60 day CIRT REVIEW REPORT
May 21, 2007[1].

I. CIRT REASON

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 was attempting 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 her 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 with her mother. Please refer to the 30 day report for background information on this case.

II. CIRT response and Case Status Update

a. Criminal Investigation and CPS Assessment

Christa Dolan has been charged with two counts of first-degree Criminal Mistreatment and one count of Assault II. She was incarcerated at the Marion County jail.

On March 28, 2007, DHS received the following written statement from the District Attorney's office. "The defendant was found unable to Aid and Assist in his or her own defense. The defendant is committed to the Oregon State Hospital until such time the defendant is found able to Aid and Assist".

Christa Dolan entered a no contest plea on December 17, 2007 and was convicted on February 19, 2008, of three counts of Criminal Mistreatment 1 and one count of Assault 2. She was sentenced to a total of 110 months,

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

with one of the criminal mischief changes running consecutive. The case is on appeal concerning the sentencing.

The CPS assessment has been completed and resulted in 2 founded dispositions related to Destiny's injuries and 1 founded disposition related to Destiny's younger sibling.

Both Destiny and her younger sibling remain in foster care. Destiny is in a medical foster home and her younger sister has been placed in foster care with the family who adopted the older sister. The local Children, Adults and Families (CAF) staff continue to work closely with District Attorney's office.

a. Media response

There have been no newspaper reports. Channel 12 News did cover the story with details obtained from law enforcement. A morning talk show on 97.1 also mentioned the case, but did not give further details of the incident.

b. 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 compliance with policy, statute and practice focused on child safety.

c. Staff Interview Process:

DHS Administration and Human Resource staff interviewed eight staff who were involved with this case from November 2005 to the time of the incident. All are staff from Marion County and included three intake screeners, the intake supervisors, a CPS assessment worker, two permanency workers and the permanency supervisor. The information obtained in staff interviews was consistent with the issues identified in this report. Human Resources concluded that no staff actions are warranted. Training and supervision actions are addressed in the following section.

III. CIRT IDENTIFIED ISSUES, ANALYSIS, AND ACTION STEPS

1. Identified Issue: The case review indicated there were numerous identified concerns about the 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.

Analysis: Information and concerns presented to the Court in the January 2007 report were sufficient to continue court wardship and DHS supervision. The information and concerns would have been sufficient to ask the Court for removal of the child. That request was not made. There is some indication in the staff interviews that the worker's concerns were not shared by the other parties, and, therefore, the worker did not feel confident that the Court would continue wardship or support removing the child. That may have led DHS to not request removal of the child from the mother's home.

It is important for DHS to state clearly its concerns regarding safety and that any DHS recommendations specifically reflect the identified concerns. In a case such as this, consultation with an AAG may have been appropriate and would have met the legal review criteria. Review of the case and legal advice by an AAG may have assisted the caseworker in preparing the court report and clearly stating the safety concerns and recommendations of DHS. In addition, AAG representation in the courtroom would have allowed DHS' concerns and recommendations to be clearly articulated and legal arguments presented to the court.

Action Steps:

a. Local CAF Managers will review with staff the current criteria for AAG representation and determine whether additional training is required to facilitate use of the legal review process.

- Local Program Managers will add AAG legal review and representation to the weekly Supervisors meeting agenda for review and discussion.
- Supervisors will review the legal review criteria with their staff.
- Timeline: Review is to be completed by Sept. 30, 2007. If training is indicated it will be completed within 30 days.

b. Local Managers will revise the branch court training project. This is an internal training to assist workers with becoming familiar with their role in the court process. This revision will include adding curriculum training on writing court reports and courtroom presentations. It will specifically focus on the need to clearly state the agency's position, including concerns and recommendations on a case regardless of the anticipated outcome.

- A court training curriculum already exists. Two current supervisors along with the CET's who mentor workers in court will develop the additions to the training. This is to be completed and part of the training within 60 days.

c. Local Managers will use existing unit meetings to discuss expectations for court performance and continue the practice of having Supervisors periodically observe each employee in court.

- Supervisors are to complete discussion with their units within 90 days (Sept. 01,2007)

d. Central Office staff will discuss with field Child Welfare Program Managers at their September meeting how casework staff use the criteria for legal representation. Consideration will be given to further training if needed to facilitate access to legal review and representation in cases

2. 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.

