

Initial 30-day Critical Incident Response Team (CIRT) Report J.W.

May 06, 2008

Summary of reported incident

March 29, 2008: The Oregon Department of Human Services (DHS) received a report that J.W., born Feb. 25, 2008, was brought to the emergency department of Emmanuel Hospital with severe and unexplained injuries.

March 31, 2008: J.W. died at Emmanuel Hospital from his injuries. An autopsy confirmed J.W.'s injuries were non-accidental. The circumstances surrounding J.W.'s death are under investigation by the Gresham Police Department.

April 06, 2008: DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened. This is the review team's first report.

Context for recommendations to DHS

Prior to J.W.'s death, DHS received two Child Protective Services (CPS) referrals about J.W. For the purpose of this CIRT report, the first referral is designated as assessment 001 and the second as assessment 002.

CPS assessment 001, received Feb. 26, 2008, completed Mar. 25, 2008: This referral was an assessment to determine the "threat of harm" regarding a minor teen mother and her newborn baby, J.W. The reported concern was that the minor teen mother and her infant would be discharged from the hospital to the home of her boyfriend and his parents, where there was a history of documented abuse. The father of this minor teen mother had legal custody of his daughter, and he agreed she and J.W. should be discharged to his home. However, because the minor teen's father was going to be out of Oregon on business the day of discharge, he made arrangements for his daughter and her infant to temporarily stay with an aunt. This plan was determined to be safe in that it resolved the reported concern. Based on the father's plan, this assessment found there was not reasonable cause to believe a threat of harm to the infant was present.

CPS assessment 002, pending: This referral was related to J.W.'s severe injuries resulting in his death. This assessment is not complete pending the receipt of the police report. Per CIRT practices, this assessment will be released upon completion. If it is not completed within 30 days, a status report will be released.

Additional assessment: In assessments 001 and 002, CPS assessed the safety of the infant J.W. and whether there were adequate supports in place for his minor teen mother

to care and provide for him. An additional assessment is being conducted regarding the teen parent as a child in her father's care.

Recommendation 1: Relating to assessment 001, the CPS manager should evaluate the current policies, procedures and practices to determine whether safety assessors have sufficient guidance to assess protective service referrals when one or both parents are minor teens. The CPS manager's evaluation should address, but not be limited to, the following questions: 1) When a referral involves a minor teen parent, does the protective capacity assessment of the minor teen parent sufficiently address the vulnerability of that parent as a child? 2) Do safety assessors apply consistent practices in assessing the needs of a minor teen parent as a child? If the CPS manager determines that safety assessors do not currently have sufficient guidance related to these matters, the CPS manager should convene a workgroup to identify and overcome barriers to providing such guidance to CPS assessors. If the CPS manager determines that sufficient guidance is currently available, the CPS manager should immediately send an Information Memo (IM) to CPS field staff to clarify the existing policy and practice requirements.

Timelines: The CPS manager should report initial findings within 30 days of posting this initial report.

Rationale: To the extent policy clarification and guidance can be provided to CPS assessors, it should be done so immediately.

Status as of date of this report: Begun and ongoing.

Audit points: The CPS manager should report on initial findings and a plan to proceed no later than June 30, 2008.

Purpose of critical incident 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 relating to each child. Results of the reviews are posted on the DHS Web site. Actions are implemented based on the recommended improvements.

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.