

CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT D.J.

November 30, 2015

Executive Summary

On March 27, 2015, the Department of Human Services (DHS) Child Welfare Program received a report that a child, D.J., was found deceased in the family home and the cause of death was under investigation.

Since 2006, DHS was contacted eight times regarding D.J.'s family, including notification of the fatality. Of the eight reports, one was Closed at Screening, and seven were assigned for a Child Protective Services (CPS) assessments.

On July 20, 2015, DHS Director Erinn Kelley-Siel declared a Critical Incident Response Team (CIRT) be convened, once it was determined that the child's death was the result of neglect. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.

On July 21, 2015, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On August 18, 2015, the team met a second time to discuss the case file review. The team raised questions and requested additional information to assist the team in identifying systemic issues that may have given rise to the incident. At that time, three areas were identified as potential systemic issues regarding the Department's work on this case.

On November 12, 2015, the final CIRT meeting was held and identified comprehensiveness of assessments as a continued area of concern. Comprehensiveness of assessments has been highlighted in multiple previous CIRTs and the Department is engaged in ongoing efforts to address this issue.

Any time a child known to the Department dies or is seriously injured as a result of abuse or neglect, the Department is committed to evaluating its processes and learning how the child welfare system may be improved in

order to keep Oregon's children safer. The Critical Incident Response Team's efforts to identify issues are an important component of agency accountability and improvement when tragedies like this occur. In addition to the CIRT, but in a separate process, the Department will address any necessary personnel actions.

This is the initial and final report of the CIRT.

Summary of Reported Incident and Background

On July 21, 2006, DHS received a report alleging Physical Abuse of D.J. and D.J.'s sibling. The reporter indicated D.J. and D.J.'s sibling had recently relocated to Oregon and were residing with their guardians. The report alleged one of the guardians was using a spatula to discipline the children. This report was assigned for CPS assessment with a timeline of Within 24 Hour Response. While the guardian admitted to using a spatula for discipline, neither child had injuries. The CPS worker documented that one of the guardians had health issues; however no concerns were noted regarding the family's ability to provide adequate care for the children. At the conclusion of the assessment, the disposition was coded as Unfounded.

On November 25, 2006, DHS received a report alleging Threat of Harm to the children due to alleged domestic violence in the home. The report was assigned for CPS assessment with a timeline of Within 5 Days. The children's mother and her boyfriend had recently moved into the guardians' home with another child. The mother's boyfriend was arrested due to the domestic violence and a no contact order was issued. The children did not make clear and consistent disclosures that they were exposed to the domestic violence and the mother denied they witnessed the violence. The referral was coded with a disposition of Unable to Determine.

On January 16, 2007, DHS received a report alleging Threat of Harm to the children because the mother's boyfriend returned to the family home. The boyfriend was arrested for failing to comply with the no contact order. The report was assigned for an assessment with a timeline of Within 5 Days. The referral was coded with a disposition of Founded for Threat of Harm against the boyfriend.

On July 9, 2007, DHS received a report alleging Neglect of the children due to the conditions of the home and lack of supervision of D.J. The report alleged the guardians had health issues and were unable to provide care for D.J. This report was assigned for assessment with a timeline of Within 5 Days. A review of the documentation indicates that the child's mother and one of the children were no longer living in the home. The CPS worker made multiple visits to the home and noted that the living conditions were appropriate and the family had support in place to meet the child's basic needs. The referral was coded with a disposition of Unfounded.

On March 20, 2013, DHS received a report alleging Neglect of D.J. The report indicated D.J. had a chronic medical condition and D.J.'s medical needs were not being met. This report was Closed at Screening. Additional collateral calls may have led to a decision to assign this report for assessment.