Analysis: Team Decision Meeting's (TDM) were used periodically throughout the case. While the TDM notes clearly outlined the safety concerns that existed in this case, the written plan from each TDM resembled a service agreement rather than a safety plan; the focus of the plan was on services and the completion of those services. The final plan developed through a TDM, prior to the child returning home, relied on the mother's promise to engage in services and her reported motivation to change.

Administrative Rule clearly outlines requirements for the use of a TDM to include a review of the safety plan and worker responsibility for assessing child safety, approving a safety plan, and monitoring that plan. The local practice of creating the service agreement from the TDMs appears to have led to staff missing critical, safety plan components. What was required was a safety plan that contained concrete and immediate interventions related to the safety threats listed in the notes. Those concrete and immediate interventions should have listed persons, other than the mother, who were responsible for monitoring safety.

Action Steps:

a. The implementation of the Oregon Safety Model (OSM) will address this issue. The use of TDM's has been narrowed in practice and OSM rules regarding monitoring child safety require that each case have a

documented set of actions or interventions that manage a child's safety throughout case. The local office has an extensive training plan already underway on the OSM.

- Effective immediately, all management staff within the local office is involved in the OSM implementation training.

3. Identified Issue: The 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.

Analysis: There is documentation that service providers attended the TDMs, participated in that process, and therefore should have known what the safety issues were. It is unclear whether there was a clearly defined process for those providers to report to DHS on these safety concerns. During the staff interviews, it was learned that there was frequent verbal communication with the service providers involved in this case. However, written documentation from important service providers was missing.

Actions steps:

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

- Effective immediately, local supervisors are responsible to assure implementation of these reviews within their respective units.

b. The Family Decision Meeting, which service providers and safety plan participants are urged to attend, will include a detailed discussion of the safety threats in the case. All service providers will be provided with copies of the action agreement developed in the meeting. The action agreements will identify the safety threats, name specific providers or safety plan participants and outline their roles in monitoring safety.

- Effective immediately, local supervisors are responsible to assure implementation within their respective units.

c. Caseworkers will request written information from the service providers and safety plan participants regarding their work with the client.

- Effective immediately, local supervisors are responsible to assure implementation within their respective units. Program Managers will be responsible to check in with supervisors within 30 days to assure implementation of the process described within this section.

4. Identified Issue: The CIRT case review indicated that DHS had extensive historical and present knowledge about the mother's condition, history and limitations.

Analysis: While there were numerous, adequately written and up to date reports on mother's significant issues, there was insufficient analysis as to how those issues were being considered along with her parenting skills and the assessment of her participation in services. While service providers reported she was "doing well" in her services, the mother was known for her inability to manage stress and it had been noted that she had a harsh attitude towards Destiny. Given the mother's limitations, her capacity to be a dependable protective parent in the absence of continual close monitoring and supervision was questionable. Therefore, her potentially dangerous behaviors could be expected to emerge during unsupervised periods. It is unclear whether workers and supervisors had adequate qualifications and training to understand information from evaluators and service providers and use that information to develop safety plans, or to determine if an individual has the capacity to be a safe parent.

Action Steps:

a. The branch will implement a training focusing on the use of psychological evaluations in identifying safety threats and parental protective capacity. Using the expertise of a psychologist/psychiatrist and an AAG, the training will focus on reviewing written diagnoses and interpreting assessments and recommendations.

- Program Managers will be responsible for assuring the training is arranged. The training will be arranged by the end of July, 2007 and will be completed by September, 2007.

b. The local office will develop a template to be used when writing referral letters for psychological evaluations. The format will include appropriate questions regarding both service planning and safety planning. The office will seek advice from an AAG when crafting the referral letters to psychologists in complex cases or in cases where there is already AAG representation of DHS.

- Program Managers will be responsible for assuring the completion of the template. The template to be completed and in use by August 1, 2007.

c. Referral letters for psychological evaluations will be reviewed by the appropriate supervisor prior to mailing. The supervisor will evaluate whether appropriate service and safety planning questions are included. Psychological evaluations will be reviewed by the appropriate supervisor.

- Effective immediately, the supervisors will begin the required reviews.

d. District 3 will develop a process to seek additional consultation from the evaluator conducting the psychological evaluation when interpretation of the diagnosis or implementation of the recommendations requires clarification to assure parental capacity to provide a safe environment for a child. District 3 will share this process at the September District Manager meeting.

- Discussion of the process will occur immediately at the Leadership Team including the District and Assistant District Managers.
- This issue may have statewide implications. Central Office staff will discuss this issue with District Managers and Child Welfare Program Managers at their October meetings and determine if each office needs a plan.

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

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