next day, Saturday, April 28, 2007. He telephoned the BTW social worker, but was unable to reach her so he left a recorded message. IW also went to [REDACTED]\* in an effort to make contact with the family and assess the situation. He could not remember the approximate time of his visit, but no one responded to his knocks. IW told the team that there was a lot of “junk mail” outside the front door, and that he did not hear any noise (i.e., television or radio) coming from the home. He said he placed an envelope, with a letter asking [REDACTED]\* to contact him, in the house’s outer security

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<sup>122</sup> The team made numerous attempts to meet with [REDACTED]\* “aunt,” but she declined to be interviewed.

<sup>123</sup> A January 2004 assessment of CFSA’s hotline operations conducted by the Center for the Study of Social Policy noted, “Currently, the workers jot down notes on pieces of paper during the phone calls and then, after the call is over, enter data into FACES. While workers are generally following a checklist of items to cover during the call, the amount and quality of information documented as a result of this practice varies [sic].” CENTER FOR THE STUDY OF SOCIAL POLICY, AN ASSESSMENT OF THE FUNCTIONING OF THE CHILD ABUSE AND NEGLECT HOTLINE OF THE DISTRICT OF COLUMBIA CHILD AND FAMILY SERVICES AGENCY 18 (Jan. 20, 2004).

<sup>124</sup> According to CFSA policy, a Priority 1 call must receive immediate attention; a Priority 2 call must be responded to within 24 hours.

door. At some point on Saturday, April 28, IW also searched FACES and reviewed information regarding the July 2006 call from the Chartered behavioral health case manager to the CFSA hotline.

According to IW, he received a call from MPD Officer #1 (Officer #1) on Monday, April 30. IW noted in FACES<sup>125</sup> that Officer #1:

[REDACTED]

IW told the team that Officer #1 did not tell him why MPD went to the house that morning (see page 125); he said the officer called him “out of the blue.” According to IW, MPD Officer #1 did not indicate that [REDACTED]\* was uncooperative during the visit. IW said that during the telephone call, he did not ask Officer #1 any questions about conditions in the home or whether the officer made contact with [REDACTED]\* during their visit. According to IW, the officer would have told him if anything was wrong at the house. He and Officer #1 agreed to meet at the house at 10:00 a.m. the next day. According to an entry in FACES, the purpose of the visit was to “ [REDACTED]\*.”

IW said he then called and spoke with the BTW social worker. IW told the team that the BTW social worker sounded worried, and that during his conversation with her, he was weighing her observations against those of Officer #1.<sup>126</sup> IW relayed the officer’s observations from the visit earlier in the day, and asked the social worker whether she had contact information for any known relatives. According to IW, she provided him with the telephone number for [REDACTED]\* “aunt,” and after the call ended, he telephoned her.<sup>127</sup> She informed him that she was not a biological aunt, but rather a friend of the family. She told him that [REDACTED]\* had once lived with her for a month or so. In his notes regarding information about the family imparted by the “aunt,” IW also wrote: “ [REDACTED]\*.”

At approximately 10:00 a.m. on Tuesday, May 1, 2007, IW drove to the house and met Officer #1, who (along with two colleagues) reportedly had interacted with [REDACTED]\* and some of

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<sup>125</sup> Contacts entered into FACES are date stamped but are not time stamped.

<sup>126</sup> The team was unable to verify this chronology. The BTW social worker told the team that she telephoned MPD to ask that they check on the welfare of the children after she spoke with IW. IW stated that he spoke first with one of the MPD officers who responded to the house, and then spoke with the BTW social worker. Furthermore, according to CFSA’s final *Child Fatality Case Review* report, dated January 29, 2008, [REDACTED]\*.<sup>v</sup> However, as explained in greater detail in the next section of this report, Officer #1 was not dispatched to the house until approximately 12:00 p.m. The team was unable to determine exactly when the two spoke.

<sup>127</sup> IW did not document his telephone call with the “aunt” in FACES. He did, however, provide the team with handwritten notes, dated May 2, 2007, that he believes support his assertion that he contacted a family member as required by CFSA policy.

her children the day before. IW arrived first and waited for Officer #1. Officer #1 arrived, dressed in plain clothes, and the two approached the house. IW told the team that the mail he observed during his April 28 visit was still in front of the door, and that the envelope he had placed in the security door was there as well. After knocking and receiving no response, IW said he and Officer #1 left the house after approximately 10 to 15 minutes.

IW returned to the [REDACTED]\* home for a third time on May 2.<sup>128</sup> IW said he knocked on the door and listened for noise. The pile of mail he observed on his two previous visits was still in front of the door, as was the envelope he had left in the security door.

IW didn't document his request or the resulting information in FACES, but IW told the team he asked a CFSA colleague to query IMA's ACEDS<sup>129</sup> database to determine whether the family was receiving District benefits. IW said his colleague informed him that the family was not receiving benefits. This information "surprised" him, so he decided to call IMA in an attempt to get more information on the family.<sup>130</sup> According to notes he entered in FACES, IW [REDACTED] [REDACTED]\*" IW told the team that no one from IMA returned his call.

Although IW did not note the activity in FACES, on May 3 he mailed a certified letter to [REDACTED]\*. The form letter was addressed to "[REDACTED]\*" asked her to contact IW directly, and stated: "[REDACTED] [REDACTED]\*"

According to FACES, [REDACTED] [REDACTED]\*

On Friday, May 11, in support of his effort to locate and make contact with the family, IW partially completed a *Diligent Search/Parent Locator Referral Form* and hand delivered it to an investigator (DSI#1) in CFSA's Diligent Search Unit (DSU).<sup>134</sup> IW provided the DSU with

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<sup>128</sup> The approximate time of the visit is not noted in FACES, nor did IW remember the time during an interview with the team.

<sup>129</sup> ACEDS, which stands for Automated Client Eligibility Determination System, is IMA's client information database.

<sup>130</sup> The FACES *Contact Report* indicates [REDACTED]\*<sup>v</sup>, but IW's handwritten notes indicate [REDACTED]\*<sup>v</sup>.

<sup>131</sup> USPS left notice of the certified letter at the house on May 5, but the letter was never claimed. The letter was eventually returned to CFSA on June 6, 2007.

<sup>132</sup> IW's handwritten notes suggest [REDACTED]\*<sup>v</sup>.

<sup>133</sup> IW told the team that he contacted DCPS' Penn Attendance Intervention Center at some point to determine whether any of the children were enrolled in DCPS or were known to the Center, and was told the Center had no information on the children; however, he did not document this action in FACES.

<sup>134</sup> "[DSU's] primary mission is to locate missing parents for the purpose of case planning and permanency which may lead to Adoption, Termination of Parental Rights, Guardianship, Legal Custody, where this action leads to any



obtain the name of a caseworker to whom he could send a fax.<sup>138</sup> After the call, he faxed a letter to CCCPS regarding ‘ [REDACTED] \*√’ In the one page fax, [REDACTED]

[REDACTED] \* . IW requested no specific information or action from CCCPS. Rather, he stated:

[REDACTED]

IW told the team that he spoke with the CCCPS investigator to whom he sent the fax on May 16 and on several subsequent occasions, but he did not document any of these conversations in FACES. IW then telephoned BTW’s social worker to tell her that CFSA had closed the case, and that he had referred the issue to CCCPS.<sup>139</sup>

On Thursday, June 14, approximately 1 month after sending his letter, IW received a response via fax detailing CCCPS’s attempts to locate [REDACTED] \* and her daughters: [REDACTED]

[REDACTED]

[REDACTED] \* IW filed the fax from CCCPS and took no further action on the case. He told the team that, at the time, he was not surprised by his inability to locate the family, and that it was not uncommon to have families move to other jurisdictions.

### **ISSUES AND FINDINGS**

#### **CFSA hotline worker’s written narrative failed to capture vital language used by the BTW social worker during the telephone call.**

The team listened to the April 27, 2007, hotline call in order to compare the content of the report lodged by the BTW social worker with the information HW#2 documented in the call narrative section of FACES. The team found that the *Referral Acceptance Snapshot (Snapshot)* posted in FACES did not capture important language used by the caller, such as these excerpts:

[REDACTED]

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<sup>138</sup> IW wrote in the case closure comment section of FACES, ‘ [REDACTED] \* ’ CFSA Investigation Summary (Draft) 4 (emphasis added).

<sup>139</sup> During an interview with the team, BTW’s social worker could not recall the specifics of this conversation, or whether it was clear to her at the time that CFSA had closed the case.

[REDACTED]

During an interview with the team, HW#2 said he was under the impression that the narrative in the *Snapshot* did not have to be verbatim. He acknowledged that the portion of the call in which the BTW social worker states that [REDACTED]\* is not included in the narrative. In hindsight, HW#2 felt that the [REDACTED]\* information was important, however, he still would characterize the case as educational neglect. When asked about the references to [REDACTED]\*, HW#2 stated that such information, in general terms, could be an indicator that a child is out of control. He said, “[CFSA brings] kids back home every day. Parents are supposed to control their children.”

**The hotline worker’s written summary of the call was not reviewed for accuracy.**

No one at CFSA listened to a recording of the call. IW told the team that it was not routine practice for investigators to listen to calls that had been assigned to them. When asked whether he thought it should be standard practice, he replied, “I trust that they [the hotline workers] took the call right” and asked the necessary questions.

HS also told the team that it is not routine practice for her to listen to calls. She said that random quality assurance is conducted, however, there is no policy or procedure that dictates how many calls a supervisor must review, and with what frequency. HS said she reviews 12-16 *Snapshot* narratives per day for grammar, flow, and content.

After listening to the call with the team, HS said HW#2’s narrative of the call lacked information regarding the caller’s use of the word “[REDACTED]\*”. She also said she would have asked more questions regarding the allegation that the children [REDACTED]\*.

**CFSA’s IW failed to complete two investigative procedures, failed to determine that the family was receiving District public benefits, and made an erroneous assumption about information communicated to him by CFSA’s DSU.**

Based on an interview with IW, and a review of his documentation of the case and CFSA’s policy regarding investigations, the team noted the following deficiencies.

1. IW failed to “[document] all investigation activities, contacts, and decisions in FACES within 24-hours of event occurring.” For example, IW did not document the results of the ACEDS database query, or conversations he had with the BTW social worker, [REDACTED]\* “aunt,” and the CCCPS investigator.
2. IW failed to “interview neighbors, resident managers, or landlords to confirm the address or determine the whereabouts of the family.”

When asked about the requirement to contact neighbors, IW said that CFSA investigations are “supposed to be confidential” and that talking to neighbors compromises confidentiality. “You don’t do casework like that,” he said.

The team also identified the following as areas where IW either could have fulfilled his duties more accurately and more effectively, or where he made a mistake:

1. IW could have called the Collaborative (SWWR) cited on the July 2006 I&R to determine whether someone there knew the family’s whereabouts.
2. IW could have called the Collaborative (Far Southeast) cited on the April 2007 *Snapshot* to determine whether someone there knew the family’s whereabouts.<sup>140</sup>
3. IW telephoned [REDACTED] \* IMA caseworker [REDACTED] [REDACTED] \*<sup>v</sup> but was unable to reach the caseworker. IW could have followed up continuously with IMA until he was able to confirm whether his understanding of the family’s benefits status was correct. Had he spoken with someone at IMA, he might have learned that [REDACTED] \* was in fact receiving District benefits, and could have obtained information regarding [REDACTED] \* that strongly suggested the family had not moved from the District. Specifically, someone (presumably [REDACTED] \*) used the family’s [REDACTED] \* to either make a food purchase or withdraw cash on May 1 (two transactions), May 4, May 8 (two transactions), and May 10, 2007. All of these transactions occurred at businesses located less than 3 miles from [REDACTED] \*.
4. IW neglected to clarify the information provided to him by the DSU, which he considered to be a “typo,” and simply assumed that the address information pertained to [REDACTED] \*, instead of [REDACTED] \* mother, as noted on the report.

**The DSU’s investigation was poorly documented and incomplete.**

One of the DSU investigators told the team that she never referred to a policy/procedure manual in order to complete her assignments, and that to her knowledge, one did not exist. Another said that such a document does exist, but that it is “old and outdated.” The DSU Supervisory Investigator provided the team with a nine-page document entitled *Diligent Search Operational Procedures*, which was last revised in December 2003. The procedures provide no specific guidance on how an investigator should complete and document a search request made by a CFSA social worker. As a result, the team was unable to determine whether any of the DSU’s errors and omissions constituted violations of CFSA procedures. However, based on a review of the documents and interviews, the team identified the following deficiencies and inaccuracies in the DSU’s work:

1. DSI#2 failed to document the investigative activities she conducted.

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<sup>140</sup> At the team’s request, Far Southeast searched their records and found no documentation regarding any interactions with the family. Therefore, it appears the family had no contact with the collaborative.

