

CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT C.S.

November 10, 2014

Executive Summary

On March 4, 2014, the Oregon Department of Human Services (DHS), Child Welfare Program was contacted regarding C.S., a 2 year old child, who had been critically injured and ultimately died on March 6, 2014. It was determined by DHS and Law Enforcement that C.S.'s death was due to Physical Abuse. The mother's partner confessed to causing C.S.'s injuries and has been charged with three counts of murder.

From 2006 to 2014, DHS was contacted eight times regarding C.S.'s family, including the last report, dated March 4, 2014, which detailed injuries resulting in his death. Of the eight reports to DHS, four were Closed at Screening and four were assigned for CPS assessment.

On March 7, 2014, DHS Director, Erinn Kelley-Siel, declared that a Critical Incident Response Team (CIRT) be convened to review C.S.'s death. This is a mandatory CIRT pursuant to Oregon Revised Statute 419B.024. This is the initial and final report of the CIRT.

On March 10, 2014, the initial CIRT meeting was held and a case file review was initiated. Records from another state as well as two separate DHS case files were reviewed as part of a comprehensive report regarding the family's involvement with child protection agencies.

On April 23, 2014, the CIRT met a second time to discuss the case file review. The team identified several issues in this case that required further analysis prior to determining if they were systemic issues.

On June 20, 2014, the CIRT met a third and final time to discuss the issues identified in the file review which the team discussed at the April 23rd meeting, however no systemic issues were identified.

Summary of Reported Incident and Background

On January 24, 2006, DHS received the first report regarding this family concerning the birth of C.S.'s older sibling. This was assigned for Threat of Harm due to reports that the mother had another child out of her care in another state, and her parental rights to that child were terminated involuntarily due to concerns of abuse and/or neglect. There were also concerns that the mother tested positive for marijuana prior to and at the time of the child's birth. This report was coded Unable to Determine. The mother agreed to participate in voluntary services with DHS. This report should have been coded

Unfounded as the mother had made substantial changes to her circumstances since her parental rights to the other child were terminated.

On September 22, 2006, DHS received a report indicating drug paraphernalia and marijuana were found in a vehicle driven by the mother. The child was not present at the time. This report was Closed at Screening. This report did not meet criteria for assignment therefore the decision to close at screening was appropriate.

On December 27, 2006, DHS received a report indicating there was drug dealing out of the mother's home. This was assigned as a 5-day response. The mother denied any knowledge of drug activity and left the state during the assessment, before it could be completed. This referral was coded Unable to Locate as the mother had left the state. This disposition was appropriate.

On February 28, 2011, DHS received a report indicating the mother was pregnant with C.S. and was smoking marijuana in the presence of her other child. A high risk pregnancy alert was sent out to local hospitals and the report was Closed at Screening. This was the appropriate decision.

On May 18, 2011, DHS received a report concerning C.S.'s older sibling, alleging Physical Abuse perpetrated by the mother. This report was assigned for CPS assessment due to a report that the child had a cut on his lip from being hit by his mother. The worker observed a slight bump on the inside of the child's lip; however there was no cut observed and the child denied his mother had hit him. This referral was coded Unfounded for Physical Abuse of C.S.'s sibling. Insufficient information was gathered through this assessment to make a determination of child safety.

On June 13, 2011, DHS received a report alleging Threat of Harm to C.S., who tested positive for marijuana at birth. The mother also tested positive for marijuana and disclosed regular use of marijuana throughout her pregnancy. This referral was Closed at Screening. This referral met criteria for assignment and should have been investigated for Neglect by CPS.

On July 19, 2011, DHS received a report of Neglect of C.S. and drug use by the mother. It was reported that the mother had no parenting skills and did not respond to the basic needs of C.S., including not adequately changing his diaper and not taking formula or diapers for C.S. when traveling to the beach for the day. The mother also reported she smoked marijuana daily. The report was Closed at Screening. This referral met criteria for assignment and should have been investigated for Neglect by CPS.

On January 8, 2014, DHS received a report alleging Physical Abuse and Neglect of C.S. The report indicated that on December 21, 2013, law enforcement responded to a report of abuse. The father reported to law enforcement that C.S. had multiple bruises and abrasions all over his body after having been with his mother and her partner. The cross report to DHS indicated that photos had been taken by law enforcement

approximately 18 days earlier. The mother gave multiple inconsistent explanations to the father about the causes for the injuries.

This referral was assigned as an Immediate Response for Physical Abuse and Neglect. The case was identified as a Karly's Law case due to the child having bruising to the head and concerns that the injuries were indicative of abuse. The father was instructed to take C.S. to the physician; however he did not follow through on this request. When DHS attempted to schedule an examination of the child in accordance with Karly's Law protocols, the Designated Medical Professional declined to perform a physical examination of the child due to the time that had elapsed since the injuries. This referral was coded Unfounded for Physical Abuse and Neglect. There were several areas within this report that required further investigation. The documentation did not support a conclusion that the child was safe, and did not support the Unfounded disposition.

DHS received the final report regarding C.S. on March 4, 2014, when C.S. was taken to the hospital with multiple injuries, including significant head trauma, that were believed to be the result of abuse. This referral was assigned as an Immediate Response for Physical Abuse of C.S. The mother's partner admitted to causing significant injuries to C.S., resulting in his death. The mother acknowledged that her partner was violent with C.S. prior to this incident; however, she continued to allow her partner to care for C.S. unsupervised. This assessment was completed and was coded Founded for Physical Abuse of C.S. by the mother's partner, and Neglect (lack of supervision and protection), of C.S. by his mother.

Systemic Issue Identification

The CIRT identified concerns in this case that required further analysis prior to determining if they were systemic issues or limited to this particular case. These issues are:

1. Full identification of safety issues during the screening process. This concern is being addressed as an audit point in an earlier CIRT, to determine if this is a systemic issue. In order to determine if this is a systemic issue DHS will review a sample of screening decisions throughout the state and develop a plan to address issues identified by the review. If a systemic issue is identified, it will be addressed through the prior CIRT.
2. In this case, as with prior CIRTs, the issue of comprehensiveness of assessments was identified. In the N.W. CIRT, the actions taken to address this issue were noted and included additional training and support for the field in completing comprehensive assessments. The staff involved in this case had only recently completed the revised training when the January 8, 2014 referral was received. An Oregon Safety Model (OSM) consultant is currently assigned to the Child Welfare office to reinforce the OSM training and practice related to comprehensive assessments. Additionally, the CPS program will meet with the worker, supervisor and program manager regarding the practice in this case.

Purpose of Critical Incident Response Team Reports

Critical incident reports are to be used as tools for Department actions when there are incidents of serious injury or death involving a child who has had contact with DHS. The reviews are launched by the Department Director to quickly analyze DHS actions in relation to each child. Results of the reviews are posted on the DHS Web Site. Actions are implemented based on the recommendations of the CIRT Review Team.

The ultimate purpose is to review Department practices and recommend improvements. Therefore, information contained in these incident reports includes information specific only to the Department's interaction with the child and family that are the subject of the CIRT Review.