60 day CIRT REVIEW REPORT
July 26, 2007[1]

I. CIRT Reason/Case Update

On 4-26-07 BM was life-flighted to OHSU from Silverton Hospital. He was reported to have a severe bilateral cranial hematoma. The child was reportedly injured while in the care of Christian Moranchel, the fiancé of the mother, JD. Mr. Moranchel was later arrested and charged with Assault I and Criminal Mistreatment 1.

At the time of his injuries, BM and his brother were in the custody of their mother and DHS had an open voluntary in-home case. There was a history of chronic neglect and JD having repeated relationships with men who were violent to her in front of her children.
Since the 30 day CIRT report BM moved from OHSU to Legacy Emmanuel Hospital where he received physical therapy, occupational therapy, and surgery. He was released from Legacy and moved to a foster home on July 12, 2007. BM has made remarkable progress since first hospitalized. He originally had almost no brain activity and no vision. Today he is sitting and standing with help, attempting to say words, feeding himself and can track visually part of the time. BM's brother remains in foster care in a separate foster home.

II. CIRT response and Case Status Update

a. Criminal Investigation and CPS Assessment

The Oregon State Police Department and Silverton Police Department participated in the criminal investigation. Mother's boyfriend, Christopher Morenchel was arrested and charged with Assault 1 and Criminal Mistreatment 1. His trial is set for December of 2007. He remains in the Marion County jail.

Update: Christopher Morenchel was acquitted of all charges during a trial in May 2008.

[1] Finalization of this written report was delayed but the case review process was conducted pursuant to protocol timelines. Report delayed pending outcome of criminal prosecution.

The Marion county CAF staff continue to work closely with the District Attorney's office.
The CPS assessment was completed on 5-31-07. There were three (3) founded dispositions related to BM and two (2) founded dispositions related to his brother. A "founded" disposition means that there was reasonable cause to believe that abuse or neglect occurred.

b. Media Response

There have been no media contacts.

c. Case Review Process

CAF Child Welfare program staff reviewed and evaluated all case record information including documents related to prior screening and assessment contacts with or about the family. The areas of focus in this review were in compliance with policy, statute and practice focused on child safety.

d. Staff Interview Process:

DHS Administration and Human Resource staff interviewed two screeners, two assessment workers, one ongoing worker and four supervisors, one who is now the Program Manager. The information obtained in staff interviews was consistent with the findings in this report. Human resources concluded that there are no staff actions warranted.

III. CIRT Identified Issues, Analysis, and Action Steps

1. Identified Issue: The case review indicated that "close at screening" decisions appeared to be made without consideration of previous information. In addition, reports made by LEA that indicated abuse and neglect were also closed at screening without adequate documentation as to why the decision was made not to assign the report for a face to face assessment.

Analysis: Because of the way FACIS (Family and Child Information System) has operated since 2002 when changes occurred with the implementation of Client Index, screeners, assessment workers, and supervisors do not automatically see previous closed at screening actions which occur prior to the first assessment being opened.

During staff interviews, it was learned that as a result of the above data problem, significant information was unknown to subsequent screeners regarding escalating domestic violence and risk to the children in this case. This lack of information contributed to the first assessment worker closing the founded case at assessment. It was also learned during staff interviews that there were several instances where police reports arrived significantly after the case was closed at screening and once when the case was closed following a founded assessment. In some of these instances, including the closed assessment, the information in the police report was more detailed and significant than the verbal report received by the screener by telephone from the LEA officer. In those instances, it appears that a worker noted the referral had already been processed and therefore filed the LEA report, without cross checking the reports for additional or different information.

There is a temporary solution for the FACIS data problem that has been shown to supervisors and workers but it is not 100% effective and often not used when things are extremely busy at the screening desk. There is also no consistent protocol in place that makes sure all screening staff are aware of the temporary solution. Other problems with FACIS and how additional information on family members is captured exacerbate the problem. The program consultants have addressed the use of the temporary solution but it does not appear to be that the information on the temporary fix has been given in an ongoing and consistent way.