2. Handwritten notes attached to the DSU case report clearly state that [REDACTED]\* [REDACTED]\*. However, this information was not included as part of the typewritten investigation report, an omission that likely contributed to IW's erroneous impression, based on information apparently provided by a colleague, that the family was not receiving District benefits, and therefore may have moved out of the District.
3. A supervisor did not sign the DSU case report. The "supervisor's" signature block on the report indicates such a signature is required. The DSU's Supervisory Investigator told the team that he reviews the quality and thoroughness of each case report before it goes to the requestor, but there is no indication he did so in this instance.
4. The report is dated June 4, 2007, even though DSI#2 said it was completed and submitted to IW on May 16, 2007.
5. DSI#1 conducted the majority of the search tasks, but DSI#2 authored the case report. DSI#1 told the team that the goal of her efforts was to locate [REDACTED]\*; DSI#2 was under the impression that IW was looking for relatives of [REDACTED]\*.

DSI#2 acknowledged that it seems as though IW misinterpreted some of the information in the DSU report. In addition, DSU#2 and IW never discussed the case or the report. One DSU employee told the team that many DSU employees do not prepare written documents well.

**CFSA policy does not clearly define who has the authority for closing an investigation. Neither IW nor his supervisor, IS, clearly documented in FACES the decision to close the investigation.**

IW told the team that an Investigations Worker does not have the unilateral authority to close an investigation; he said only an Investigations Supervisor can close a case, which is often done based on an Investigations Worker's recommendation. CFSA policy Chapter 1000, entitled "Investigations," does not clearly define case closure procedures; it implies, though, that an Investigations Worker has the authority to close an investigation:

The Investigations Worker must take all feasible and practical steps to locate children who are the subject of a report and to interview them. An Investigations Worker shall determine that the investigation cannot be completed when they are unable to locate the family or when the family has moved out of the jurisdiction. The Investigations Worker shall complete the following procedures prior to closing the investigation: ....

CFSA's *Child Fatality Case Review*, dated January 29, 2008, [REDACTED]

[REDACTED]\*

Following a review of the information in FACES, the team was unable to determine who closed the investigation. Neither IS nor IW explicitly documented in FACES the decision to close the case. CFSA policy requires both IW and IS to document “all investigative activities, contacts, and decisions in FACES within 24-hours of event occurrence,” yet, inexplicably, neither documented the decision to close the investigation. There are no entries in FACES attributed to IS; IW’s entry dated May 16, 2007, regarding a telephone contact he had with the BTW social worker merely states “[REDACTED]”<sup>141</sup>

IW told the team he was required to complete the investigation within 30 days, and speculated that had he been given more time, he might have been able to make contact with the family. It is important to note, however, that he recommended closing the case 20 days after the call came in to the CFSA hotline.

IS wrote the following in an email to the team:

We have been repeatedly instructed by Upper Management to immediately “shut down” a case at the discovery that the family resides out of jurisdiction. When [IW] could not locate the family, despite repeated visits at various hours of the day and noting that none of his letters were being picked up and that newspapers remained on the porch, and being unable to locate the family through ACEDS or the school system, at my instruction and following established protocol, he conducted a Diligent Search. The Diligent Search revealed that the family was located in Maryland. As such, a minimal Summary was put together and the investigation was closed and forwarded to the identified jurisdiction.<sup>141</sup>

On March 7, 2008, CFSA distributed an Administrative Issuance regarding *Immediate Requirements for All CPS Investigators*. (See Appendix 8.) In it, CFSA’s Deputy Director for Program Operations wrote:

No investigation will be closed solely on the grounds that the child could not be located until thoroughly exhaustive efforts have been made by the CPS worker to locate the child and family. If the child or family cannot be immediately located, investigative efforts must be elevated and the following steps taken concurrently with a sense of urgency .... **NO** unable to locate investigation shall be closed without review and approval of the assigned Program Manager. (Emphasis in original.)

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<sup>141</sup> IS did not make herself available for an interview. She only responded to questions emailed to her by the team.

**RECOMMENDATIONS**

- That CFSA implement a policy requiring Investigations Workers to listen to the recording of all hotline calls that have been assigned to him/her for investigation.
- That CFSA give Investigations Workers remote (i.e., off-site) access to FACES and ACEDS so that they are able to enter and search for information while in the field.
- That CFSA establish a protocol with IMA through which it can gain timely access to EBT card activity reports in order to enhance its ability to locate individuals and families who are receiving benefits from the District.
- That CFSA explore the feasibility of giving its Investigations Workers and DSU employees access to the Collaborative Council’s “Efforts to Outcomes” client information data system in order to enhance CFSA’s ability to locate individuals and families.<sup>142</sup>
- That CFSA update and enhance DSU policies and procedures in order to standardize search procedures and improve the quality and thoroughness of its written work products by, among other things, requiring corroborative evidence (where possible) to support findings and prevent such erroneous inferences or assumptions as occurred here with respect to the locations of individuals.
- That CFSA amend its procedures and information systems (if needed) so that Investigations Workers are required to promptly, accurately, and thoroughly record the dates and times of all investigative actions they take and information received.
- That CFSA examine, and clarify if necessary, its procedures regarding Investigations Workers’ interaction with neighbors and family members so that the need to gather information during an investigation is appropriately balanced with the need to maintain the proper level of confidentiality.
- That CFSA amend its policies and procedures so that they clearly define who has the authority to close an investigation and how the decision to close an investigation should be documented and recorded in FACES.

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<sup>142</sup> As part of CFSA Administrative Issuance CFSA-08-2 (Mar. 7, 2008), CPS Investigations Workers are now required to “[c]ontact the Healthy Family/Thriving Communities Collaboratives to determine whether the family is known to them or has received services from them ....” *Id.* at 3.



**MPD RESPONSE TO [REDACTED] \***  
(APRIL 30 AND MAY 1, 2007)

Key Findings:

- There is a lack of certainty that any MPD officer actually saw [REDACTED] \*, the subject of the “check on the welfare” call.
- The team was told that none of the officers who responded on April 30, 2007, documented their interactions with the family; the only account of events from that day is dated 4 days after the discovery of the girls’ bodies in January 2008.
- MPD radio transmissions from April 30, 2007, do not support the officer’s written account of the “check on the welfare” call.

On Monday, April 30, 2007, the BTW social worker telephoned CFSA to determine what actions CFSA had taken over the weekend in response to her Friday, April 27 hotline call. She learned from CFSA that her report had been assigned to an Investigations Worker (IW) in CFSA's Child Protective Services division. She telephoned his desk and reached his voicemail. After leaving him a message, she telephoned and spoke with his supervisor (IS). IW returned the BTW social worker's call and the two spoke. The BTW social worker told the team she became frustrated with what she perceived to be a lack of appropriate action over the weekend by CFSA, and that she felt no sense of urgency from IW. After her conversation with him, she consulted with BTW's principal, who instructed her to call the Metropolitan Police Department (MPD).

After calling and being transferred to several MPD offices, the BTW social worker contacted MPD's non-emergency (i.e., 311) number. The following is an excerpt of some of the information she communicated to the Office of Unified Communications<sup>143</sup> (OUC) dispatcher:

I need someone to go out to a home where I believe abuse and neglect is occurring, and I don't want to be transferred to someone else .... Our student, [REDACTED]\*, hasn't been to school since March. I went to the home. The mother says she isn't allowing her to leave the house in fear she's going to run away. She would not allow us to speak to her. She's 16 years old. While there, I noticed there were two or three younger children between the ages of 6 and 9 .... I wasn't allow[ed] in the home, but from what I could see, the home did not appear clean, the children did not appear clean, and it seemed that the mother is suffering from some mental illness and what she's ... holding all of her children in the home hostage .... This was on Friday, and it hasn't been officially followed up on. I am extremely concerned.

MPD officers were dispatched to [REDACTED]\* shortly before noon on April 30, 2007. Due to a "gag order" imposed in [REDACTED]\* criminal case, the special evaluation team was unable to interview any MPD personnel. Consequently, the team could not reach a clear understanding of what the officers encountered at the home and the extent of their interactions with [REDACTED]\* and any other occupants in the house.

The team obtained and analyzed three sources of information pertaining to MPD's April 30, 2007, response: (1) a written "event chronology" of dispatch and communication events from the OUC; (2) an audio recording of radio communications between OUC and MPD officers regarding the officers' visit to the house; and (3) a memorandum dated January 13, 2008, that was written by one of the officers who visited the house on April 30, 2007. (See Appendix 7 for the event chronology and the MPD memorandum dated January 13, 2008.) A summary of events from each of these sources is presented below.

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<sup>143</sup> OUC centralizes the coordination and management of public safety communication systems and resources and responds to emergency and non-emergency calls in the District. OUC handles emergency 911 and non-emergency "311" calls for MPD, FEMS, and District government customer service operations.

(1) Summary of April 30, 2007, events based on OUC “event chronology”

- 11:50 a.m. – “EVENT CREATED ... CHECK ON THE WELFARE ... 16 YO [REDACTED] \* HAS BEEN WITHDRAWN FROM SCHOOL SINCE EARLY MARCH ... COMPL[AINANT] STATES MOTHER HAS A MENTAL ILLNESS AND IS HOLDING 16 YO AND 2 OTHER SMALL CHILDREN 6-10 YRS INSIDE THE HOME AND WILL NOT LET THEM ATTEND SCHOOL[.] COMPL IS CONCERNED CHILDREN MAY BE BEING ABUSED .... CFS HAS BEEN CONTACTED. [SIC]”
- 11:53 a.m. – Officer #1 is dispatched to [REDACTED] \* (scene)
- 11:58 a.m. – OUC dispatcher keys Officer #1 into system as having arrived on the scene.
- 12:02 p.m. – Sergeant is dispatched to scene.
- 12:03 p.m. – Officer #2 is dispatched to scene.
- 12:31 p.m. – OUC dispatcher keys sergeant into system as having arrived on the scene.<sup>144</sup>
- 12:38 p.m. – OUC dispatcher enters Officer #2’s status as “AV” (available to go to another location).
- 12:42 p.m. – OUC dispatcher enters status of “AQ” for sergeant (“AQ” is synonymous with “AV”).
- 12:42 p.m. – OUC dispatcher enters the “disposition” of the call, i.e., how the call was settled, as “advised,” “CHECK ON THE WELFARE EVENT CLOSED.” Officer #1 is available to go to another location.

(2) Summary of April 30, 2007, events based on audio recording of OUC radio communications<sup>145</sup>

- 11:53 a.m. – “Units assist social worker check on the welfare of three juveniles, [REDACTED] [REDACTED] \*”
- 11:54 a.m. – Officer #1 radios dispatcher that he is “pulling into the block.”
- 11:54 a.m. – The dispatcher informs Officer #1, “I’m on a landline now. This is the social worker at Booker T. Washington Public Charter School. She’s advising a 16 year-old was withdrawn from school by the mother and the 6 year-old and a 10 year-old have not been at school and they want to check on the welfare of the juveniles.”
- 11:57 a.m. – Officer #1 tells the dispatcher to “clear the last call. 10-8 [I’m available for assignment.] There’s an adult on the scene.” The dispatcher responds, “Okay, we are aware that there’s an adult on the scene. Advise that the mother has withdrawn all the children from school, sir. She has mental problems and they’re trying to check on the welfare of the children.” Officer #1 then replies, “Okay. The kids seem fine to me, ma’am.”
- 11:58 a.m. – The dispatcher responds, “Well, they’re supposed to be in school.”
- 11:59 a.m. – Officer #1 asks the dispatcher, “Can you send a truant car to my location?”

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<sup>144</sup> A communications supervisor in the OUC said that it is possible for an officer to have arrived on a scene before the dispatcher keys the officer’s status into the system as having arrived at the scene. Officer #2 did not radio the dispatcher to say he had arrived at [REDACTED] \*

<sup>145</sup> Times referenced in this summary are periodically recited by dispatchers and can be clearly heard on the recording.

The dispatcher calls for a truant car and then replies to Officer #1, “They don’t have a truant car. They’re all held on assignments.”

12:00 p.m. – Dispatcher radios Officer #1: “Okay, just to advise, I just called the social worker at Booker T. Washington Charter School in reference to 16 year-old and she advises that they’ve been withdrawn for about 2 months, just to update you.” The officer responds, “Okay. If possible, can you send an official to my location then?”

12:02 p.m. – Sergeant radios in, “I’m just down the street. I’ll respond.” Officer #2 then informs the dispatcher, “I’m on the scene with [Officer #1] at [REDACTED] [REDACTED] \* (indiscernable.)”

Following this radio transmission, there is no communication for the remainder of the recording between any of the MPD officers and the OUC dispatcher regarding [REDACTED] \* or the children.

The next radio communication comes at 12:11 p.m., when the sergeant asks the dispatcher, “Can you pick up the phone? I’m waiting on hold.” Approximately twenty minutes later, the dispatcher checks in with the sergeant again via radio.

12:30p.m – “12:30 hours. And [sergeant’s cruiser number.] [sergeant’s cruiser number.] No acknowledgement at 12:31.”

