

## **Initial 30-day Critical Incident Response Team (CIRT) Report**

**April 11, 2007**

### **Summary of reported incident**

**March 9, 2008:** The Oregon Department of Human Services (DHS) received a report that N.L.<sup>1</sup>, a 2-year-old child, died at the Salem Hospital.

**March 11, 2008:** Citing statements from a Marion County prosecutor, the Associated Press reported that an autopsy revealed that N.L. died of “blunt force trauma.” The same source reported that the boyfriend of N.L.’s mother had been charged in Marion County with murder and sex abuse of N.L., and that the boyfriend also had been charged with criminal mistreatment of N.L.’s older brother.

**March 11, 2008:** DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened. This is the team’s interim report.

### **Context for recommendations to the Department based on the Critical Review to date**

Prior to N.L.’s death, DHS received two Child Protective Service (CPS) referrals about N.L. and her brother. For purposes of this Interim CIRT Report, the first referral is designated “Assessment 001” and the second “Assessment 002.” In addition to the referrals, DHS received a third report. It is designated “Closed at Screening 001” for purposes of this Interim CIRT Report.

**CPS Assessment 001, completed April 25, 2006:** After this referral was received, DHS concluded that the following family risk factors likely existed in N.L. and her brother’s household: likely child neglect, teenage mother, young adult father, two young children, and parental lack of judgment. This assessment found reasonable cause or belief that neglect occurred. DHS did not open a child welfare case.

**CPS Assessment 002, completed April 24, 2007:** After this referral was received, DHS concluded that the following risk factors likely existed in N.L. and her brother’s household: physical abuse of N.L.’s brother, teenage mother, two young children, and that the perpetrator of the physical abuse of N.L.’s brother was the live-in boyfriend of N.L.’s mother.

DHS created a written safety plan for N.L. and her brother during assessment 002. This assessment found reasonable cause or belief that third-party physical abuse occurred. DHS did not open a child welfare case. N.L.’s maternal grandmother signed the safety

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<sup>1</sup> The full name may be available upon request, subject to an analysis under the public records laws.

plan as the parent/guardian of N.L.'s teenage mother. DHS had previously received CPS referrals concerning this grandmother. The prior referrals included allegations that the grandmother had not adequately protected her teenage daughter, the mother of N.L. and her brother.

**Closed at Screening 001:** The caller reported information she had heard from another party. The information reported was that the mother was in a "bad crowd" and that mother's boyfriend "beat them all up." DHS closed this referral at screening citing no identifying information regarding the boyfriend, and no report of injuries.

**Cross-systems information sharing:** In CPS assessments 001 and 002 as well as Closed at Screening 001, Child Welfare and Self-Sufficiency workers viewed some information about the family from each others' divisions to gain a larger picture of DHS involvement with this family, but their access was limited. Gaps in information sharing exist because some means of communication have not been institutionalized and current technology does not support Self-Sufficiency staff viewing pertinent Child Welfare Screens.

**Recommendation 1:** The Child Protective Services (CPS) Manager should immediately issue instructions to the field offices reinforcing DHS's existing policy requiring a CPS case to be opened whenever a CPS safety plan is adopted.

**Timeline for implementation:** Immediately

**Rationale:** Existing policy requires a CPS case to be opened whenever a CPS safety plan is adopted.

**Status as of date of this report:** Completed. Recommendation implemented by DHS April 9, 2008.

**Audit points:** Beginning May 1, 2008, the DHS auditors should sample CPS safety plans on a quarterly basis to determine the degree of compliance with DHS policy requiring every such plan to be accompanied by an open CPS case. The first audit should be completed on July 1, 2008. Auditors should report their quarterly findings to the Director and to the CPS Manager.

**Recommendation 2:** Relating to Assessment 002, the CPS Manager should evaluate whether safety assessors use and have access to sufficient information (such as prior CPS referrals and background or criminal records) to fully assess an individual's suitability to perform as guardian in a safety plan. If safety assessors do not currently have access to such information, the manager should work with the Oregon Department of Justice to identify and attempt to overcome any legal barriers to providing such information to assessors. If safety assessors currently have access to such information, but do not regularly use it, the manager should clearly communicate the expectation that assessors will use all the information relevant to assessing the proposed guardian's suitability to protect the child.

**Timeline for implementation:** Implement the recommendation within 30 days of posting of initial report.

**Rationale:** Assessors require this information to assess the effectiveness of a proposed safety plan.

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

**Audit points:** The CPS Manager should report on the completion of the work to the director on or before May 30, 2008.

**Recommendation 3:** The Critical Incident Response Team should continue its examination of the circumstances surrounding CPS Assessment 001 including staff interviews with completion by May 11, 2008.

**Timeline for implementation:** Immediately.

**Rationale:** The Critical Incident Response Team has not completed its examination of the decision to close CPS Assessment 001 without opening a case.

**Status as of date of this report:** The CIRT continues its examination of the circumstances surrounding CPS Assessment 001.

**Audit points:** Dependent upon completion of the work required by this recommendation.

**Recommendation 4:** The Critical Incident Response Team should continue its examination of the circumstances and decision-making around the Closed at Screening Referral 001 including staff interviews with completion by May 11, 2008.

**Timeline for implementation:** Immediately.

**Rationale:** The CIRT has not completed its examination of the decision to Close at Screening a referral on a family with previous referrals.

**Status as of date of this report:** The Team continues its examination of the circumstances surrounding Closed at Screening Referral 001.

**Audit points:** Dependent upon completion of the work required by this recommendation.

**Recommendation 5:** Program Administration in Child Welfare and Self-Sufficiency should work with DOJ to identify and attempt to overcome any legal barriers to providing information between Child Welfare and Self-Sufficiency staff when serving mutual clients. Additionally, Program Administration in Child Welfare and Self-Sufficiency

should work with Office of Information Systems and FACIS to address and overcome barriers in technology that prevent sharing pertinent information.

**Timeline for implementation:** Report initial finding within 30 days of posting of initial report.

**Rationale:** To the extent information can be made available to each division, the divisions should use the data to help provide the most current information and status of a family to ensure children's safety.

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

**Audit points:** The Administrators of Child Welfare and Self-Sufficiency should report on initial findings and plan to proceed on or before May 30, 2008.

### **Purpose of Critical Incident Reports**

The Critical Incident Reports are to be used as tools for the Department and the Public to improve the Department's accountability to the families and public it serves in order to keep children safe and thriving.

The Critical Incident Review Team (CIRT) assesses Department actions when there are incidents of serious injury or death involving a child who has had contact with the Department. The Reviews are launched by the Department Director to quickly analyze DHS actions relating to each child and are posted on the DHS website. Coinciding with the Reviews, 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 or family.