30-Day CIRT Review Report

July 21, 2007

I. Introduction

Oregon Department of Human Services (DHS) 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; and
- To increase the Department's ability to recommend necessary changes to statutes, administrative rules, procedures, practices, training, and personnel matters.

II. CIRT REASON/ CASE BACKGROUND

Stephanie Kuntupis (DOB 4/13/05) collapsed at her foster home and was transported by ambulance to Legacy Emanuel Hospital on June 22, 2007. Stephanie has critical head injuries that have been diagnosed as non-accidental injuries. Stephanie's injuries occurred while she was in foster care, in the care and custody of the State of Oregon.

Stephanie and her brother were placed in protective custody on 1/31/07. They were initially placed at the Children's Receiving Center. On 2/12/07 Stephanie and her brother were placed in a regular foster home. That foster parent had concerns about the brother and reported that Stephanie could not be consoled. On 2/16/07 Stephanie was moved to the foster home where she was residing when she was injured. Her brother was placed in a separated foster home until 2/23/07 when he joined Stephanie. This foster family asked that he be removed on 4/23/07 and he was placed in another home. Stephanie and her brother were in separate placements at the time of Stephanie's injuries.

III. CIRT RESPONSE AND CASE STATUS

Detectives from the Child Abuse Team in Multnomah County continue to conduct a criminal investigation. No arrests have been made at this time. Child Welfare staff continues to work closely with law enforcement.

Because of the unexplained injury to Stephanie, all children residing in the foster home have been removed and placed in other foster homes.

Stephanie has been moved to Emanuel Rehabilitation Unit where she is expected to remain for 4-6 weeks.

Media Response: There has been a great deal of media interest and coverage of this incident. The Oregonian, Portland Tribune and Statesman Journal have all provided stories. KGW,FOX NEW 12, and KOIN, all had stories on the morning and evening news; and KOIN and OPB had radio interviews.

IV. CIRT REVIEW PROCESS

a.) Case review process

Child welfare program staff reviewed and evaluated all case record information regarding Stephanie and her family. The certification record regarding the foster family was also reviewed. Areas of focus for this review were: compliance with policy and statute; casework practice focused on monitoring safety in foster care; and foster home certification.

b.) Staff Interview Process

DHS administrative and human resource staff will complete interviews of all identified staff and managers who were involved with this case.

V. IDENTIFIED ISSUES AND PENDING QUESTIONS

A. Identified Issue: The file review process raised questions about how information is shared among DHS staff.

Pending Questions:

1. Stephanie's 13 year old brother had 5 lines on his arm. It was suspected that he was cutting himself.

Whether this suspicion was accurate or not, was this information shared with the appropriate staff person? What is the local process for sharing

information among staff who have responsibilities on a single case? For example, was a mental health assessment requested?

2.) During a 5/29/07 supervised visit, Stephanie's mother pointed out bruises on Stephanie's forehead and back.

Was this information shared with appropriate staff according to policy? Should this information have been reported to the Child Abuse Hotline?

3.) A report was made to the Child Abuse Hotline when bruises were seen on another child in this same foster home a few weeks after bruises had been observed on Stephanie.

What is the protocol for sharing information between multiple workers with responsibility for children in the same foster home?

B. Identified Issue: The file review raised questions regarding the role of both foster parents in the foster home certification process, assessment of applicants who have multiple aliases names and the assessment of applicants who may not be able to perform the duties of a foster parent.

The foster family was initially certified as a relative placement, and then certified as a regular foster home. Review of the certification file indicates that all required paperwork for the initial certification was completed. Both foster parents had criminal histories and the necessary exceptions were obtained. The original certification and the home study renewal did not list any concerns. However, the role of the foster father in the certification process and as a caregiver in the home is unclear. DHS policy requires that both parents be interviewed as part of the certification process. It does not appear that the foster father was interviewed as part of the certification and was listed as "other" on the application at one time. He did not complete the 10 hours of required training, and it is unclear if the certifier ever had a face to face meeting with him.

Pending Questions

1. What is the local process for interviewing applicants for foster home certification? Was there discussion with the foster father about his failure to complete required training?

2. The foster father has a number of aliases.

How was this information, along with his criminal history, considered and assessed? Did DHS perform CPS background checks using the foster father's aliases?

3. The foster father may not have been able to perform the day to day duties of a foster parent.

What assessment was made regarding his ability to perform those duties for young children with special needs in his home?

C. Identified Issue: Stephanie had significant medical evaluations and medical procedures performed on two occasions and had emergency room visits. There is no documentation that DHS was aware of these evaluations, procedures or visits.

Pending Questions

Who signed the approval for the medical procedures that were performed on Stephanie? Was DHS staff aware of the medical issues and the visits to the emergency room? What is the process used for foster parents to notify DHS staff about medical issues and needed or planned treatment?

VI. Next Steps

Staff interviews will be completed and recommendations forwarded to the CIRT review team.

Analysis of the identified issues will be completed. Recommendations, action steps and timelines to achieve those steps will be developed and implemented. Persons responsible to carry out the actions will be identified.

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