At 12:37 p.m., the dispatcher begins discussing another call involving an assault, and she asks Officer #2 whether he is “still held on [REDACTED] \* or can you be cleared to assist [sergeant] down there?” At 12:42 p.m., it appears that Officer #1, Officer #2, and the sergeant have concluded the call at [REDACTED] \* and Officer #2 is en route to another location.

12:42 p.m. – The dispatcher asks, “[Officer #2], are you on the scene [of the call regarding the assault] yet?” Officer #2 responds, “We’re pulling around the corner.” The sergeant informs the dispatcher that he is clear and to “advise from 6<sup>th</sup> Street.” The dispatcher asks Officer #1, “you’re clear also?” Officer #1 says that he is “back on [his] detail.” The dispatcher then sends Officer #1 and the sergeant to a call on 18<sup>th</sup> St., S.E.

(3) Summary of April 30, 2007, events excerpted from January 13, 2008, internal MPD memorandum<sup>146</sup>

On April 30, 2007, [Officer #2] and [Officer #1] responded to [REDACTED] \* .... When [Officer #2 and Officer #1] arrived on the scene, they encountered [REDACTED] \* who would not allow them entry and would not allow them to see the children. The

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<sup>146</sup> The memorandum is dated 4 days after the discovery of [REDACTED] \* children and 3 days after the sergeant and a member of MPD’s Internal Affairs Division attended a January 10, 2008, “Critical Event Meeting” that was convened at CFSA to discuss services provided to and interactions with the [REDACTED] \* family. Also in attendance were employees from CFSA, the Executive Office of the Mayor, the Office of the Attorney General, and the Office of the City Administrator. CFSA convenes a Child Fatality Critical Event Meeting within 24 hours of notice of a child fatality. The goals of the meeting are to explore the circumstances of a child fatality; determine the risk to other children in the home and the family’s needs; and recommend further investigative action.

officers then called for a supervisor. I [sergeant] responded to their call for assistance. When I arrived on the scene, ██████████\* was in the doorway of the residence speaking with the officers. She appeared at that time to be annoyed. [Officer #1] advised me what the situation was. I then spoke with ██████████\*. She was belligerent and uncooperative at first. She was advised that we just needed to check on the welfare of the children. She was asked if we could step inside and she refused stating that if we didn't have a warrant we could not come in. ██████████\* was advised that we needed to see the kids. She eventually relented and she allowed us to speak with the children. The ones I clearly remember are the three youngest. I believe the oldest, ██████████\* was on the scene as well after I thought about it some more because that is the one we were there to check on .... During our conversation with ██████████\*, she advised us that she was home schooling the children because she doesn't like the fact that young kids are exposed to sex education at a young age and they were bringing home inappropriately drawn pictures and that during sex ED they were teaching about homosexuality and other thoughts along those lines. I then contacted communications and was given the contact name and number for [the BTW social worker who called CFSA and MPD]. I called [her] and advised her that the kids were okay and appeared to be in good condition. While [sic] speaking with [the BTW social worker], [Officer #1] actually sat down with one of the children, who was showing him a book that ██████████\* had bought for home schooling purposes. [The BTW social worker] was advised that ██████████\* was planning on home schooling the children. [The social worker] advised me that there [were] criteria for home schooling the children and she explained what she knew about the process. ██████████\* was then relayed the same information and she was being very stubborn about not wanting to go by the DC Government's curriculum because of the previously cited [sic] reasons .... After several attempts to get through to her the importance of enrolling the kids in a home school program and her arguing her point about not liking the school systems curriculum, I along with the other officers left. I contacted [the BTW social worker] and got the name and number of the family services person who was handling the case and called and left a message.<sup>147</sup> I told [Officer #1] and [Officer #2] to be sure to follow up with the family services office and try to get them help and get their attention towards the case because [the BTW social worker] felt they were not taking the case seriously.

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<sup>147</sup> During an interview with the team, IW was asked whether he spoke with or received a message from anyone else at MPD. IW said that he only had contact with MPD Officer #1.

## ISSUES AND FINDINGS

### **There is a lack of certainty that any MPD officer actually saw [REDACTED] \*, the subject of the “check on the welfare” call.**

As he wrote in his memorandum of January 13, 2008, the MPD sergeant who responded to [REDACTED] \* “believe[s]” he saw [REDACTED] \*. Apart from this statement, the team found no documentation or any reference on the recorded radio transmissions to indicate the MPD officers saw or interacted with [REDACTED] \* on April 30, 2007.

During the radio communications between the responding officers and the OUC dispatcher, [REDACTED] \* name is never mentioned. Approximately 3 minutes after he informs the dispatcher that he is pulling onto the block of [REDACTED] \*, Officer #1 “clears” the call and states, “There is an adult on the scene.” There is no indication that Officer #1 identified the adult on the scene. The dispatcher never provided Officer #1 with [REDACTED] \* name; the only family member mentioned by name over the radio is [REDACTED] \* when the dispatcher informs Officer #1 she is the subject of the “check on the welfare” call.

### **MPD radio transmissions from April 30, 2007, do not support the MPD officer’s recollection of the “check on the welfare” call.**

The team noted a significant incongruity between the primary events as documented by the audio recording of MPD radio transmissions and the sequence of events presented in the January 13, 2008, MPD memorandum. According to the audio recording, approximately 3 minutes after informing the OUC dispatcher that he is pulling onto the block, Officer #1 states there is an adult on the scene and that “the kids seem fine.”

This sequence of events differs significantly from the sequence of events put forth in the memorandum. The sergeant who reportedly visited with [REDACTED] \* indicated in his memorandum that when Officer #1 and Officer #2 first arrived on the scene they encountered “[REDACTED] \*[,] who would not allow them entry and would not allow them to see the children. The officers then called for a supervisor. I responded to their call for assistance ....” Due to the “gag order,” the team was unable to interview the MPD officers to clarify, among other things, what led Officer #1 to radio to the OUC dispatcher after only several minutes on the scene that the kids seemed “fine,” while the sergeant recalled that even after he arrived, [REDACTED] \* was “belligerent and uncooperative at first,” refused to allow the officers to see the children, but “eventually relented.”

The team was also unable to fully understand and assess the actions the officers reportedly took following their visit to the house. For example:

- Why, after the sergeant told the BTW social worker during an April 30, 2007, telephone call he placed from [REDACTED] \* that “the kids were okay and appeared to be in good condition,” did he instruct Officer #1 and Officer #2 “to be sure to follow up with the family services office and try to get them help and get their attention towards the case ...”?

- Why did MPD Officer #1 return to the house, reportedly out of uniform, on May 1, 2007, with CFSA’s Investigations Worker?

**There is no specific guidance in MPD for handling and documenting a “check on the welfare” call. The team was told that none of the officers who responded on April 30, 2007, took notes or completed a report regarding their interactions with the family.**

The team asked MPD to furnish all policies and procedures that detail a proper response to a “check on the welfare” call. A senior MPD officer informed the team, “there is no policy for every situation that [officers] encounter” and agreed to provide relevant General Orders.

MPD provided two General Orders: General Order 302.1, entitled *Calls for Police Service*, and General Order 401.1, entitled *Field Reporting System*. General Order 302.1 has an effective date of April 28, 1981 (revised 1986), and it neither defines nor enumerates procedure for a “check on the welfare” call. The *Field Reporting System* General Order states that an officer “shall file a report for all reported crimes and incidents brought to his/her attention. Self-initiated police action taken and calls for police service shall be accurately and thoroughly documented to ensure that a follow-up investigation can be conducted for potential adjudication.” As with General Order 302.1, however, the *Field Reporting System* General Order does not define a “check on the welfare” call and provides no specific instruction as to how an officer responding to such a call must document the situation encountered, the individual(s) that he or she interacted with, and the actions he or she took.

When asked to provide all notes and reports used to produce the memorandum cited above, the sergeant who went to [REDACTED] \* on April 30, 2007, informed the team that “there were no hand written notes or 251<sup>148</sup> prepared in reference to the contact we (meaning all 7<sup>th</sup> District personnel) had on April 30 and May 1, 2007.” If the sergeant’s statement is accurate, then the officers’ failure to document their actions would appear to constitute a violation of the *Field Reporting System* General Order.

Due to the lack of criteria for how an MPD officer should respond to and document a “check on the welfare” call, the absence of notes and reports taken by the officers who responded, and the D.C. Superior Court “gag order,” the team was unable to conduct interviews to fully assess the actions of the MPD officers who went to [REDACTED] \* on April 30, 2007.

In response to the request for applicable policies and procedures, an MPD Assistant Chief also told the team that after discovery of the girls’ bodies, MPD issued a teletype regarding an updated “protocol.” However, members of MPD’s Policy Development Division were unable to locate the new protocol.

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<sup>148</sup> A PD Form 251 is an event report that is used for “documenting reported incidents or offenses that indicate a violation of the laws and ordinances established in the District of Columbia and the United States, as well as for documenting miscellaneous reports.” MPD General Order 401.01 (Mar. 4, 2004) at 7.

### RECOMMENDATIONS

- That the Chief of the Metropolitan Police Department ensure that MPD General Orders are revised to provide clear guidance on how MPD officers should respond to and document “check on the welfare” calls.
- That the Chief of the Metropolitan Police Department explore the legality and feasibility of providing information to both CFSA and the Healthy Families/Thriving Communities Collaboratives regarding the disposition of “check on the welfare” calls that involve minor children.

**BTW TRUANCY REFERRAL TO D.C. SUPERIOR COURT**  
(MAY 2007 – JUNE 2007)

Key Finding:

- The Court's Social Services Division mishandled the truancy referral regarding [REDACTED]\*, and sent its response to the referral to DCPS instead of the Booker T. Washington Public Charter School.

On May 11, 2007, BTW's attendance counselor mailed a truancy referral to the Court Social Services Division of the D.C. Superior Court (CSSD).<sup>149</sup> The referral stated that:

[REDACTED]

When asked to summarize the "intervention efforts" already made, the counselor wrote:

[REDACTED]

Included with the referral were [REDACTED]<sup>150</sup> and [REDACTED]<sup>151</sup>. The attendance summary indicated that [REDACTED]. The referral, dated May 10, 2007, was assigned to a CSSD probation officer on May 23, 2007.<sup>151</sup>

With the school year coming to a close, BTW mailed a letter to the family's home on June 1, 2007, informing [REDACTED] that the school's admission commission had decided, based on a review of academic, behavioral, and attendance records, that [REDACTED]. On June 13, the school withdrew [REDACTED] from the D.C. Stars attendance system.

[REDACTED]'s final report card was generated 2 days later, and with a final grade point average of [REDACTED], she was "promoted" to the 10<sup>th</sup> grade.

On June 29, 2007, the CSSD probation officer sent a determination letter regarding the referral to the Division of Student and School Support Services (DSSSS), a DCPS office

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<sup>149</sup> D.C. Code § 8-247 requires all youths between the ages of 5 and 18 to attend school. According to DCPS Truancy Reporting and Intervention Protocols, school absences for 15 days or more for students over 12 "will trigger a referral from DCPS to CSS for petitioning determination and referral to the assigned Assistant Attorney General..." See FAMILY COURT/COURT SOCIAL SERVICES INTAKE SERVICES BRANCH PROCEDURAL GUIDELINES II (2007).

<sup>150</sup> The office index card lists [REDACTED]'s demographic information, her parent's contact information, and a brief school history.

<sup>151</sup> Probation officers are responsible for case management and supervision activities of youth under CSS supervision, including children and youth referred for truancy. See Probation Officer II B JS-0101-11 and Probation Officer I JS-09 job descriptions.

<sup>152</sup> According to BTW, the school's standard practice is to withdraw every student at the end of the school year and re-enter returning students at the beginning of the next school year. Put another way, all students are "withdrawn" at the end of the school year.



signed the CSSD referral on Thursday, May 10, 2007, the school had recorded [REDACTED]<sup>v</sup> unexcused absences since March 9. Using the 15-day standard enumerated in DCPS Directive 522.4 as a benchmark, BTW did not make a timely referral to CSSD.

**CSSD mishandled BTW’s truancy referral and sent its response to DCPS instead of BTW.**

In order to assess CSSD’s response to [REDACTED]\* referral, the team requested all documents pertaining to its handling of the referral. The OIG received the following information from the CSSD Executive Officer:

- probation officer and supervisory probation officer job descriptions;
- truancy policies and procedures effective May 2007;
- revised<sup>157</sup> determination letters (i.e., the form letter typically sent to schools that outline actions the school and/or CSSD need to take); and
- the referral BTW sent to the Court.

