

CRITICAL INCIDENT RESPONSE TEAM (CIRT) INITIAL REPORT L.B.

September 18, 2015

Executive Summary

On January 22, 2015, the Department of Human Services (DHS) Child Welfare program received a report that 2 month old L.B. was found deceased in the family home and the cause of death was under investigation.

Since 2012, DHS was contacted eleven times regarding L.B.'s family, including notification of the fatality that occurred on 1/22/15. Of the eleven reports, seven were Closed at Screening and four were assigned for Child Protective Service assessments.

On April 2, 2015, the DHS Director 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 April 3, 2015, the initial CIRT meeting was held and a comprehensive case file review was initiated. On April 22, 2015, the team met a second time to discuss the case file review. The team raised questions and requested additional investigation to assist the team in identifying systemic issues that may have given rise to this incident.

This is the initial report of the CIRT and is issued as an activity report and status update.

Summary of Reported Incident and Background

On September 20, 2012, DHS received a report alleging domestic violence in the family home. This report was assigned for assessment with a timeline of Within 24 Hour Response. The department made contact and the mother agreed to a protective action plan preventing contact between the children and a third party. The children were taken into DHS custody after contact occurred. This referral was coded with a disposition of Founded for Threat of Harm and Neglect and a case with DHS was opened. Based on the documentation this disposition appears consistent with policy.

On September 25, 2012, DHS received a report alleging Physical Abuse and Threat of Harm Physical Abuse after bruises were noticed on the arm of the eldest child and the bruises were at variance with the child's explanation. This report was Closed at Screening. This report met criteria for assignment.

On June 2, 2014, DHS received two separate reports, both alleging the mother was three months pregnant and had not mitigated concerns that led to her daughter's placement in foster care. As the mother had no children in her care, both reports were Closed at Screening and hospital notification letters were sent. The decision to close this report at screening was consistent with policy.

On August 19, 2014, DHS received a report alleging Physical Abuse and Mental Injury by the biological father of the youngest child. The report did not constitute a report of abuse or neglect and was Closed at Screening.

On October 23, 2014, DHS received a call reporting the mother's polydrug use during her first trimester and her history of children being involuntarily out of her care. This report was Closed at Screening. Closing this report at screening was consistent with policy.

On November 5, 2014, DHS received an additional report regarding the mother's pregnancy and her other children not being in her care. This report was Closed at Screening. Closing this report at screening was consistent with policy.

On November 21, 2014, DHS received a report regarding the birth of L.B with no immediate concerns noted. This referral was Closed at Screening. Additional required contacts were not documented in this report and may have led to a decision to assign for a CPS assessment.

On November 21, 2014, DHS received an additional report concerning the birth of L.B. This report was assigned with a timeline of Within 24 Hour Response. The CPS worker conducted the assessment with the assistance of the caseworker for the older children. During the assessment a strong attachment between mother and L.B. was observed and the mother reported participating in and or completing services. This referral was determined to be Unfounded for Neglect.

On January 22, 2015, DHS received a report from local law enforcement that L.B. was found deceased, and the cause of death was under investigation. A CPS assessment was initiated as a result of the report, and the criminal investigation continues as of the date of this initial report.

On January 23, 2015, DHS received a report alleging substance abuse in the home of L.B.'s mother. This referral had been initially called in on January 21, 2015, however the reporter provided inaccurate spelling of the family member's names and this delayed the assignment of this report. Once accurate information was obtained, the report was assigned for Within 24 Hour Response, however, L.B. was already deceased.

CIRT Activity Report and Status Update

Pursuant to CIRT protocol, the CIRT team has met twice regarding this case. At the first meeting, the team reviewed preliminary information and identified issues of interest in the case. Subsequently, a file review of CPS and Permanency records was conducted, and the results were presented at the second meeting.

The Critical Incident Response Team will reconvene once additional information is gathered in order to determine whether systemic issues exist and make recommendations to address those issues.

Potential Systemic Issues

Additional analysis is necessary in order to determine if the issues identified by the CIRT are isolated, local issues or statewide and systemic. A preliminary review of the files has identified the following potential systemic issues regarding the Department's work in this case:

- Application of the Oregon Safety Model beyond comprehensive assessment.
- Comprehensiveness of the screening process.
- Comprehensiveness of assessments.
- Extent to which CPS workers rely upon an ongoing case worker to assist in conducting a comprehensive CPS assessment.
- Adequacy of in-home safety planning.
- Communication between non contracted service providers and the Department and the ability to gather information.

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 website. 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.