

Critical Incident Response Team (CIRT) Final Report E.S.

April 29, 2010

Executive Summary

On May 23, 2009, 4-year-old E.S. died after being thrown from a bridge into frigid water. His sister, T.S., was also thrown in the water but survived. The mother of both children was convicted of aggravated murder and attempted aggravated murder after pleading guilty. The Oregon Department of Human Services (DHS) had received referrals on the family prior to this incident.

The Critical Incident Response Team (CIRT) has identified three systemic issues regarding the Department's work in this case:

- First, the Department's screening of reports of abuse involving domestic violence;
- Second, the comprehensiveness of Child Protective Services (CPS) assessments, specifically consideration in those assessments of prior child abuse referrals involving a family; and
- Third, the Department's use of photos of suspected abuse when the photos were taken by someone other than child welfare or law enforcement.

Two of the systemic issues identified in this case—the issue of domestic violence screening and comprehensive assessments—have also been identified in other CIRTs, underscoring the need to ensure that the Department is taking appropriate steps to improve its practice in those critical areas.

The Department is committed to meeting the timelines set forth in the CIRT process in order to identify and implement systemic improvements as quickly as possible to ensure that children are safe and protected. In this case, however, DHS notes that the publication of this CIRT report has been delayed. The delay is due to the increased number of CIRT reviews called by the agency as part of its effort to improve child welfare practice, transparency and accountability. In order to address the issue, DHS has reallocated staff resources to add a dedicated position to oversee the CIRT process and ensure that all CIRT reports are completed and released in a timely manner.

Summary of Reported Incident

On May 23, 2009, the Department of Human Services (DHS) received a report that two young children had been found in the Willamette River near the Sellwood Bridge at around 1:45 a.m. There were no adults with the children, and their identities were

unknown. Both children were taken to the hospital, where the younger of the two was pronounced dead. The deceased child was identified as 4-year-old E.S., and the older child was his 7-year-old sister, T.S. Law enforcement personnel began investigating the circumstances related to this incident and subsequently located and arrested the children's mother (A.S.). Upon receipt of this information, a referral was generated and assigned to a CPS worker.

On May 26, 2009, DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened. This is the initial and final report of the CIRT team.

Background

Prior to this fatality, DHS had received a total of 10 reports from outside parties about this family over a nine-year period. Five reports were referred to a CPS worker for investigation. For the purposes of this CIRT report, those five referrals will be known as Referral 001, Referral 002, Referral 003, Referral 004 and Referral 005.

Two of the remaining reports were documented as Logged Calls, and three were Closed at Screening. The difference between a Logged Call and a call that is Closed at Screening is the type of information contained in the report. A Closed at Screening is used when the information reported describes family conditions, behaviors, or circumstances that pose a risk to a child but do not meet the definition of child abuse as defined in Oregon Revised Statute. A Logged Call is a report that lacks any concerning information that could be considered a risk to a child. The first five reports were received prior to E.S.'s birth and were related to his older siblings.

In 2005, the Department discontinued keeping records of Logged Calls. When a report is Closed at Screening or Logged, it means that a CPS worker was not assigned for follow-up. For the purposes of this CIRT report, the Logged Calls will be referred to as Logged Call 001 and Logged Call 002. The Closed at Screening will be identified as Closed at Screening 001, Closed at Screening 002 and Closed at Screening 003.

REFERRAL 001: Allegation of Threat of Harm; Disposition – DHS closed the case without conducting an investigation.

On June 7, 2000, DHS received information that police had been dispatched to an incomplete 911 call. The children's mother told police that her boyfriend, J.S., held her by the wrists to prevent her from leaving, and that this type of behavior had happened on more than one occasion. J.S. was subsequently arrested for Assault IV, Menacing and Interfering with making a 911 call. Although the record indicates the referral was initially assigned for an assessment, the referral narrative indicates that

the information was forwarded to a domestic violence liaison for follow-up. There was no information to indicate whether the domestic violence liaison ever contacted the mother. Ultimately, DHS closed this referral without contacting the family. The CIRT team concluded that this referral warranted a field assessment.

LOGGED CALL 001

On July 24, 2000, DHS received a report that the mother was caught shoplifting and had 3-year-old G.S. with her. Police did not take her into custody. The CIRT team concluded that this report outlined behaviors by A.S. that presented a risk to the child and should have been documented as a Closed at Screening.