In accordance with D.C. Superior Court Family Division Rule 103, governing juvenile proceedings, CSSD should screen all referrals from DCPS, parents, and legal guardians to determine if a case needs supervision.<sup>158</sup> The Court further clarified for the team that it is required to respond to all cases referred from schools in the District, including charter schools. The CSSD intake unit shall consider “the mental and physical condition of the respondent, the number of alleged absences from school, the circumstances surrounding such absence, the efforts of the school or other community resources to remedy the situation, and whether or not judicial action appears appropriate and reasonably likely to remedy the situation.”<sup>159</sup>

A CSSD manager acknowledged during an interview that the probation officer did not follow procedure. According to CSSD policy, probation officers are required to screen new referral packages within 2 business days of receipt to determine whether additional information is needed from the referral source for a comprehensive screening of the youth and family referred.<sup>160</sup> Once additional information is received, CSSD screens the youth and family within 5 business days to determine if interventions as defined by D.C. Superior Court Family Division Rule 103 were implemented. She acknowledged that CSSD exceeded the 5-day timeframe for follow-up, that there was no conference between the probation officer and her unit supervisor to determine a course of action, and that the determination letter was not sent to the referring school - BTW.

CSSD provided the following explanation as to why the determination letter went to DCPS:

Further complicating the process was a procedural change by D.C. Public Schools (DCPS) that was not communicated to CSSD. When the Mayor was granted control over the DCPS, the charter

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<sup>157</sup> The letters appear to have been updated since May 2007.

<sup>158</sup> See FAMILY COURT/COURT SOCIAL SERVICES INTAKE SERVICES BRANCH PROCEDURAL GUIDELINES II (2007).

<sup>159</sup> D.C. SUP. CT. FAM. DIV. R. GOV. JUV. PROCEEDINGS 103(b).

<sup>160</sup> See FAMILY COURT/COURT SOCIAL SERVICES INTAKE SERVICES BRANCH PROCEDURAL GUIDELINES II (2007).

schools were given authority to contact the court directly, rather than work through the DCPS Office of Student Support Services (OSS) as had previously been the practice. Not knowing of that change in procedure, the Court returned the [REDACTED]\* referral to OSS for additional action and information.

Thirty-eight days elapsed from the date the BTW referral was submitted to CSSD, and the date the request for additional information was erroneously sent to DCPS. In fact, BTW's attendance counselor did not learn that the referral regarding [REDACTED]\* had not been petitioned until the OIG team informed her during an interview.

#### **RECOMMENDATIONS**

- That the Public Charter School Board (PCSB) continue to work closely with DCPS to ensure that their policies and procedures for tracking truancy and referring truant students to CSSD are comparable.
- That PCSB and DCPS promulgate policies that (1) prevent schools from closing out a truancy referral without receipt of documentation or a determination letter from D.C. Superior Court, and (2) require the referring school to contact the Court in the event it has not received a response to its referral within 5 business days.
- That PCSB and DCPS ensure that all schools are provided with CSSD truancy referral policies and procedures.
- That DCPS implement procedures to ensure that it acts promptly to address all determination letters from CSSD and contacts CSSD if it receives a determination letter for a non-DCPS school.





( [REDACTED], Washington, D.C.)

**\* – INCOME, EXPENSES, AND EVICTION**  
(AUGUST 2006 – JANUARY 2008)

Key Findings:

- After placing the family in the house, TCP never saw the family again.
- TCP was unaware that the house it was renting on the family's behalf had been foreclosed on and the family was being evicted.



\*√

From January 2006 to November 2006, the family's ██████████\*√ was consistently loaded onto ██████████\*√ on the 3<sup>rd</sup> or 5<sup>th</sup> day of every month. The family generally made purchases using the ██████████\*√ benefit throughout each month, i.e., the monies lasted until the end of the month. The family's ██████████\*√ benefit on the other hand, which was loaded onto the card on the 1<sup>st</sup> day of each month and could be withdrawn in the form of cash from ATMs, would often be depleted within the first 7-10 days of each month.

Beginning in August 2006, TCP paid \$1,580 in monthly rent to a management company so that the family could live in the three bedroom row house at ██████████\* ██████████\* was responsible for the utilities: D.C. Water and Sewer Authority (WASA), Washington Gas, and Potomac Electric Power Co. (PEPCO). It appears that ██████████\* and ██████████\* relied primarily on their ██████████\*√ and ██████████\*√ benefits in order to cover their household expenses. During this time, ██████████\* also appears to have been receiving child support payments.<sup>161</sup>

Shortly after the family moved into the house, a social worker at George Washington University's ██████████\* Center provided ██████████\* with a referral to Food & Friends, a District-based non-profit organization that delivers prepared meals and groceries to individuals and families

<sup>161</sup> Records of calls made from the ██████████\*/██████████\* cell phone indicate that someone made frequent calls to the automated information system of the Child Support Enforcement Division (CSED) of the Maryland Department of Human Resources. Through this system, a caller is able to obtain information about his/her case, such as support payment dates, court hearing dates, and case status. Due to confidentiality laws, however, the team was unable to confirm the amounts and frequency of the child support checks that ██████████\* received from the State of Maryland.

who are facing serious illness. Based on this referral, ██████████\* and the four girls, whom the program viewed as his dependents, began receiving meals.<sup>62</sup>

In October 2006, the family was receiving ██████████\*<sup>√</sup>, ██████████\*<sup>√</sup>, and ██████████\*<sup>√</sup> income,<sup>163</sup> along with deliveries of prepared meals 3 days per week. Each of the four girls was attending a D.C. public charter school and the family appears to have achieved a level of stability it had not known for quite some time. As described throughout this report, many hands had helped lift the family to this point, and many elements for success seemed to be in place. Soon, however, the family's system of support began to unravel.

██████████\* visited the IMA office on November 30, 2006, in order to recertify the family's ██████████\*<sup>√</sup> and ██████████\*<sup>√</sup> benefits, which were due to expire that day. She lacked requisite documents regarding ██████████\* school attendance and ██████████\* income, and was asked to return with them. On December 8, she provided IMA with information confirming ██████████\* enrollment at BTW, but appears to have lacked the information regarding ██████████\* income. She did not return with the information necessary to determine the family's eligibility, and as a result, the ██████████\*<sup>√</sup> benefit lapsed and the family's monthly income dropped by nearly 50%.<sup>164</sup> IMA told the team that the ██████████\*<sup>√</sup> and ██████████\*<sup>√</sup> benefits are "linked" in such a way that once a client stops receiving a ██████████\*<sup>√</sup> benefit, the ██████████\*<sup>√</sup> benefit is discontinued several months later if the client doesn't make the necessary contact. In the case of the ██████████\* ██████████\* family, the ██████████\*<sup>√</sup> benefit was last loaded onto the EBT card on November 5, 2006, but IMA continued to load the ██████████\*<sup>√</sup> benefit onto the card for another 11 months.

According to a Food & Friends manager, on February 12, 2007, a family member informed the non-profit that ██████████\* was in the hospital; in accordance with their policies, they discontinued the food deliveries but planned on resuming them once he returned home. ██████████\* died on February 19, 2007, and the meal deliveries, therefore, did not resume.

A friend of ██████████\* told the team that ██████████\* would on occasion sell a portion of the medications he received in order to provide additional money for the family. Interviewees commonly characterized ██████████\* as the manager of the family's affairs, an assessment that is supported by the fact that after his death, the family's household bills essentially went unpaid.

Call records for the family's primary cell phone stop on April 27, 2007, and resume very briefly on May 28, 2007, which suggests that ██████████\* may have run out of prepaid minutes.<sup>165</sup> On

<sup>162</sup> From September 2006 up until ██████████\* death on February 19, 2007, prepared meals were delivered to the family 3 days per week. In total, the family received nearly 75 deliveries.

<sup>163</sup> In September 2006, the Social Security Administration (SSA) sent a letter to ██████████\* at his mother's home stating that he was entitled to ██████████\*<sup>√</sup> beginning February 2006, ██████████\*<sup>√</sup> SSA decided to withhold the benefits from February 2006 through August 2006, but beginning September 2006 and for each month after, it appears ██████████\* began receiving a monthly check ██████████\*.

In November 2006, the family's ██████████\* monthly ██████████\*<sup>√</sup> benefit represented 47% of the monthly benefits loaded onto their EBT card.

<sup>165</sup> The last call on April 27, 2007, was to the MD Child Support Enforcement Division. On May 28, one call was placed to the OCFO EBT office. The last call in the records obtained by the team was made to WASA on May 29, 2007.

May 31, 2007, the Washington Gas service was disconnected. By this time, only a ██████████\*<sup>√</sup> benefit of ██████████\*<sup>√</sup> was being loaded each month onto ██████████\* EBT card. Whoever was using the card, presumably ██████████\*, appears to have stayed close to the house. From June 9, 2007, until 5 months later when the benefit was exhausted, the only transactions made using the card occurred at a food market located a half block north of ██████████\*.

Unknown to both TCP and the property management company to which it was sending monthly rent payments, ██████████\* was sold at a foreclosure auction. On June 25, 2007, a Virginia-based law firm delivered a Notice to Vacate, instructing the occupants to leave the premises within 30 days.

If you are a legal tenant of the former owner of the Premises, the Notice to Vacate does not apply to you. Kindly immediately send a copy of your lease to me at the above address or fax number, so that the [new owner] will be able to meet its landlord obligations to you.

In a continuation of efforts to clear the home, a process server visited the home on June 24 and June 26, 2007. On the second visit, a *Quit and Vacate* notice was posted on the front door of the house.

On August 8, 2007, two PEPCO customer credit field representatives visited the house. No one answered the door, so they left a collection letter. Following a filing by the law firm in the Landlord and Tenant Branch of the District of Columbia Superior Court, a summons to appear was mailed to ██████████\*, instructing the owner and/or occupants of the home to appear the following month to answer a complaint that they had failed to vacate the property. A process server continued to visit the home, attempting to deliver a court summons on August 19 and August 25, 2007.

By August 25<sup>th</sup>, the balance on the WASA account had grown to over ██████████\*, at which point the utility terminated water service to the house. On September 5, 2007, two PEPCO representatives visited the house again, and due to the lack of a response at the door, they left a disconnection notice. The electricity to the house was shut off that same day.

In a letter dated September 10, 2007, IMA informed ██████████\* of a mandatory benefits review that was scheduled for the following week. “If you fail to keep your scheduled appointment, your ... ██████████\*<sup>√</sup> ... benefits may be terminated.” ██████████\* did not keep the appointment and IMA terminated her case, but not before loading one last month of ██████████\*<sup>√</sup> benefits, ██████████\*<sup>√</sup>, onto the EBT card on October 1, 2007.

TCP mailed ██████████\* a letter on October 12, 2007, informing him that TCP needed to inspect the house.

Please know that **the inspection of your home is not an option** and your assistance is required to ensure we remain in compliance and can continue to receive the funds that pay your rental subsidy.

It is imperative that you contact [us] immediately to schedule an inspection that can be conducted at a time that is convenient to you .... We continue to support you as a citizen of the District of Columbia and appreciate your adherence to all program requirements. Thank you for your assistance with this matter.

Nineteen months after ██████████\* acceptance into the S+C program and over 8 months after his death, TCP sent another fax to DMH indicating that he and a number of other S+C “expansion” families had not yet been linked with supportive services. On this same day, November 5, 2007, the final transaction on the family’s EBT card was processed: a purchase of ██████████\*<sup>v</sup> against the ██████████\*<sup>v</sup> benefit.

The U.S. Marshals Service originally planned to evict the occupants of ██████████\* on January 8, 2008, but the weather forecast called for rain. In accordance with its procedures, the Marshals postponed the eviction by 1 day. A realtor who had been hired by the new owner to prepare the house for resale was unaware of the postponement, and went to the house anyway. He first spoke with a neighbor, who told him she hadn’t seen anyone in the house for several months and thought the house was vacant. The realtor knocked, and after receiving no answer, he rattled the doorknob. ██████████\* opened the door and stuck her head out. She told the realtor she had been sick and out of work. He spoke with her about social services that might be available to her, to which she responded, “I’ve burnt them all out.” He informed her that the Marshals would be back the next day to process the eviction.

On the morning of January 9, 2008, the Marshals arrived with a writ of restitution to remove the occupants of the house. Upon entering the home, the Marshals encountered ██████████\* and found the bodies of her four daughters.

#### ISSUES AND FINDINGS

**██████████\* and her children were eligible to live in ██████████\* with their rent paid by the S+C program, for up to 1 year after ██████████\* death.**

The “Rental Assistance Contract” that ██████████\* signed at “lease up” clearly allows surviving family members to remain in the house for a period of time. ██████████\* and her children are identified as “secondary occupants” on the lease and in the rental assistance contract that ██████████\* signed. As a result of this designation, they were “authorized to receive assistance on behalf of the deceased participant for a maximum of (1) year .... Each case will be reviewed individually by The Community Partnership to ensure fair housing.” It appears that ██████████\* and her children could have stayed in the house at least until February 2008; presumably they would have been linked to other services and benefits when they were no longer eligible to remain in the house.