On April 11, 2013, DHS received a report alleging Neglect of D.J. and describing the child as medically fragile. The reporter indicated D.J. had special medical needs that were not being met. The report was assigned for assessment with a timeline of Within 24 Hour Response. During the assessment, one of the guardians acknowledged that D.J. monitored the child's own medical condition and administered the child's own medication. The guardian indicated D.J. had been hospitalized in the previous year due to the child's medical condition and records were requested and received by DHS. It is documented that the guardian ensured the child attended medical appointments, however it is unknown if the CPS worker spoke with the child's physician. It was also noted in the assessment that both guardians suffer from medical conditions of their own. The assessment was closed with an Unfounded disposition.

On January 23, 2015, DHS received a report alleging Neglect of D.J. The reporter indicated that D.J. had been hospitalized and expressed concern that D.J. was managing the child's own medical condition due to the guardians' health issues. The report was assigned with a timeline of Within 5 Day Response. Initial contact with the guardians was documented; however the assessment had not been completed prior to the death of D.J. This assessment was later closed with a disposition of Unable to Determine.

On March 27, 2015, during the course of the previous assessment, DHS was notified of the death of D.J. and a new referral was assigned alleging Neglect. The report indicated D.J. had complained of stomach pain the night before and was found deceased the following morning. The report was assigned for CPS assessment with a timeline of Within 24 Hour Response. Based on information obtained as part of the assessment, the disposition was coded as Founded for Neglect of D.J. by the guardians.

Identification of Systemic Issues

The CIRT identified concerns in this case that required further analysis prior to determining if they were systemic issues or isolated to this case. Those issues and the resulting findings are as follows:

1. Communication between community partners about children when the Department is not involved or the Department's involvement is limited to a CPS assessment only.
 - Determination: A statewide workgroup was convened in order to examine the issues presented in this CIRT and the impact of these issues on the child welfare system. The discussion revealed this not to be a systemic issue, rather an isolated issue, to this specific case.
2. Child welfare consultation with professionals when the agency receives information in areas beyond the Department's expertise. An example of this concern surrounds reviewing medical records with complex medical information and not seeking consultation from medical experts.
 - Determination: The statewide workgroup also determined this concern is not a systemic issue, rather isolated to this specific case. Workgroup members indicated that local resources including Designated Medical Professionals, psychologists and other subject matter experts in their communities are regularly contacted when complex medical and mental health issues exist in families that require department intervention.
 - Recommendation: While this has not been determined to be a systemic issue the team believes the concerns surrounding the necessity of consulting with medical experts when reviewing

medical records and complex medical information is critical to ensuring the safety of children and requires reinforcement of existing policy and practice.

- Action Item: The Department will engage in practice forums using the statewide supervisor and CPS quarterly structure to continue to disseminate information about the Department's policy and procedure in order improve practice.

3. Comprehensiveness of assessments, particularly in assessing reports involving allegations of medical neglect.

- Determination: Consistent application of the Oregon Safety Model in conducting comprehensive CPS assessments has been identified as a systemic issue in previous CIRTs. This concern will be addressed by the ongoing efforts surrounding strengthening comprehensiveness of CPS assessments.

Recommendation: The Department continues to focus on practicing with fidelity to the Oregon Safety Model and has increased resource allocation and coaching to the field. As a result of the comprehensiveness of the assessments being identified in multiple previous CIRTs, in October 2013 the Department began delivering updated training regarding the Oregon Safety Model including comprehensive assessments to child welfare supervisors and program managers. This branch received the updated Oregon Safety Model training beginning in February 2014. The Department also allocated additional resources towards strengthening the Oregon Safety Model including additional consultant positions and computer based training for child welfare caseworkers and to other DHS staff. See CIRT N.W. (2014) for more details on this training. Quality assurance instruments have been developed and are being tested throughout the state during implementation of Differential Response and the Department is building a quality assurance system around the continued work of Oregon Safety Model and CPS consultants and their engagement with field offices.

Specific concerns regarding comprehensiveness of assessments that have been highlighted in this CIRT are currently being addressed through increased coaching by Oregon Safety Model consultants with child welfare staff in the field. The child welfare supervisor and CPS quarterly meetings will also be used to address specific concerns regarding comprehensive assessments in this and previous CIRTs.

Purpose of Critical Incident Response Team Reports

Critical incident reports are 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.