Action Steps:

a.) All screening and intake staff for the branch will be re-trained on the temporary solution to the FACIS data problem. Each screener will use this new process to search for prior closed at screening reports each time a call is received by the hot line.

- Training is to be completed with every screening and intake staff member within 60 days of this report. The training is to be done by intake supervisors with consultation from Oregon Information System (OIS) if needed.

b.)All screening and intake workers will be trained on how to handle Law Enforcement reports that are received after a verbal referral is either closed at screening or assessed. In these instances, the screener will read the LEA report in its entirety and cross check it with what has already

been entered on a close at screening or assessed referral. If the written report does not contain new or different information than what was received in the verbal report, the written report will be filed. If the written report does contain new or different information than what was received in the verbal report, whether a new 307 should be generated will be considered.

- Training is to be completed with every screening and intake staff member within 60 days of this report. The training is to be done by intake supervisors.

2. Identified Issue: The case review indicated a chronic pattern of behavior and circumstances with this family that included reports of diminished parental protective capacity, neglect/lack of supervision, exposure to violence and substance abuse. The records lack information about adequate assessment of parental protective capacity, identification of appropriate services or development of a plan to assist in needed changes within the family.

Analysis: Once the case was opened for services, collateral work was very limited. The worker did not consult with the probation office; Women, Infants, and Children (WIC), the maternal grandmother, who lived with the mother on and off during the case; or the mother's boyfriend, who moved into mother's home during the time the case was open. Appropriate referrals were made for parenting services but there was no follow up by the worker. The worker said that a significant wait list for contracted parent training services was an issue. However, there was no documentation that efforts were made to look for alternative service providers or to address the need for services in another way. It was the probation officer who eventually referred the mother to Family Building Blocks for parenting services many months later. While face to face contact with the family did occur close to policy expectations, only two face to face visits were made at the home. There was no interaction with mother's boyfriend and no assessment as to his threat to the children, his parental protective capacity or his need to be included in the family services. Contact with mother's boyfriend may have led to an assessment of a possible threat to the children.

It does not appear to have been appropriate to open this case as an in home voluntary case. Once the case was opened, the management of the case plan does not appear adequate. And it appears the case was treated as presenting a low level of safety threat to the children.

Action Steps:

a.) A county resource guide for the local office is already developed and available to staff. Supervisors will re-introduce the resource guide to all staff and reinforce to staff that if contracted services are not readily available due to wait lists, there are other community resources that can be pursued.

- Supervisors are to discuss this at unit meetings within the next 60 days.

b.) Assigned office staff will work with contracted providers in order to more effectively manage the long wait lists for core DHS services in Marion County.

- A district Policy Analyst has already begun to work with the Marion contracted provider on keeping the wait lists updated and providing workers with periodic feedback as to the status of their referral. The Policy Analyst will perform regularly scheduled audits of the wait list.
- District 3 management will meet quarterly with management from the Marion contracted provider on service utilization, wait lists, and other issues regarding contracted services
- The first meeting is scheduled between the District Management team, Program Managers, and the Contractor for September 10, 2007

c.) As directed by the Oregon Safety Model (OSM), caseworkers will review the case plan a minimum of every 90 days. This review will always include input from service providers and will include an assessment of the progress that has been made in achieving the expected outcomes of the case plan and, when the child is in substitute care, the progress toward meeting the conditions of return. The review will include observations of improved parental protective capacity based on specific behaviors, conditions, or circumstances that have measurably changed.

- Effective immediately Supervisors are responsible to assure implementation of the OSM within their respective units.

d.) Staff will be instructed and re-trained on the appropriate level of face to face contact on an in home case, including the requirements that the contacts must include visits to the home environment and the content of those contacts will include review of the case plan. Caseworkers will conduct the review on all members living in the household.

- The appropriate supervisor will present this information at individual unit meetings; to be completed within 60 days.

V. Next Steps: Each month Program and field administration will review the action steps identified in this report to assure timely completion and achieve necessary practice improvement.

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