**TCP did not retain a set of keys to ██████████\*.**

TCP’s *Sponsoring Agency Contract* states that the sponsoring agency must “retain in their possession, a copy of keys for each unit identified in their Community Partnership Shelter

Plus Care housing inventory. Keys must be kept in a safe location and used only for emergencies and unit inspections when necessary.” ██████████\* was never assigned a sponsoring agency, the entity that would have been responsible for keeping a set of keys to the house. TCP’s property administrator told the team that it does not have keys to properties being used as S+C program residential units. The owner of the property management company responsible for the house told the team that he had a set of keys to the house, but that (1) he was not aware of the annual S+C program inspection requirement, and (2) TCP never contacted him about using the keys to gain entry to the house.

**TCP was unaware that the house it was renting on the family’s behalf had been foreclosed on and they were being evicted.**

The principal of the property management company, which received the rent payments from TCP on behalf of the house’s owner, told the team that he was unaware the property had been sold at foreclosure until he saw the news of the discovery of the girls’ bodies during the eviction proceeding. Similarly, TCP staff members did not learn of the foreclosure and resulting eviction until news of the discovery of the girls’ bodies prompted them to contact the owner of the management company.

**When U.S. Marshals process an eviction, they do not refer the family to or notify a social services agency or provider.**

If the eviction had been routine, and on January 9, 2008, the Marshals had not encountered four dead children but, instead, ██████████\* and her four children alive and well in the house, the Marshals would have given ██████████\* and her children a brief period of time to collect their valuables, and then instructed them to exit the house and wait for the hired movers to bring out their remaining property.

Standard operating procedures provided by the Marshals Service offer brief guidance on dealing with unattended minor children and sick individuals. There is nothing in the procedures, however, that indicates ██████████\* and her children would have been referred to a support services agency such as a Collaborative or the District’s Department of Human Services following eviction from their home.

**RECOMMENDATION**

That the U.S. Marshals Service collaborate with the District’s Department of Human Services to develop and document procedures through which (1) all persons who are evicted from their home are given contact information for a specific support services agency, and (2) the support services agency is provided with the name and contact information for each person evicted from the home.

**APPENDICES**

## APPENDICES

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- Appendix 1: VWFRC Intake Form for [REDACTED]\*
- Appendix 2: Families Forward General Application for [REDACTED]\*/[REDACTED]\* Family
- Appendix 3: Shelter Plus Care Sponsoring Agency Contract (blank sample, partial)
- Appendix 4: Shelter Plus Care Program Home Visit Report (blank sample)
- Appendix 5: Transcript of April 27, 2007, Call from BTW Social Worker to CFSA Hotline; CFSA Hotline Worker's Written Summary of the Call
- Appendix 6: May 2007 Report by CFSA's Diligent Search Unit
- Appendix 7: Office of Unified Communications Event Chronology; January 13, 2008, Memorandum Regarding its April 30, 2007, Response to [REDACTED]  
[REDACTED]\*
- Appendix 8: CFSA Administrative Issuance dated March 7, 2008

**APPENDIX 1**

# Coalition for the Homeless

Date Completed:                       
 Program/Site: WMMC

Staff:                     

## BASIC INTAKE FORM

The information on this form should be filled out as completely as possible. Please let the client know that ALL information given will be confidential, and that providing as complete information as possible will help us provide more complete service.

<b>Profile Information</b>		First <u>                    </u> * Middle <u>                    </u> * Last <u>                    </u> *		Suffix <u>                    </u>	
Other Name Used to Receive Services Previously		First <u>                    </u> * Middle <u>                    </u> * Last <u>                    </u> *		Suffix <u>                    </u>	
2.1 Social Security number: <u>                    </u>		SSN quality: <input checked="" type="checkbox"/> Full SSN Reported <input type="checkbox"/> Don't know SSN		2.3 Date of Birth: <u>                    </u> / <u>                    </u> / <u>                    </u> <input type="checkbox"/> No Response, then Estimated Age: <u>                    </u>	
2.2 Ethnicity and Race		2.4 Racial Background: <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Asian & White		2.5 Residency prior to program entry: <input type="checkbox"/> Foster Care <input type="checkbox"/> Rental Property <input type="checkbox"/> Staying with Family <input type="checkbox"/> Owned Property <input type="checkbox"/> Staying with Friends <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> No Response <input type="checkbox"/> Other	
2.6 Gender: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male		2.7 Disabling Condition: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		2.8 Length of Stay in Previous Place: <input type="checkbox"/> One week or less <input type="checkbox"/> 1 week - less than 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> More than 3 months, but less than 1 year <input type="checkbox"/> One year or longer	
2.9 Zip code of last residence: Zip Code: <u>                    </u> If unknown, Address/City of last stable residence: <u>                    </u>		2.10 Primary Language: <u>                    </u>		2.11 Primary Language: <u>                    </u>	
<b>Chronically Homeless Criteria</b>					
Is this person seeking shelter only for themselves? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
<b>Unaccompanied</b>					
1. At least four (4) episodes of homelessness in the past three (3) years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
2. Has either been continuously homeless for a year or more <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
<b>Time Period:</b>					
1. Diagnosable substance use disorder <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
2. Developmental disability <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
3. Chronic physical illness or disability <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
4. Serious Mental illness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
<b>Disabling Condition:</b>					
If client is unaccompanied and if yes to either time period criteria and at least one disabling condition, then the client is considered chronically homeless. By this definition, is Client chronically homeless? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Additional Profile Information: City of Birth: <u>                    </u> State of Birth: <u>                    </u> Primary Language: <u>                    </u> Country of Birth: <u>                    </u> Emergency Contact Name: <u>                    </u> Contact's Address: <u>                    </u> City: <u>                    </u> State: <u>                    </u> Phone Number: <u>                    </u> Alternate: <u>                    </u> Emergency Contact Relationship: Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown Do you have any children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? <u>                    </u> What are their ages? <input type="checkbox"/> 0-7 (elementary) <input type="checkbox"/> Some college <input type="checkbox"/> Post Graduate <input type="checkbox"/> 8-12 (some HS) <input type="checkbox"/> College Degree <input type="checkbox"/> Technical Training Education: <input type="checkbox"/> GED/HS Diploma <input type="checkbox"/> Unknown Comments: <u>                    </u>					

**Coalition for the Homeless: BASIC INTAKE FORM, Continued**

<b>Employment Status</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please select reason:</i> <input type="checkbox"/> Student <input type="checkbox"/> Unpaid internship/ work experience <input type="checkbox"/> Retired <input type="checkbox"/> Unable to work <input type="checkbox"/> Homemaker <input type="checkbox"/> Unable to find work <input type="checkbox"/> Other: _____ <i>Comments/Further Explanation:</i> _____	
Are you currently employed? If yes, please indicate type of current employment: <input type="checkbox"/> Full-time (40 hours/week) <input type="checkbox"/> Part-time (less than 40 hours/week) <input type="checkbox"/> Full-time Seasonal <input type="checkbox"/> Part-time Seasonal How many hours are you currently working? _____		Are you currently seeking employment? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently in school or working on a degree or certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Source and Amount of Income (Insert the monthly dollar value of each source)</b>			
<input type="checkbox"/> Earned income \$ _____	<input type="checkbox"/> Worker's Comp \$ _____	<input type="checkbox"/> Child Support \$ _____	
<input type="checkbox"/> Unemployment Insurance \$ _____	<input type="checkbox"/> TANF \$ _____	<input type="checkbox"/> Alimony or other spousal support \$ _____	
<input type="checkbox"/> Supplemental Security Income \$ _____	<input type="checkbox"/> Interim Disability Account (DC) \$ _____	<input type="checkbox"/> Other Source \$ _____	
<input type="checkbox"/> Social Security Disability Income \$ _____	<input type="checkbox"/> Social Security Retirement Income \$ _____	<input type="checkbox"/> No Financial Resources	
<input type="checkbox"/> Veterans Disability Payment \$ _____	<input type="checkbox"/> Veteran's Pension \$ _____		
<input type="checkbox"/> Private Disability Insurance \$ _____	<input type="checkbox"/> Pension from former job \$ _____		
<b>Non-Cash Benefits (please indicate all categories that apply)</b>			
<input type="checkbox"/> MEDICAID Health Insurance	<input type="checkbox"/> WIC	<input type="checkbox"/> TANF Transportation Services	
<input type="checkbox"/> MEDICARE Health Insurance	<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Other TANF-funded Services	
<input type="checkbox"/> SCHIP-DC Healthy Families	<input type="checkbox"/> TANF Child Care Specialists	<input type="checkbox"/> Section 8, Public Housing or Other Rental Assistance	
<input type="checkbox"/> Food stamps or Food Money on a Benefits Card	<input type="checkbox"/> Other Source:	<input type="checkbox"/> No Non-Cash Benefit currently received	
<input type="checkbox"/> US Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Honorable Discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Military Service Related Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, describe:</i> _____
Receiving Veterans Services? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe:</i> _____			
<b>Legal Assessment</b>			
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Current or Pending Charge(s)	Date of Arrest	Convicted? <input type="checkbox"/> Yes <input type="checkbox"/> No Served Time? <input type="checkbox"/> Yes <input type="checkbox"/> No
On Parole? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Parole Officer Name: _____	Phone: _____	Parole End Date: _____
On Probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Probation Officer Name: _____	Phone: _____	Probation End Date: _____
<b>Special Needs (check all that apply)</b>			
<input type="checkbox"/> Physical disability	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Mental Health problem of long duration	<input type="checkbox"/> Domestic Abuse
<input type="checkbox"/> Developmentally Disabled	<input type="checkbox"/> Mental Health problem	<input type="checkbox"/> Chronic physical health problem	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Substance Abuse (please check all that apply below)	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Substance Abuse problem of long duration	Years, _____ Months, or _____
<input type="checkbox"/> PCP last used on: _____	<input type="checkbox"/> Heroin last used on: _____	<i>If yes, how long have you used drugs? Since _____</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Crack last used on: _____	<input type="checkbox"/> Methadone last used on: _____	<i>If yes, have you participated in a drug program? _____</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Medical Assessment</b>			
<input type="checkbox"/> Insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> No Coverage
Referral: How did you learn of this service? _____			

Check when entered Into ServicePoint: Name \_\_\_\_\_ Date Entered \_\_\_\_\_

**APPENDIX 2**

Families Forward General Application

Page 1 (to be filled out for all Programs)

Name of Applicant (First): [Redacted] (Last): [Redacted] Date of Referral: 12-14-05  
 Current Address: 1900 Mass Ave SE Apt #: 4441 City: Washington, DC ZIP: 20003  
 Home Phone: [Redacted] Work Phone: [Redacted]

Monthly Income at Intake: [Redacted] TANF:  Employment:  Social Security:  SSI:  Other:   
 Current Monthly Income: [Redacted] (Repeat) TANF:  Employment:  Social Security:  SSI:  Other:   
 Social Security #: [Redacted] Sex:  M  F Date of Birth: [Redacted]

Race:  African American  Hispanic  White  Asian/Pacific Islander  Native American or Alaskan Nati  Other  
 Marital Status:  Married  Divorced  Separated  Single  Widowed  
 Head of Household?  Yes  No  
 Family Size: # of adults: 2 # of children: 4

Type of household:  Female-headed  Male-headed  Two-parent  
 Highest Grade Completed: [Redacted] Check highest certificate received:  GED  High School Diploma  Tech School Diploma  Some College  College Diploma  Graduate School Diploma  
 Agency?  Continuing  New  Continuing

Other members of Household

First Name	Last Name	Soc. Sec. #	Date of Birth	Sex	Race	Adult or Child (A/C)
[Redacted]	[Redacted]	[Redacted]	[Redacted]	F	B	C
[Redacted]	[Redacted]	[Redacted]	[Redacted]	F	B	C
[Redacted]	[Redacted]	[Redacted]	[Redacted]	F	B	C
[Redacted]	[Redacted]	[Redacted]	[Redacted]	F	B	C

Referred by: 25 MSH SW

Source of Referral:  Self  Other medical staff  Police  
 Street outreach workers  Mental health outpatient clinic  PHA waiting list  
 Emergency or transitional housing staff  Alcohol or drug program  Church staff  
 Psychiatric hospital staff  Other social service staff  Other  
 Unknown

Veterans Status: # of Male Veterans in Household: 0  
 # of Female Veterans in Household: 0

Families Forward General Application

Name of Client (First): [Redacted] (Last): [Redacted]

Homeless Information:

Primary reason for being homeless:

- Domestic Dispute, Eviction, Drug Abuse, Overcrowded, Incarceration, Unemployment, Building Condemned/Fire, Other - Do where to live due to giving up lease, Not Homeless

Living situation at the time of referral:

- Streets, Emergency Shelter, Transitional Housing, Psychiatric Facility, Substance Abuse Treatment Facility, Hospital, Jail/Prison, Domestic Violence Situation, Living With Relatives/Friends, Rental Housing, Participant owned housing, Other Hotels, Not recorded

Date Entered Shelter (if applicable): 12-14-05 Date Entered Shelter Waitlist

Most recent NON-shelter address: Address: [Redacted] Wait list Number

City: Wash, DC

ZIP Code: Ward (if DC)

Name of Staff Member completing Form: [Redacted] Date: 1-24-06

APPENDICES

FAMILIES FORWARD  
INITIAL INTERVIEW ASSESSMENT FORM

(Please attach copies of pages 1 and 2 of the General Application.)