REFERRAL 002: Allegation of Threat of Harm; Disposition – Unable to Locate

On August 29, 2000, DHS received a report of domestic violence. The report indicated that J.S. strangled A.S. in front of the child. When A.S. was finally released, she attempted to call the police from a payphone, but J.S. hung up the phone and took her money. A.S. managed to get inside a store with her child where she called the police. When police arrived, they found the tires to her vehicle had been punctured, and J.S. had left the area on foot. She told police about additional incidents of domestic violence, where she was held down and pinched on the nose and lips. One of the witnesses who was interviewed reported seeing J.S. puncture the tires with a knife.

The referral was assigned to a CPS worker; however, documentation in the case file indicates the worker was unable to locate the family. The assessment was closed without contact. The CIRT team concluded that this referral was handled appropriately.

LOGGED CALL 002

On May 1, 2001, DHS received a report that 4-year-old G.S. was left unattended in a vehicle while J.S. went inside a store. Police and paramedics responded to a call, and when the child was removed from the car he was reported to be in poor condition — sweating, lethargic and confused. At one point G.S. collapsed on the ground. J.S. was cited by police and allowed to leave with the child. The CIRT team concluded this report should have been assigned for a CPS assessment because the neglect of the child met the legal definition of child abuse.

REFERRAL 003: Allegation of Physical Abuse; Disposition – Unable to Determine

On January 6, 2003, DHS received a referral about physical abuse. The referral indicated that J.S. physically abused 6-year-old G.S. by spanking him, leaving several

bruises on the back of his legs. The caller indicated that he had spanked the children before and left marks but never to this degree, still visible after three days.

The referral was assigned to a CPS worker as an immediate response. The worker interviewed A.S. at home. T.S. had been born by this time, and she and G.S. were also interviewed. The interviews occurred on the day the report was received, and G.S. still had significant bruising on the back of both legs. He disclosed to the worker that he was struck by J.S. The worker photographed the injuries. Despite the disclosures by G.S. and the visible injuries he suffered, the disposition was recorded as Unable to Determine, and the worker indicated that the injuries could have been the result of excessive discipline. The assessment was reviewed and closed by the worker's supervisor on September 15, 2003.

The CIRT team concluded that injuries inflicted during the course of excessive discipline are child abuse, and that Unable to Determine was an incorrect disposition. The physical abuse allegation in this referral should have resulted in a founded disposition because the incident met the legal definition of child abuse.

CLOSED AT SCREENING 002

On June 30, 2006, DHS received a report that G.S. had disclosed past physical abuse that resulted in bruising by J.S. The youngest child, E.S., had been born by this time but was not mentioned in the report. The reporting party indicated the mother and J.S. had moved out of state and were living in Hawaii. G.S. was visiting with his biological father in Oregon for two weeks. The caller indicated that G.S. had no current injuries, but that when he was asked about returning to his mother and J.S. he became tearful. When he was asked questions about J.S. hurting his mother he answered in the affirmative, but he was unable to provide any clarifying information. The report indicates that DHS understood the child was referring to past injuries which were assessed in referral 003 and not new allegations.

The CIRT team concluded this report was handled appropriately based on the policy and practices at that time. Today under the Oregon Safety Model and guidelines, staff would take a more comprehensive look at past incidents and patterns.

CLOSED AT SCREENING 003

On August 11, 2008, DHS received a report that A.S., now back in Oregon, left her children at swim lessons and had not returned by the time the lessons were over. Police were called to the pool and took a report. While the police were at the pool, the mother returned and explained she had been getting snacks for the children and was involved in an automobile accident which caused her to be late.

The CIRT team concluded this report was handled appropriately.

REFERRAL 004: Allegations of Physical Abuse; Disposition – Unable to Determine

On August 12, 2008, DHS received a referral that 11-year-old G.S. was physically abused by A.S. The caller reported the child had what appeared to be grab marks on his arm which were caused by his mother. The caller reportedly photographed the bruises on August 1, 2008, and described them as four light semi-circle bruises. The bruises were gone by the time the caller made this report to DHS. According to the caller, G.S. initially did not disclose that the bruises were caused by his mother but later stated that he had “been in trouble and his mother grabbed him to move him out of the way”. The caller also reported that on a separate occasion, they observed A.S. to be visibly intoxicated and driving with G.S. in the car. When referral 004 was generated, G.S. was on a three-week visit with his biological father.

A CPS worker was assigned, and an assessment was completed. When interviewed, G.S. disclosed that his mother grabbed his arm and left bruises. He also disclosed that he has witnessed domestic violence between his mother and J.S. in the past. T.S. disclosed that she had seen her parents fight and described incidents where her mother locked J.S. out of the house. She also disclosed that on one occasion her mother fled from J.S. and that the children and mother had to sleep in a car.

