Critical Incident Response Team Final Report

July 16, 2008

Executive Summery of JW CIRT

J.W., a one-month old infant, died in a hospital from non-accidental injuries on March 31, 2008.

Prior to the injuries that resulted in J.W.'s death, DHS received and investigated a referral regarding J.W. The focus of that investigation was the immediate safety threat to J.W.

In reviewing this case, the CIRT team determined that a review of DHS policy regarding assessments of safety threats to children of teen parents is needed. Specifically, the CIRT team recommends that DHS consider a dual assessment process that will evaluate both the immediate safety of the alleged victim child, as well as the teen parents' own safety.

The CIRT Team recommended the Child Protective Services Manager convene a workgroup to develop specialized procedures for referrals involving the children of teen parents. This workgroup has begun their work and is expected to finalize its recommendations by October 01, 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 Emanuel Hospital with severe and unexplained injuries.

March 31, 2008: J.W. died at Emanuel 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 Gresham Police Department.

April 06, 2008: DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened.

May 06, 2008: The initial CIRT report was completed.

June 19, 2008: The final CIRT report was completed.

Background

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 is assessment 002.

CPS assessment 001, completed March 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 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 the 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 is 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, completed June 27, 2008: This referral was related to J.W.'s severe injuries resulting in his death. This assessment found there is reasonable cause to believe this fatality is the result of abuse. The disposition of this assessment will be founded.

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 was conducted regarding the teen parent as a child in her father's care. That assessment found reasonable cause to believe that no abuse or neglect occurred and the parent is making appropriate plans for his daughter.

Recommendations

Recommendation 1, made in May 06, 2008 report: 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 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.

Progress/status report: The CPS manager conducted a review of the procedure manual, administrative rule, and policy. He reports that there is no explicit guidance to CPS staff regarding assessing a child abuse allegation where the parent is a minor teen. The current CPS process does not distinguish between minor teen parents and adult parents. The CPS manager further found that the DHS procedure manual does not instruct safety assessors to do a duel assessment: assessing the parental protective capacity of the minor teen parent as well as the vulnerability of the minor teen who is a parent.
The CPS manager has convened a workgroup that will focus on developing procedures that will provide guidance to safety assessors on how to complete a comprehensive assessment of child abuse allegations involving minor teen parents.

Audit points: The CPS manager will report the progress of this workgroup to the Director every 30 days beginning August 01, 2008. This workgroup should complete their work, and a final product be implemented by Oct 01, 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 and 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 reports includes information specific only to the department's interaction with the child and family.

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