\* Participant's Name: [Redacted] \*

HOUSING REQUIREMENTS AND HISTORY

- 1. Number of bedrooms needed? 3 bedrooms
- 2. Is there anyone in your family who is not seeking shelter with you? no If yes, why not?

3. What are the circumstances surrounding your being homeless?

Family stated that they gave up apartment assuming they were going to live with a relative + some money but then aunt got sick

4. Have you applied for Public Housing/Section 8? yes When? 11/05 Status? pending

5. How many times have you moved in the past 5 years? 2

6. What were the reasons for these moves? Moved from Charles county to Washington DC.

7. How long have you been in the District of Columbia? 1 1/2

8. Is there a quadrant (SE, SW, NE, NW) in the city that is better suited to assist you with stabilizing your family? yes If the answer is yes, which one NE or NW explain why:

Family is not familiar with these areas.

9. Do you have housing, personal and credit references? yes If yes list below:

- a. Housing [Redacted] - 301 - [Redacted]
- b. Personal [Redacted]
- c. Credit no

EDUCATION

- 1. What grade did you finish in school? [Redacted]
- 2. Do you have a High School Diploma or GED? [Redacted] If yes, which [Redacted] Date Rec. [Redacted]
- 3. Are you or any member of your family a veteran? no

**APPENDICES**

Initial Interview Assessment Form Continued

Name	Branch	Dates of Service	Reason for Discharge
_____	N/A	_____	_____

4. Have you ever been in or completed any training programs? NO Would you like to? YES

\* If yes, list which ones and dates completed:  
 \* [redacted] wants to do a training program in electrical + plumbing and [redacted] has a hair dresser license

**EMPLOYMENT**

1. What kind of work have you done and what is the length of time in each job?

Position	Company	Dates
* [redacted]	* [redacted]	92-05
* [redacted]	* [redacted]	2001

2. What kind of work have other members of your family done?

Member	Position	Company	Dates
_____	N/A	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. If not employed, what do you want to be employed as?

\* [redacted] would like to be employed as a hairdresser.

4. What have you done recently to seek employment?

\* [redacted] has been applying to salons once a week.

**FINANCIAL:**

1. Do you have any outstanding debts?

\* [redacted]

2. Do you or have you ever had a bad credit rating? If yes, explain why:

\* [redacted]

APPENDICES

Initial Interview Assessment Form Continued

- 3. Would you be willing to file for a credit rating report? Y or N
- 4. What are your current sources of income? What is the net amount of income from each source?

Source <sup>#</sup> ✓  
\_\_\_\_\_

Amount <sup>#</sup> ✓  
\_\_\_\_\_

5. Do you receive assistance from any nutrition program such as food stamps or WIC? If yes, give amounts: \_\_\_\_\_

6. Do you have any assets? (bank account, car furniture, etc.) \_\_\_\_\_  
Name of Bank: \_\_\_\_\_ Amount: \_\_\_\_\_

7. Have you ever filed for bankruptcy? If so, explain. \_\_\_\_\_  
\_\_\_\_\_

8. Have you ever filed for child support? \_\_\_\_\_ If eligible, would you be willing to? \_\_\_\_\_

9. Do you make out a monthly budget? \_\_\_\_\_

10. Are you willing to start a savings account? \_\_\_\_\_

MEDICAL HISTORY

1. Do you or any member of your family have any physical illness or disability? \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

2. Do these illnesses prevent you from working? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

3. Do you or any member of your family have any mental/emotional problems, learning disabilities, or mental retardation? \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Are you or any member of your family on medications? \_\_\_\_\_ If yes, what are they? \_\_\_\_\_  
\_\_\_\_\_

5. Do you or any member of your family have a history of or current problem with drug abuse? \_\_\_\_\_  
\_\_\_\_\_

Initial Interview Assessment Form Continued

6. Have/Are you or any other member of your family been in a drug treatment program? \_\_\_\_\_  
If yes, how many times? \_\_\_\_\_  
a. Most recent treatment: (date & place)

PSYCHOSOCIAL/FAMILY

1. Have you ever been legally married? \_\_\_\_\_ Status of that marriage: Legally separated \_\_\_\_\_  
Divorced\_\_ (Date) \_\_\_\_\_  
If common law marriage, how long together: \_\_\_\_\_

2. Who are your sources of support?

<u>Name</u>	<u>Relationship</u>
-------------	---------------------

3. How many people do you know who you could call in an emergency? \_\_\_\_\_ Please name: \_\_\_\_\_

4. Do you belong to any clubs or churches? \_\_\_\_\_ If yes, please name: \_\_\_\_\_

5. Have you ever worked with Child Protective Services? \_\_\_\_\_ If yes, why? Who was your case worker? \_\_\_\_\_

6. Describe your relationship(s) with the children's other parent if not living with you: \_\_\_\_\_

7. What emotions do you feel most often? (happy, sad, lonely, etc.) \_\_\_\_\_ Why? \_\_\_\_\_

APPENDICES

Initial Interview Assessment Form Continued

8. Have there been any significant changes in your life, besides homelessness, which have been stressful for you? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

\_\_\_\_\_

9. Have you or anyone in the household ever been convicted of a criminal offense? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

10. Have you or any member of the household been a victim of a crime? \_\_\_\_\_

\_\_\_\_\_

11. Have you or any other family member witnessed a violent act? \_\_\_\_\_

\_\_\_\_\_

12. How do you feel about your parenting skills? Do you ever feel like you need help with those skills? \_\_\_\_\_

\_\_\_\_\_

13. What kind of help would you find useful? \_\_\_\_\_

\_\_\_\_\_

14. How do you and your children spend time together? \_\_\_\_\_

\_\_\_\_\_

<u>Name of Child</u>	<u>Age</u>	<u>School</u>	<u>Grade</u> or	<u>Day care</u>
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a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

d. \_\_\_\_\_

15. How are your children doing in school? \_\_\_\_\_

\_\_\_\_\_

Initial Interview Assessment Form Continued

16. Has homelessness affected the children's progress in school? If yes, how? \_\_\_\_\_

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17. What kind of help do you think the children need? (Tutoring, etc.) \_\_\_\_\_

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18. Are your children involved in any clubs, organizations, or churches?

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19. What kind of activities would you like to see your children involved with? (ex. sports, church, etc.) \_\_\_\_\_

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20. Who do your children associate with the most - friends or family members? Who are they?

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21. What are your family's goals for the future? \_\_\_\_\_

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ASSESSOR'S SUBJECTIVE OBSERVATIONS

1. Do you feel the interviewee(s) were valid informants? \_\_\_\_\_ Why?

2. If more than one family member was present, how did they interact?

3. Was conflicting information provided either during the interview or when making follow-up phone calls?



Questions to be asked in addition to the Initial Interview packet

1. What would you view as 3 of your personal strengths and weaknesses?  
\_\_\_\_\_  
\_\_\_\_\_
2. When was the last time you held employment over 6 months?  
\_\_\_\_\_  
\_\_\_\_\_
3. In the last 5 years, what have you done to enable your family to be self-sustaining? If you did not work in the last 5 years, what was the reason?  
\_\_\_\_\_  
\_\_\_\_\_
4. Do you have reliable daycare at the present time? Do you have a backup sitter in case your primary daycare provider is unable to care for your children?  
\_\_\_\_\_  
\_\_\_\_\_
5. Describe your support system? If you are employed and have to work additional shifts, do you have someone who could care for your children?  
\_\_\_\_\_  
\_\_\_\_\_
6. When was the last time you had a lease in your name? How did you leave that unit? Can we have the name and telephone number of that landlord? Did you leave with a rental balance? If so, how have you worked to satisfy that debt?  
\_\_\_\_\_  
\_\_\_\_\_
7. If you have never had a lease in your name, please explain why?  
\_\_\_\_\_  
\_\_\_\_\_
8. How do you manager your monthly income? Do you have enough money to last the entire month or do you need assistance with budgeting?  
\_\_\_\_\_  
\_\_\_\_\_

**APPENDICES**

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9. Please list all outstanding debts—these must include; past rental debt, old cell phone bills, utility bills i.e.....(gas, electric, water) credit card debt, motor vehicle fines, car loans, and child support.

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10. Do you have a current resume?

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11. If you had a family member that became homeless, would you allow them to live with you? If so, for how long?

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12. Do you currently have any charges pending against you? If so, what are they for?

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13. Are you currently involved with Child Protective Services? If so, what is the disposition of that case? If you have worker, please provide their name and phone number.

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14. This is a 12 month program, how do you feel this program will be able to benefit your family and assist you in becoming self sustaining?

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15. Why do you believe you will be able to become self sustaining with the assistance of our program? Please be specific.

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**APPENDIX 3**



## SHELTER PLUS CARE PROGRAM SPONSORING AGENCY CONTRACT

**AGENCY NAME** hereafter referred to as the "Contractor" and The Community Partnership for the Prevention of Homelessness hereafter referred to as "The Partnership" mutually agree to the following contract hereafter referred to as the "Contract" for Shelter Plus Care Rental Subsidies in the District of Columbia.

**SCOPE OF SERVICE:**

The Contractor shall provide **SPONSOR-BASED RENTAL ASSISTANCE (SRA)** permanent housing and supportive services to **(00)** homeless individuals living with **MENTAL ILLNESS, SUBSTANCE ABUSE AND/OR HIV/AIDS**. The Contractor understands that they are required to identify permanent housing and ensure a dollar for dollar in aggregate match for the delivery of supportive services to all participants receiving a Shelter Plus Care rent subsidy. The Contractor also understands that their Shelter Plus Care housing inventory consists of the following units:

(0)	One Bedrooms	(Individual Units)
(0)	Two-Bedrooms	(Shared Units)
(0)	Three-Bedroom	(Shared Units)
(0)	Four-Bedroom	(Shared Units)
(0)	Five-Bedroom	(Shared Units)

Failure to adhere to the aforementioned conditions may result in non-authorization of future rental subsidies and contract termination.

**CONTRACTOR'S ACCEPTANCE:**

\_\_\_\_\_  
Signature: Contractor's Authorized Representative

Phone: \_\_\_\_\_  
Date: \_\_\_\_\_

**THE PARTNERSHIP'S APPROVAL:**

\_\_\_\_\_  
*Chief Financial Officer, The Community Partnership*

\_\_\_\_\_  
*Executive Director, The Community Partnership*

Date: \_\_\_\_\_

*The signing of this contract certifies agreement with all the terms and conditions agreed upon by both parties hereto, and no other agreement, oral or otherwise shall be deemed to exist or be binding.*

**SERVICE REQUIREMENTS:**

1. The Contractor is required to provide or ensure the delivery of supportive services in which at least 85% of participants should demonstrate satisfactory continuity of care, as determined by a 50% sample of records by The Partnership. (At least 15% of participants will obtain employment or increase their income during program enrollment)
2. The Contractor is required to maintain case management files documenting all supportive services and referrals identified and delivered on behalf of the participant. If the Contractor does not provide direct supportive services to the participant, they must coordinate with the participant's identified supportive services agency to ensure the delivery of services. In addition, written documentation (i.e., progress notes, referrals, unusual incident reports, etc.) must be maintained within the participant's file substantiating all information/activity regarding the participant's supportive services.
3. The Contractor is required to report all supportive services match information to The Partnership's Shelter Plus Care Housing Coordinator bi-annually. Reporting periods will reflect all supportive services activities occurring during **February 1<sup>st</sup> through July 31<sup>st</sup>** and **August 1<sup>st</sup> through January 31<sup>st</sup>** of each year. In conjunction with the second supportive services match documentation report, please forward verification of match supportive funds for the provision of case management services for funds received outside of and/or directly from The Partnership. The verification should detail the grant amount and the dollar for dollar match provided. The Partnership will notify the Contractor in writing of submission dates. Reports must be received by the submission date to ensure the continuation of rent subsidy distribution.
4. The Contractor and The Partnership shall execute a **SHELTER PLUS CARE RENTAL ASSISTANCE CONTRACT** for the identified unit and participant authorized by The Partnership's Property Administrator to receive the Shelter Plus Care rental subsidy. All participants must have a Shelter Plus Care Sponsor-Based Rental Assistance Contract in their name for a unit either leased or owned by the Contractor. A copy of the lease agreement between the landlord/sponsoring agency and/or program participant must be forwarded to The Partnership's Property Administrator. This document is separate from the Shelter Plus Care Rental Assistance Contract executed at lease signing.
5. The Contractor is required to complete a **Shelter Plus Care Home Visit Report** each month on behalf of each program participant. Reports must be sent by fax or mail to the attention of the Property Administrator located at The Partnership no later than the **5<sup>th</sup> day of the following month**. If the **5<sup>th</sup> day** occurs on the weekend, reports must be submitted to The Partnership the Friday prior. If the **5<sup>th</sup>** occurs on a Monday holiday, reports must also be submitted the Friday prior. Home Visit Reports are required to be signed and dated by the staff person conducting and completing the report in addition to the Shelter Plus Care program participant. Rent subsidies will not be authorized for distribution if both signatures are not provided nor if the Home Visit Report is received after the **5<sup>th</sup> of the month**. Reports submitted after the **5<sup>th</sup> day of the month** will not receive authorization for rent subsidy payment and are therefore the responsibility of the Contractor to pay the program's portion of rent. In cases of tardy Home Visit Reports, The Partnership will notify the landlord and inform them that the Contractor is responsible for the participant's rent subsidy in addition to all late, legal and/or court fees.