As part of the assessment, the worker requested and obtained information from Hawaii Child Protective Services for the period of time the family had lived in Hawaii. Hawaii’s CPS program provided information regarding neglect concerns that were reported to them in 2006. The information was provided in a letter that described threatened neglect and lack of supervision of all three children when their mother left them in her vehicle for “longer than expected” while returning a purchase to a store. The windows were open, and the children had water with them. It was also reported that the mother had consumed alcohol on the day in question. The letter indicated Hawaii CPS conducted an assessment of the incident and concluded that the allegation was not founded.

The Oregon CPS worker interviewed multiple family members who expressed concerns about the mother’s drinking, including an incident where A.S. called a family member saying she was driving drunk and was stuck in a ditch with the children in the car. Before the family members could get to her location, someone had already assisted her with getting the car out of the ditch and she had driven home. Although both children disclosed that their mother drinks alcohol, only T.S. reported

seeing a change in her mother's behavior associated with alcohol. Both children denied that their mother would drink and drive. A.S. denied causing the bruises and denied having a problem with alcohol. When she was asked specifically about driving into a ditch, she denied the incident ever happened.

The worker cited that the reason for the Unable to Determine disposition was that the bruises were no longer on the child, and the worker could not verify the concerning information about the mother drinking and driving. The CIRT team concluded this was an appropriate disposition because of conflicting and inconsistent information about the injuries and driving into a ditch.

REFERRAL 005: Allegations of Neglect; Disposition – Unfounded

On September 12, 2008, DHS received a report that 11-year-old G.S. was unable to enter his home after coming home from school to find no one home and the doors locked. According to the caller, the children's mother had made arrangements for T.S. to go to a neighbor's home after school, but had made no arrangements for G.S. The referral was assigned as a five-day response because the mother was home by the time the call was made, and the children were not considered to be in immediate danger.

On September 17, 2008, the CPS worker interviewed G.S. and T.S. at their school. G.S. disclosed being locked out of his house and checking all the doors except for one. He told the worker he used a cell phone to call his grandmother and eventually walked to the house where his sister was. He also told the worker he was scared during the incident. Both children denied drug or alcohol use by their parents, denied fighting by the adults in the home and denied physical discipline. The worker asked the mother about J.S.'s substance use, but she refused to provide the worker with any information.

A.S. told the worker she had left one of the doors unlocked, but didn't tell G.S. She indicated she had been out running errands and was late in getting home. She told the worker the reason she made arrangements for T.S. but failed to do the same for G.S. was that she was "frazzled" at being late. The worker noted there was poor communication by A.S. to her son and to the school. The worker also noted that G.S. was resourceful and had been able to manage the situation himself. At the conclusion of the assessment, the children, including E.S., were determined to be safe and the neglect allegation was unfounded.

The CIRT team concluded the assessment was handled appropriately because the incident did not constitute neglect.

**REFERRAL 006: Allegations of Physical Abuse and Threat of Harm;
Disposition - Unable to Determine**

On October 17, 2008, DHS received a report that 11-year-old G.S. had been physically abused by his mother. According to the caller, G.S. had bruising on his arm and was disclosing that his mother had grabbed him. The referral was assigned as an immediate response by a CPS worker. On the morning of October 18, the CPS worker contacted G.S. and observed the bruises on his arm. G.S. told the worker he thought he got the bruises from playing with his friends. He said he was pretty sure the marks on his arms were caused by his friends and not his mother. Ultimately, G.S. made no disclosures of abuse and denied being afraid to return to his mother and J.S.

T.S. was also interviewed, and she made no disclosures. She also denied feeling unsafe in her home. Based on the information provided, the worker decided the allegation of physical abuse was Unable to Determine. The worker also physically observed E.S. and reported no signs of physical abuse. The worker documented that based on visual inspection, the bruises on G.S. were not indicative of abuse. The worker also expressed concern that G.S. was feeling pressured and that may be contributing to his inconsistent statements. The worker made the Unable to Determine disposition because G.S. initially disclosed to the reporter that the bruises were caused by his mother; however, he did not make that disclosure to the CPS worker.

The CIRT team concluded that while this may be the correct disposition, the referral was not comprehensive in that the non-custodial parent was again not interviewed and there was no follow up on the concerns about G.S.'s demeanor in the interview, especially given the dynamics of domestic violence that had been reported in the past.

SYSTEMIC ISSUES

1. Responding to reports of domestic violence. Members of this CIRT team are concerned with the Department's history of response in this case to reports of domestic violence where children were present. Specifically, the concern is whether Child Abuse Hotline Screeners closed at screening reports involving domestic violence that should instead be assigned to a CPS worker for a comprehensive assessment.

