30–Day CIRT REVIEW REPORT
March 16, 2007[1]

I. INTRODUCTION

Oregon Department of Human Services adopted the Critical Incident Response Team (CIRT) protocol November 1, 2004. This protocol was developed for the following purpose:

- To specify the Department of Human Services, Child Welfare procedures that will be used when a critical incident occurs;
- To increase the Department's accountability to the public;
- To ensure timely responses by the Department with respect to any critical incident in Child Welfare; and
- To increase the Department's ability to recommend necessary changes to statutes, administrative rules, policies, procedures, practices, training and personnel matters.

II. CIRT REASON/CASE BACKGROUND

On February 14, 2007 at 2:52 AM, emergency medical personnel responded to a call that Destiny Foster, age 18 months, was not breathing. The child was transported to Salem Hospital and then life-flighted to Oregon Health Sciences University (OHSU).

While medical staff attempted to clear Destiny's throat, a baby wipe was found deep in her throat. Destiny also had other minor injuries. Christa Dolan, Destiny's mother, admitted to putting the wipe down Destiny's throat. The child was on life support and the extent of brain damage was undetermined at that time.

At the time of her injuries, Destiny was a ward of the Marion County Court; her legal custody was with DHS and physical custody was with her mother.

Between 9/23/02 and 2/16/07 DHS received eight (8) Child Protective Service (CPS) referrals and one (1) preventive/restorative (p/r) referral

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

regarding Ms. Dolan and her children. Ms. Dolan's first child was placed in foster care as a result of Ms. Dolan's failure to protect her from a known sexual offender. Ultimately Ms. Dolan voluntarily relinquished her parental rights to this child. Destiny was the second child born to Ms. Dolan. She was taken into protective custody and placed in a medical foster home immediately following her birth. Ms. Dolan participated in and completed numerous services including parenting classes. Destiny was returned to her mother's care 1/26/06 with extensive in home services including a health department visiting nurse and Salem Alliance; an outreach parenting and mentoring program. On 7/08/06 a third child was born to Ms. Dolan. That child remained in the custody of Ms. Dolan until being taken into protective custody at the time of Destiny's injury. This child resides in foster care with the family who adopted her older sister.

III. CIRT RESPONSE/CASE STATUS UPDATE

a. Criminal Investigation and Child Protective Services Assessment

The Salem Police Department is investigating the events surrounding the injuries to Destiny. Destiny's sibling has been taken into protective custody and placed in foster care.

Christa Dolan was arrested and has been charged with three counts of first-degree Criminal Mistreatment and one count of Assault II. She remains incarcerated in the Marion County Jail.

The Marion County Child Welfare staff continue to work closely with LEA.

b. Media Response

There has been no media inquiry regarding this case.

IV. CIRT REVIEW PROCESS

a. Case Review Process

CAF Child Welfare Program staff reviewed and evaluated all case record information including documents related to prior CPS referrals, screening activities and assessment contacts with or about this family. Between 6/24/04 and 2/16/07 DHS received eight (8) CPS referrals. Five (5) of the

eight (8) referrals were founded for abuse or neglect. Three (3) were closed at screening and the information referred to the caseworker. All of these CPS referrals were part of the materials reviewed during this case review process.

The area of focus in this review was compliance with policy, statute, and practice in child safety.

b. Staff Interview Process

DHS Administration and Human Resource staff has been assigned to complete interviews of all identified staff and managers who were involved with this case. Staff interviews will be conducted within the next two weeks.

V. IDENTIFIED ISSUES AND PENDING QUESTIONS

a. Identified Issue: The case review indicated there were numerous identified concerns about the continuing safety of the child in the home and these concerns were clearly identified and outlined in a court report dated January 2007. Despite these documented concerns, DHS did not recommend in its report to the court that the child be removed.

Pending Questions:

- Do previous court rulings in this case or in the county generally influence what recommendations the child welfare worker made in the court report?
- Would on-going consultations with Assistant Attorneys General and/or having them present during the court hearing have had an impact on DHS making a different recommendation to the court, or on the outcome of the court hearing?
- Should this case have been staffed with an Assistant Attorney General pursuant to the mandatory or discretionary criteria for legal review?
- Is there a need for more training on the application of the legal review criteria, either in this county or statewide?

b. Identified Issue: The CIRT case review indicated the focus of this case was the mother's participation and completion of services. It appears that assessment and review of safety was secondary and there was not a clear

written safety plan during the period of time the child was being served in her own home.

Pending Questions:

- Did local practice of using the Team Decision Meeting (TDM) to create the service agreement meet the policy and practice expectation of monitoring safety in an in-home case?
- Did DHS adequately assess the mother's capacity to safely parent given her history?
- Were appropriate services for the mother identified and offered?

c. Identified Issue: CIRT file review indicates DHS relied heavily on progress reports from other professionals who were providing both community-based and in-home services to this mother.

Pending Questions:

- Providers participated in the safety plan. Did DHS have a clearly defined process or specific request for providers to report safety concerns?
- Did professionals understand the safety concerns identified in this home? Were providers aware of or understand the mother's abilities, limitations and needs? Did DHS make clear to service providers the importance of the mother understanding parenting information intended to improve safety and then demonstrating a change in her behavior?

d. Identified Issue: The case review indicated that DHS had extensive historical and present knowledge about the mother's abilities, limitations and needs.

Pending Questions:

- How were the mother's abilities, limitations and needs being considered at the same time her parenting skills and service participation were being assessed?

- Do DHS caseworkers and supervisors have adequate training and knowledge to understand information provided by service providers and then transfer that information to the development of safety plans?

VI. NEXT STEPS:

As part of the CIRT protocol, DHS will complete the following activities within the next 60 days:

- Staff interviews will be completed and recommendations forwarded to the CIRT review team.
- The local child welfare and Central Program office will finalize recommendations and identify action steps and time lines in response to the findings.

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