## APPENDICES

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*In cases that warrant the Contractor to pay the program's portion of rent on behalf of the participant, documentation substantiating payment must be forwarded to the program's Property Administrator located at The Partnership prior to the disbursement of future rental subsidies.*

6. If a participant is unable to sign their Shelter Plus Care Home Visit Report as a result of (hospitalization, in-patient treatment, incarceration), the Contractor is required to forward a **Shelter Plus Care Sponsoring Agency Home Visit Report Waiver Request** to the Property Administrator located at The Partnership. In addition, supporting documentation must also be attached substantiating the waiver request. The Property Administrator will review each request for appropriateness and make a final decision regarding waiver authorization. It is the responsibility of the Contractor to ensure that staff and non-agency Case Management Advocates conducting home visits are aware of these requirements.
7. The Contractor is required to retain in the participant's file, documentation of the participant's portion (30% of the participant's income) of monthly rent payment to the landlord. Acceptable documentation identified by The Partnership to substantiate payment may include; copies of rent receipts, copies of completed money order receipts, copies of cancelled checks or a letter from the landlord stating receipt of payment. All payments and correspondence must be made payable and forwarded to/from the program's landlord of record. The Contractor is responsible for developing a system to track receipt of monthly payments to the landlord and reporting to The Partnership as requested.
8. In the event the Contractor assumes responsibility for ensuring that the delivery and receipt of the participant's portion of rent is forwarded to the landlord, documentation must also be retained in the participant's file substantiating the landlord's receipt of payment.
9. The Contractor must retain in their possession, a copy of keys for each unit identified in their Community Partnership Shelter Plus Care housing inventory. Keys must be kept in a safe location and used only for emergencies and unit inspections when necessary.
10. The Contractor must adhere to all Shelter Plus Care policies and procedures as outlined in The Shelter Plus Care Policies and Procedures Manual.
11. The Contractor agrees to assist homeless individuals to obtain and remain in permanent housing by providing housing and supportive services.
12. The Contractor shall provide long-term, community based housing and supportive services for homeless persons with disabilities. This enables special needs populations to live as independently as possible in a permanent setting.
13. The Contractor shall make and substantiate eligibility determinations prior to participants entering the program.
4. Participants in the program should indicate a satisfactory to very satisfactory answer on 85% of the response to the twice yearly Client Satisfaction Survey. The Partnership will require the Contractor to conduct these surveys to measure the quality of life for participants. Quality of life will be measured by such factors as housing quality, participation in recreation and social activities,

## APPENDICES

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volunteer assignments, developments of friendships and personal relationships, and ties to community organizations.

15. The Contractor shall provide services and/or refer participants to other providers that will provide case management, health and mental health services, substance abuse recovery services, budgeting, money management, tenant and landlord education, job training and life skills and assistance to increase the skills and/or income of participants, if applicable.
16. The Contractor shall explain Universal and Additional Program Rules and procedures to each client and provide them with details of their rights and responsibilities as a resident of the program. Clients must sign the Universal and Additional Program rules to be kept in the client record and be given a copy of all documents.
17. The Contractor shall abide by the Client Rights (Section 9) and Additional Rights for clients in temporary shelter or supportive housing (Section 10) of the Homeless Services Reform Act of 2005.
18. The Contractor shall abide by the Common Standards (Section 12) and Additional Standards for providers of temporary shelter and supportive housing (Section 15) of the Homeless Services Reform Act of 2005.

### **CONTRACT TYPE AND SOURCE:**

The source of funding for this Contract is the Department of Housing and Urban Development (HUD) through the Shelter Plus Care **RENTAL ASSISTANCE CONTRACT**. **Sponsor-Based Rental Assistance (SRA)** provides rent assistance through contracts between The Partnership and the Contractor. The Contractor may be a private nonprofit organization or community mental health agency established as a public nonprofit organization.

Participant(s) receiving assistance through this option reside in housing owned or leased by the Contractor. For the purpose of lease signing, the participant, landlord/Contractor and The Partnership will sign one **SHELTER PLUS CARE RENTAL ASSISTANCE CONTRACT** per unit. The **SHELTER PLUS CARE RENTAL ASSISTANCE CONTRACT** will specify the responsibilities of all parties under Shelter Plus Care. The Contract will also outline conditions for program termination.

### **STAFF REQUIREMENTS:**

1. The Contractor shall maintain a listing of competent staff to manage the program as outlined in their The Partnership Shelter Plus Care Contractor's Sponsor-Based Rental Assistance (SRA) Contract. In addition, the Contractor shall employ staff pursuant to performing this contract that possesses the requisite training, qualifications and competence to perform the duties to which they are assigned.
2. The Contractor must submit a listing of all Shelter Plus Care personnel with the signed contract agreement. The list must include position title and name of the staff person assigned to the position.
3. In the event changes occur with Shelter Plus Care staff assignments, the Contractor is required to forward documentation to The Partnership substantiating the change. Documentation must be forwarded within (48) hours of the official change execution.
4. The Contractor shall provide and/or attend required staff trainings that review and include, but are not limited to, the Common Standards, Best Practices, Cardio Pulmonary Resuscitation and

## APPENDICES

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Emergency First Aid. The Contractor shall provide Emergency Preparedness training to all staff to ensure readiness when there is a disaster or declared emergency and must maintain appropriate documentation of all training(s) provided and received.

5. The Contractor shall maintain an individual locked personnel file for each staff person and all program volunteers containing the applicable application for employment, resumes, professional and personal references, applicable credentials and certifications, personnel actions including time records, documentation of all training received, an annual evaluation for the current or preceding year, and notation of any allegations of professional misconduct including documentation of the Contractor's actions with respect to such and documentation of a current Tuberculosis Test. In the event of staff being terminated, the date and cause(s) for termination of employment shall be placed in the file. All personnel materials shall be made available to the Partnership's Contract Administrator and Program Monitor upon request.
6. The Contractor shall test all employees or staff that has direct contact with families and children (and) for drug and alcohol use. Service providers are Safety Sensitive employees as defined by the Child and Youth, Safety and Health Omnibus Congressional Review Emergency Amendment Act of 2004 (Act) and shall be tested pursuant to the Act. DHS must have documents certifying negative drug and alcohol test results by the specified time period.
7. In compliance with Chapter 4 of Title 27 of DCMR, Criminal Background Checks for District Government Contractors that Provide Direct Services to Children and Youth, the contractor will secure criminal background checks for individuals and unsupervised volunteers, employees, and applicants for employment as required for contracting entities contracting with the District of Columbia to provide direct services to children or youth.
8. The contractor shall provide for clearance of employees that have direct contact with families and children from the FBI and the Police Departments of the jurisdictions in which they have resided for the five years prior to employment under this contract and as otherwise required by District law. Service providers are Safety Sensitive employees as defined by the Child and Youth, Safety and Health Omnibus Congressional Review Emergency Amendment Act of 2004 (Act) and shall be tested pursuant to the Act. DHS must have documentation certifying such clearances for all affected employees. All documentation must be submitted to the Partnership by the specified time period.

### **PLACEMENT:**

The Contractor is required to adhere to the housing placement policies and procedures in accordance with the guidelines identified in the Shelter Plus Care Policies and Procedures Manual. The Partnership will not authorize execution of rent subsidy payments without receipt of all required placement documentation.

### **HOUSING INSPECTION:**

Units receiving Shelter Plus Care rent subsidies must be inspected and authorized by The Partnership prior to occupancy. Units must comply with the Housing Quality Standards (HQS) mandated by the District of Columbia Housing Authority and the Department of Housing and Urban Development (HUD). *Refer to the Shelter Plus Care Policies and Procedures Manual for housing inspection procedures and Housing Quality Standards.*

**APPENDIX 4**



# SHELTER PLUS CARE HOME VISIT REPORT

FAX COMPLETED REPORT BY THE 5<sup>TH</sup> DAY OF THE FOLLOWING MONTH TO: THE  
COMMUNITY PARTNERSHIP  
PROPERTY ADMINISTRATOR  
Fax# (202) 543-5361

Participant's Name: \_\_\_\_\_ Sponsoring Agency \_\_\_\_\_

Address: \_\_\_\_\_ Unit # \_\_\_\_\_

Participant's Telephone #: \_\_\_\_\_

1. Current monthly income: \$ \_\_\_\_\_ Source \_\_\_\_\_

2. Has income changed since last month? Y N (Please circle)

If yes, what is new amount? \$ \_\_\_\_\_ Source: \_\_\_\_\_

3. Has income documentation been submitted to The Community Partnership? Y N (Please circle) (please note rent can not be adjusted until documentation is submitted)

4. Has there been a rent increase during this reporting period? Y N (Please circle)  
If Yes, you must attach a copy of the rent increase letter from the landlord.

5. INDICATE PHYSICAL CONDITION OF APARTMENT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Is apartment in need of maintenance repairs? Y N (Please circle)

If yes, please list all maintenance requests: (provide specific information).

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

7. Did participant notify landlord of repairs needed? Y N (Please circle)

If Yes, when? \_\_\_\_\_

8. Are all smoke detectors in unit operable? Y N (Please circle) # tested: \_\_\_\_\_

\_\_\_\_\_  
Case Management Advocate's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

SPC-1001-015  
Revised January 2007

**APPENDIX 5**

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**APPENDIX 6**

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**APPENDIX 7**

# Event Chronology

Event Number: I20070227242

Date	Time	Term	Operat	Action
04/30/07	11:50:58	c128	501003	EVENT CREATED: Location= [REDACTED] DC, Cross Streets= CHESAPEAKE ST SE / DARRINGTON ST SE, Name= [REDACTED], Address= EXT [REDACTED], Phone Number= 202- [REDACTED] Agency= MPD, Group= 7D, Beat= 706, Status= P, Priority= 2, ETA= 0, Hold Type= 0, Primary Member= 0, Current= F, Open Current= F, Type Code= CKWF - CHECK ON THE WELFARE EVENT COMMENT= COMPL STATES SHE IS A SOCIAL WORKER AT BOOKER T WASHINGTON PUBLIC CHARTER...16YO [REDACTED] HAS BEEN WITHDRAWN FROM SCHOOL SINCE EARLY MARCH...COMPL STATES MOTHER HAS A MENTAL ILLNESS AND IS HOLDING 16YO AND 2 OTHER SMALL CHILDREN 6-10YRS INSIDE THE HOME AND WILL NOT LET THEM ATTEND SCHOOL COMPL IS CONCERNED CHILDREN MAY BE BEING ABUSED...CFS HAS BEEN CONTACTED
04/30/07	11:50:59	c128	501003	EVENT UPDATED: Location= [REDACTED], Cross Streets= CHESAPEAKE ST SE / DARRINGTON ST SE, Name= [REDACTED], Address= EXT [REDACTED], Phone Number= 202- [REDACTED] Agency= MPD, Group= 7D, Beat= 706, Status= P, Priority= 2, ETA= 0, Hold Type= 0, Primary Member= 0, Current= F, Open Current= F, Type Code= CKWF - CHECK ON THE WELFARE
04/30/07	11:51:04	ucc-con	501003	EVENT COMMENT= ** LOI search completed at 04/30/07 11:51:04
04/30/07	11:52:50	c128	501003	EVENT UPDATED: Location= [REDACTED] DC, Cross Streets= CHESAPEAKE ST SE / DARRINGTON ST SE, Name= [REDACTED], Address= EXT [REDACTED], Phone Number= 202- [REDACTED] Agency= MPD, Group= 7D, Beat= 706, Status= A, Priority= 2, ETA= 0, Hold Type= 0, Primary Member= 0, Current= F, Open Current= F, Type Code= CKWF - CHECK ON THE WELFARE
04/30/07	11:53:08	d106	1006	Unit= 7063D, Status= DP, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	11:53:12	d106	1006	Unit= 7063D, Status= ER, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	11:53:49	d106	1006	EVENT UPDATED: Location= [REDACTED], Cross Streets= CHESAPEAKE ST SE / DARRINGTON ST SE, Name= MS. [REDACTED], Address= EXT [REDACTED], Phone Number= 202- [REDACTED] Agency= MPD, Group= 7D, Beat= 706, Status= A, Priority= 2, ETA= 0, Hold Type= 0, Primary Unit= CR722, Primary Member= [REDACTED], Current= F, Open Current= F, Type Code= CKWF - CHECK ON THE WELFARE
04/30/07	11:58:45	d106	1006	Unit= 7063D, Status= AR, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:02:24	d106	1006	Unit= CR722, Status= DP, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:02:27	d106	1006	Unit= CR722, Status= ER, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:03:25	d103	1628	Unit= 7062D, Status= DP, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:03:27	d103	1628	Unit= 7062D, Status= ER, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:12:28	cic2	2136	Unit= CR722, Status= ~, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:12:29	d103	1628	Unit= CR722, Status= CU, Comment= Alarm Timer Extended: 0, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:13:28	cic2	2136	Unit= 7062D, Status= ~, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:13:35	d103	1628	Unit= 7062D, Status= CU, Comment= Alarm Timer Extended: 0, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:18:48	cic2	2136	Unit= 7063D, Status= ~, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:18:53	d103	1628	Unit= 7063D, Status= CU, Comment= Alarm Timer Extended: 0, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:31:06	d103	1628	Unit= CR722, Status= AR, Location= [REDACTED] DC, Employee= [REDACTED]
04/30/07	12:38:14	d103	1628	Unit= 7062D, Status= AV, Location= [REDACTED] DC, Employee= [REDACTED]
3/11/2008	4:23:31			PM