In 2009, domestic violence was found to be present in 32% of confirmed reports of child abuse. For the past several years, DHS child welfare has made efforts to improve policy and increase staff training around domestic violence issues. Starting

in the late 1990's, Child Welfare began piloting the placement of domestic violence advocates in local Child Welfare offices. In 2004 the department created practice guidelines for Child Welfare to use when domestic violence was present in a case. The guidelines were recently reviewed and updated and are scheduled for publication by the end of May 2010. In 2006, each DHS Field office created local domestic violence plans outlining steps to appropriately prevent and intervene when violence between domestic partners has occurred. From 2005 to 2008 the CPS Program coordinated and provided training, specific to domestic violence (assessment and intervention), to workers and advocates in locations throughout the state.

In 2009, DHS submitted a budget request to the Legislature to expand statewide the availability of domestic violence victim advocates in child welfare offices. Although resources were not available to implement that request, legislation was passed in support of that effort when resources become available.

Recommendation:

Recent improvement efforts may have changed the Department's response to calls in this case regarding domestic violence made before 2006. However, Referrals 004 through 006 were received after those improvement efforts had begun. While referrals 004-006 did not specifically allege domestic violence, a comprehensive safety assessment would have included exploration of domestic violence issues in the family. In addition, the A.H. CIRT review (2009) identified similar concerns regarding how the Department screens reports involving domestic violence. As part of the A.H. CIRT, the CIRT Team completed an audit of sample cases to determine if the Department's current domestic violence protocols and screening guidelines are being appropriately applied. That review concluded that additional, targeted training was needed to ensure that workers are consistently and appropriately following the Department's current guidelines.

Action: By September 2010, all Supervisors and CPS workers will begin to receive additional training specific to domestic violence and the Department guidelines. In addition, a second review of sample cases will be completed to determine whether application of the guidelines has improved. The results of this second review and progress toward all staff receiving training will be audit points in this case.

NOTE: Following the event that gave rise to this CIRT, there were 14 domestic-violence-related murder-suicides in Oregon, resulting in the deaths of five Oregon women and three of their children. The history of the family involved in the event giving rise to this CIRT, as well as those subsequent tragedies, support the need for the creation of a long-term coordinated community response to domestic violence

throughout Oregon. They also support the need for the Department to continue advocating for the funding necessary to place domestic violence advocates in DHS child welfare offices to ensure that appropriate safety and intervention services are available for victims and children at the point of crisis.

2. Comprehensive Assessments. Several of the assessments in this case were incident-based assessments, and that fact is especially troubling in this case, because there was extensive history regarding this family that does not appear to have been taken into consideration as additional referrals about the family were received.

Although the CIRT team appreciates that it now has the benefit of hindsight, it is not clear from the documentation in this case that historic information about E.S.'s mother as a domestic violence victim and/or her ongoing struggles with addiction were considered in determining the safety of these children. While a more comprehensive consideration of these issues may not have changed the outcome in the case, it would have improved the way in which caseworkers approached screening and assessment decisions.

Recommendation:

In 2007, DHS Child Welfare implemented the Oregon Safety Model (OSM). One of the fundamental concepts of the safety model is that the CPS worker will conduct a comprehensive safety assessment to determine child safety, as opposed to incident-based assessments which focus almost exclusively on whether or not an incident of child abuse or neglect occurred and who is responsible. Whether a specific incident of abuse occurred or not may have very little to do with the overall safety of a child or other children in the home.

In recognition that comprehensiveness of assessments continued to be a challenge for the agency, between May and October 2009, Oregon Safety Model trainers (in conjunction with CPS Program Consultants) provided enhanced training, mentoring and coaching to child welfare supervisors throughout the state. The training specifically focused on supervision as it relates to the OSM and gathering comprehensive, safety-related information during assessments.

Also in 2009, CPS Program Consultants implemented a review tool designed to focus on the quality of information gathered and decision-making from the time a report is received (screened) through the assessment process. As of the time of publication of this report, five child welfare offices have been reviewed using the new review tool. Preliminarily, those reviews have found that workers are inconsistent in their application of the Oregon Safety Model. In particular, many cases lacked collateral

information that may have informed the worker about overall child safety. The reviews also indicated that workers are not consistently gathering the information critical to the fidelity of the Oregon Safety Model, but more importantly to ensure that children are safe.

The efforts listed above transpired after the last referral about this family was received in 2008 (Referral 006). However, the branch reviews, together with CIRT reviews that are currently underway, demonstrate the ongoing challenge workers are having in this critical area.

Accordingly, in two recent CIRT reports, it was recommended that the CPS Program Manager, with assistance from members of the Critical Incident Response Team, seek the assistance of the National Resource Center for Child Protective Services (NRC) regarding the challenges the Department is experiencing with respect to the implementation of the Oregon Safety Model expectations regarding comprehensive CPS assessments and the timelines by which to complete them.

In March 2010, the CPS program manager consulted with the NRC, a nationally recognized expert in child welfare which worked closely with Oregon in developing and implementing the OSM. The NRC consultation indicated the following:

First, Oregon has made complex practice changes connected to the Oregon Safety Model, and it is common for the full implementation of such a change to take approximately five years. In their estimation, Oregon is on track for that five-year implementation timeframe.

Second, the NRC indicated that supervisors are the key to changing practice. In order to support practice change, supervisors must be knowledgeable about the Oregon Safety Model, capable and clearly expected to direct workers toward conducting comprehensive assessments, and have time to staff cases as the case progresses through the assessment process.

Third, the NRC recommended that states develop a quality assurance tool to review CPS assessments. They indicated that using the tool to conduct reviews and provide feedback to branch offices about their practice has been demonstrated in other states as an effective way to support and facilitate improved practice.

Fourth, the NRC indicated that comprehensive safety assessments are more time consuming than incident-based assessments, requiring more information, more mandated contacts and higher levels of critical thinking, analysis and consultation.

The NRC confirmed that Oregon’s policy requirement for conducting a comprehensive safety assessment, 30 to 60 days, is an appropriate timeframe.

Action: As a part of Oregon’s Program Improvement Plan, the agency has been working with the National Child Welfare Resource Center for Organizational Improvement and the National Resource Center for Child Welfare Data and Technology to develop a strategic plan to support clinical supervision in Child Welfare. This work is specific to assisting supervisors in their work supporting and directing line staff in their application of the Oregon Safety Model. The plan has been presented to the Assistant Director and to the District and Program managers, and this plan will then be implemented statewide.

The department is in the process of developing a new child welfare case management system called OR-Kids. A basic design of the new system is a requirement for greater level of review and approval by supervisors. Additionally, the assessment process in the new system will have more mandatory fields at each step that must be completed before a supervisor can review and approve an assessment. The expectation is that these mandates will require more familiarity with the Oregon Safety Model and provide enhanced opportunities for training, teaching and clinical work for supervisors, in addition to providing more accountability.

The CPS program developed a quality assurance (QA) tool to review screening decisions and CPS assessments. The QA tool was submitted to the NRC for their feedback and recommendations about its design and efficacy. DHS will continue to seek the assistance of the NRC regarding its progress with implementing the OSM.

3. Use of photos taken by someone other than Child Welfare or Law Enforcement. In Referral 004, the reporter provided the Department with photos of the injuries G.S. sustained. However, the Department was “unable to determine” whether abuse had occurred, reportedly because the bruising was no longer present when the assessment was being completed.

The CIRT team identified as a potential systemic issue the challenge of how the Department uses photos of old injuries taken by someone other than Child Welfare or Law Enforcement: How do investigators authenticate the photos, when were the photos taken, severity of the injuries, were disclosures made to corroborate the photos, and witness statements or other corroborating information.

Recommendation:

The CIRT team believes there is a need for additional clarity for CPS staff regarding the use of photos taken by someone other than child welfare or law enforcement.

Action: By June 2010, the CPS Program Manager will convene a work team, composed of members from inside and outside the agency, to develop recommendations for the use of photos of injuries taken by someone other than a CPS worker or law enforcement personnel and how they are used during the assessment process. The recommendations of the workgroup will be audit points in this case.

AUDIT POINTS

- The agency will complete a second audit of sample cases to determine if current domestic violence protocols and screening guidelines are being appropriately applied.
- The agency will convene a work team to develop recommendations for the use of photos of injuries taken by someone other than a CPS worker or law enforcement personnel and how they are used during the assessment process.
- The agency will develop an action plan with clear timelines for implementation of specific sections of the strategic plan to support training and implementation of clinical supervision in Child Welfare that address assisting supervisors in their work supporting and directing line staff in their application of the Oregon Safety Model. The action plan will be completed within 90 days of the release of this report.

PURPOSE OF CRITICAL INCIDENT RESPONSE TEAM REPORTS

Critical incident reports are to be used as tools for determining whether there are systemic issues which need to be addressed 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.