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<u>Date</u>	<u>Time</u>	<u>Term</u>	<u>Operat</u>	<u>Action</u>
04/30/07	12:42:48	d103	1628	Unit= CR722 , Status= AQ , Employee={ Disposition Assigned= ADV
04/30/07	12:42:53	d103	1628	Agency= MPD , Group= 7D , Beat= 706 , Status= A , Priority= 2 , ETA= 0 , Hold Type= 0 , Primary Unit= CR722 , Primary Member=   , Current= T , Open Current= F , Type Code= CKWF - CHECK ON THE WELFARE EVENT CLOSED: * Unit= 7063D , Status= AV , Location= # DC , Employee= {

METROPOLITAN POLICE DEPARTMENT  
Regional Operations Command-East  
Seventh District

January 13, 2008

MEMORANDUM

TO: Commander  
Seventh District

FROM: Sergeant  
Seventh District

SUBJECT: Timeline concerning death of children at

On January 9, 1008, the undersigned responded to \_\_\_\_\_, Washington, D. C., for the unconscious persons. When the call first came over the radio, I recognized it as an address I thought I had responded to some months back in reference to a counselor requesting our assistance because she was concerned for the safety of the children inside the location. When I responded to the location on January 9, 2008, I saw a female, who was later identified as \_\_\_\_\_ who I recognized from the previous encounter. I then started to think of who the officers that had responded to the scene originally. While on the scene, Officer \_\_\_\_\_ approached me and advised that he was one of the officers. After a period of time we were able to determine that Officer \_\_\_\_\_ was the other officer on the scene with us. The time line for my encounters with \_\_\_\_\_ are as follows:

On January 14, 2007, I stopped \_\_\_\_\_ for Improper Use of Tags, Operating an Unregistered Auto and Failure to Exhibit Registration.

On April 30, 2007, Officers \_\_\_\_\_ and \_\_\_\_\_ responded to \_\_\_\_\_ pursuant to a call from a counselor from the Booker T Washington Charter School. The counselor, later identified as \_\_\_\_\_, phone number \_\_\_\_\_, was the complainant. When Officers \_\_\_\_\_ and \_\_\_\_\_ arrived on the scene, they encountered \_\_\_\_\_ who would not allow them entry and would not allow them to see the children. The officers then called for a supervisor. I responded to their call for assistance. When I arrived on the scene, \_\_\_\_\_ was in the doorway of the residence speaking with the officers. She appeared at that time to be annoyed. Officer \_\_\_\_\_ advised me what the situation was. I then spoke with \_\_\_\_\_ She was belligerent and uncooperative at first. She was advised that we just needed to check on the welfare of the children. She was asked if we could step inside and she refused stating that if we didn't have a warrant we could not come in. \_\_\_\_\_ was advised that we needed to see the kids. She

eventually relented and she allowed us to speak with the children. The ones I clearly remember are the three youngest. I believe the oldest, [redacted] was on the scene as well after I thought about it some more because that is the one we were there to check on. I recall the 10 year old crying thinking we were going to arrest her mother and I told her it was okay that mom wasn't going anywhere. During our conversation with [redacted], she advised us that she was home schooling the children because she doesn't like the fact that young kids are exposed to sex education at a young age and they were bringing home inappropriately drawn pictures and that during sex ED they were teaching about homosexuality and other thoughts along those lines. I then contacted communications and was given the contact name and number for [redacted]. I called [redacted] and advised her that the kids were okay and appeared to be in good condition. While speaking with [redacted] Officer [redacted] actually sat down with one of the children, who was showing him a book that [redacted] had bought for home schooling purposes. [redacted] was advised that [redacted] was planning on home schooling the children. [redacted] advised me that there was a criteria for home schooling the children and she explained what she knew about the process. [redacted] was then relayed the same information and she was being very stubborn about not wanting to go by the DC Government's curriculum because of the previously cited reasons. [redacted] was advised by me that if she failed enroll her children in the home schooling program that she was subject to criminal prosecution. She was also advised that if she is found neglectful towards the children, such as not having them go to school, she could be prosecuted as well. After several attempts to get through to her the importance of enrolling the kids in a home school program and her arguing her point about not liking the school systems curriculum, I along with the other officers left. I contacted [redacted] and got the name and number of the family services person who was handling the case and called and left a message. I told Officer [redacted] and [redacted] to be sure to follow up with the family services office and try to get them help and get their attention towards the case because [redacted] felt they were not taking the case seriously. Officer [redacted] later advised that he had contacted the social worker and had made arraignments to go with him on May 1, 2007 to try and make contact with the family. Officer [redacted] later advised that he was unable to make contact with [redacted] with the family services office.

On May 1, 2007, while conducting roll call, I spoke with Officer [redacted]. [redacted] She advised that she would also follow up with the family and attempt to assist in getting the kids enrolled in school or a program. Officer [redacted] advised that she went by the location but got no answer at the door. I don't recall how long after May 1, 2007 that was that I spoke with her about what she did and I don't know what other attempts were made by [redacted] or [redacted] partner, Officer [redacted].

In reference to the times that all this took place, I would have to get the 911 recordings, which I ordered on January 9, 2008, but have been unable to go to communications to pick up. I believe we were on the scene for about an hour dealing with [redacted] and the kids.

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## APPENDICES

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



Administrative Issuance: CFSA-08-2

TO: All CPS Staff  
FROM: [Redacted] Deputy Director for Program Operations  
DATE: March 7, 2008  
RE: Immediate Requirements for All CPS Investigations

The Child and Family Services Agency (CFSA) Child Protective Services (CPS) Program is the first line of intervention for ensuring the safety and protection of children (under the age of 18 years) who have been maltreated (abused or neglected) or are at risk of maltreatment. CPS is responsible for investigating every allegation of child maltreatment that is reported, as well as responsible for conducting a comprehensive assessment of the immediate safety and risk of harm to each child in the family.

CFSA's Practice Model demands that investigative work take place with the utmost professionalism, a sense of urgency, and attention to details. All information gathered during an investigation is essential for CPS to be able to protect the child(ren) and to determine a plan of action for ensuring the child's ongoing safety, permanence, and well-being.

Outlined below are CFSA's current guidelines and expectations for all CPS investigations. *These required practices are effective immediately. Note that the itemized efforts detailed in this issuance for making contact with a child and/or family are expected to take place concurrently.* There shall be no time lag between steps. Further development of CPS practice standards will be incorporated permanently into CFSA Policy in the near future. Please thoroughly discuss these standards with all CPS staff.

As always, I will make myself available to answer any questions or concerns you or your staff may have.

1. It is mandatory for all CPS investigations to be initiated as soon as possible, but no later than 24 hours after receipt of the report.
2. If a report is prioritized for "Immediate Response", the investigation *must be initiated within 2 hours of receipt of the report.*
3. The initial home visit should be unannounced. Phone contact should not precede an unannounced home visit unless the victims have been seen.
4. Initiation of an investigation is considered to have been established when the CPS worker has made face-to-face contact with the child(ren) victim(s). Good faith efforts should be made to see the child(ren) not only in the home, but in school or daycare when applicable. *It is mandatory that the worker speak with the child(ren) out of the presence of parents, caretakers or alleged perpetrators, as well as siblings and/or other children.*
5. Conduct separate interviews of each of the children, assessing not only physical health, but also the emotional and behavior health of the children.

400 Sixth Street, SW ♦ Washington, DC 20024  
Web: [www.dccchildandfamilyservices.com](http://www.dccchildandfamilyservices.com)

## APPENDICES

6. It is critical to assess any new allegations within the context of all previous reports and allegations. During the investigation, the CPS worker shall review all prior CPS reports (including inconclusive, Information and Referrals (I&R) and Additional Information) for the child, members of the household, and the alleged perpetrator. The CPS worker may also attempt to obtain and review law enforcement reports related to the child, members of the household and the alleged perpetrator, focusing on any reports of domestic violence, child abuse, or drug-related activity in the home.
7. Make diligent efforts to gain entry to the home. *If the family refuses to cooperate*, the CPS worker must complete all of the following as appropriate:
  - a. Contact CPS Supervisor immediately
  - b. Contact MPD for assistance
  - c. Contact CFSA's Office of General Counsel to determine whether a Pre-Petition Custody Order is appropriate
  - d. Convene a case staffing to determine plan of action
  - e. Complete Pre-Petition Custody Order, if appropriate
8. If the family is not at home, the following steps must be completed by the CPS worker:
  - a. Leave a notification letter in the family's primary language (if known) at the home, requesting contact within 24 hours. (**only for neglect reports**)
  - b. If the child is school age, make contact within 24 hours to interview the child at the neighborhood school or the school listed in the referral
  - c. If the child is not school age, make contact within 24 hours to interview the child at the daycare center listed in the referral.
  - d. Interview neighbors, resident managers, or landlords to confirm the address or determine the whereabouts of the family. If family is no longer residing at the address, obtain a forwarding address when possible
  - e. Conduct *at least* 2 additional home visits at different times with one of these visits taking place between the hours of 8pm - 8am
  - f. Send a *certified letter* to the last known address within 1 week of the referral date if the family fails to respond
9. *No investigation will be closed solely on the grounds that the child could not be located until thoroughly exhaustive efforts have been made by the CPS worker to locate the child and family. If the child or family cannot be immediately located, investigative efforts must be elevated and the following steps taken concurrently with a sense of urgency to thoroughly exhaust all avenues for locating the child and/or family:*
  - a. A *minimum* of three (3) unannounced home visits at different times within a 48 hour timeframe with at least one visit between the hours of 8pm - 8am
  - b. Use of Internet search engines such as <http://www.whitepages.com/>, <http://www.zabasearch.com>, and <http://www.freeality.com/>
  - c. Mailing of a certified letter, in the family's primary language, to the last known address, referral address, or address listed on the ACEDS and/or SPIS report
  - d. Contact with the reporter to obtain additional information on locating the child and family
  - e. Visit to the child/ren's neighborhood school or school if enrollment is known (or a request should be made to the DCPS Penn Attendance Intervention Center (202-541-6411) or Douglass Attendance Intervention Center (202-698-2461) if enrollment is unknown); *efforts should also be made to reach the emergency contact person on file with the school*

## APPENDICES

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- f. Contact with the Metropolitan Police Department (MPD) Truancy Officers to request assistance in gaining access to family (when allegations warrant and there has been involvement with the family)
  - g. Request that MPD check their database for any involvement with the particular family or address
  - h. Criminal background search of any known family members for access to addresses or other contact information
  - i. Referral to the Diligent Search Unit within 1 week if family has not responded and follow-up on the results of diligent search; *No report shall be closed without receipt and follow-up on diligent search results*
  - j. Interview neighbors, relatives, and other collateral resources
  - k. Confirm that the family is no longer residing in the residence (via landlord, property records or verified alternative residence)
  - l. Contact the Healthy Family Thriving Communities Collaboratives to determine whether the family is known to them or has received services from them (see attachment)
  - m. Consult with Assistant Attorney General (AAG) staff to determine if Pre-Petition Custody Order is warranted
  - n. Check with other governmental agencies for possible involvement, including the Department of Mental Health, the Department of Human Services, Income Maintenance Administration, etc.
10. **All** information must be documented in FACES within 24 hours of obtaining it, including date and time of all visits and attempted visits, and all good faith efforts to make face-to-face contact with the victim if initiation has not been established.
11. **All** past history used and considered during the course of an investigation needs to be documented in the record.
12. **NO** unable to locate investigation shall be closed without review and approval of the assigned Program Manager.

