Critical Incident Response Team Progress Report

May 20, 2008

Summary of reported incident

March 9, 2008: The Oregon Department of Human Services (DHS) received a report that N.L., a 2-year-old child, died at the Salem Hospital.

March 11, 2008: Citing statements from a Marion County prosecutor, the Associated Press reported that an autopsy revealed that N.L. died of "blunt force trauma." The same source reported that the boyfriend of N.L.'s mother had been charged in Marion County with murder and sex abuse of N.L., and that the boyfriend also had been charged with criminal mistreatment of N. L.'s older brother.

March 11, 2008: DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened.

April 11, 2008: The initial CIRT report was completed.

May 20, 2008: The CIRT Progress Report was completed. The CIRT file will remain open; progress reports will be completed until all audit points are addressed.

Background

Prior to N. L.'s death, DHS received two Child Protective Service (CPS) referrals about N.L. and her brother. For purposes of this Progress Report the first referral is designated "Assessment 001" and the second "Assessment 002." In addition to the referrals, DHS received a third report. It is designated "Closed at Screening 001" for purposes of this CIRT Progress Report.

CPS Assessment 001, completed April 25, 2006: After this referral was received, DHS concluded that the following family risk factors likely existed

in N.L and her brother's household: likely child neglect, teenage mother, young adult father, two young children, and parental lack of judgment. This assessment found reasonable cause or belief that neglect occurred. DHS did not open a child welfare case.

CPS Assessment 002, completed April 24, 2007: After this referral was received, DHS concluded that the following risk factors likely existed in N.L. and her brother's household: physical abuse of N.L's brother, teenage mother, two young children, and that the perpetrator of the physical abuse of N.L.'s brother was the live-in-boyfriend of N.L.'s mother.

DHS created a written safety plan for N.L. and her brother during assessment 002. This assessment found reasonable cause or belief that third-party physical abuse occurred. DHS did not open a child welfare case. N.L.'s maternal grandmother signed the safety plan as the parent/guardian of N.L.'s teenage mother. DHS had previously received CPS referrals concerning this grandmother. The prior referrals included allegations that the grandmother had not adequately protected her teenage daughter, the mother of N.L. and her brother.

Closed at Screening 001: The caller reported information she had heard from another party. The information reported was that the mother was in a "bad crowd" and the mother's boyfriend "beat them all up." DHS closed this referral at screening citing no identifying information regarding the boyfriend, and no report of injuries.

Cross-systems information sharing: In CPS assessments 001 and 002, as well as Closed at Screening 001, Child Welfare and Self-Sufficiency workers viewed some information about the family from each others' programs to gain a larger picture of DHS involvement with this family, but their access was limited. Gaps in information sharing exist because some means of communications have not been institutionalized and current technology does not support Self-Sufficiency staff viewing pertinent Child Welfare Screens.

Recommendations

Recommendation 1, made in April 11, 2008 report: The Child Protective Services (CPS) manager should immediately issue instructions to the field

offices reinforcing DHS's existing policy requiring a CPS case to open whenever a CPS safety plan is adopted.

Progress/status: Completed April 09, 2008.

Audit points: Beginning May 01, 2008, the DHS auditors should sample CPS safety plans on a quarterly basis to determine the degree of compliance with DHS policy requiring every such plan to be accompanied by an open CPS case. The first audit should be completed by July 01, 2008. Auditors should report their quarterly findings to the DHS director and CPS manager.

Recommendation 2, made in April 11, 2008, report: Relating to Assessment 002, the CPS manager should evaluate whether safety assessors use and have access to sufficient information (such as prior CPS referrals and background or criminal records) to fully assess an individual's suitability to perform as guardian in a safety plan. If safety assessors do not currently have access to such information, the manager should work with the Oregon Department of Justice to identify and attempt to overcome any legal barriers to providing such information to assessors. If safety assessors currently have access to such information, but do not regularly use it, the manager should clearly communicate the expectation that assessors will use all the information relevant to assessing the proposed guardian's suitability to protect the child.

Progress/status: The CPS manager's evaluation determined that safety assessors do have access to appropriate systems including the Oregon Judicial Information Network (OJIN); Family and Child Information System (FACIS); and Law Enforcement Data System (LEDS) as allowed by law. The CPS manager will provide an Information Memo (IM) to all safety assessors and their supervisors reminding them of the above-named systems, and the expectation that they will be used to assist in safety assessments of safety services providers as per the Oregon Safety Model. This completes the audit point listed below.

Prior to finalizing this recommendation, the CPS manager will meet with the Child Welfare Program managers to discuss the need for clearer direction or policy clarification regarding when background checks on safety service providers are expected. This will be completed by June 13, 2008. This will be the new audit point.

Audit point: The CPS manager should report on the completion of the work to the director on or before May 30, 2008.

Recommendation 3, made in April 11, 2008 report: The Critical Incident Response Team should continue its examination of the circumstances surrounding CPS Assessment 001 including staff interviews, with completion by May 11, 2008.

Progress/status: Staff interviews were completed the week of April 17, 2008. The CIRT team met April 23, 2008, to hear an update. The interviewers reported that the staff kept the referral open for 60 days, confirmed services were in place and being attended, and consulted with the District Attorney and law enforcement. Therefore, the decision not to open a referral on the child neglect was within appropriate decision-making. However, the CIRT team expressed concerns that even though the DA was not pressing charges regarding the underage sexual relationship between N.L.'s parents, DHS did not conduct a safety assessment regarding N.L.'s mother as a "child at risk" herself.

Audit points: NA

Recommendation 4, made in April 11, 2008 report: The Critical Incident Response Team should continue its examination of the circumstances and decision-making around the Closed at Screening Referral 001 including staff interviews, with completion by May 11, 2008.

Progress/status: Staff interviews were completed the week of April 17, 2008, and the CIRT team met April 23, 2008. Staff was asked what it would have taken for them to have opened an assessment, and the staff and their supervisor stated they would have opened an assessment if the report had been more specific than "mother's boyfriend," and if they had been given a name. The Critical Incident Review Team concurred that, given that two other men in N.L's mother's life had injured her children, it didn't matter what the name of the alleged perpetrator was, because there was documented history that multiple men in the mother's life had injured her children.

Audit points: The CPS manager should poll CPS supervisors across the state to determine their interpretation of the screening rules around impending danger. On completion of this work, the CPS manager will report

to the DHS director his findings and present a subsequent plan. This will occur on or before June 30, 2008.

Recommendation 5, made in April 11, 2008, report: Program administration staff in Child Welfare and Self-Sufficiency should work with DOJ to identify and attempt to overcome any legal barriers to providing information between Child Welfare and Self-Sufficiency staff when serving mutual clients. Additionally, program administration staff in Child Welfare and Self-Sufficiency should work with the Office of Information Systems and FACIS to address and overcome barriers in technology that prevent sharing pertinent information.

Progress/status: The two administrators have met and have reviewed information from staff interviews. They have confirmed that significant barriers exist with both technology access and a consistent understanding of confidentiality and what can and should be shared between Child Welfare and Self-Sufficiency when they serve the same clients. A workgroup consisting of Child Welfare field and central office staff, Self-Sufficiency field and central office staff, and DOJ has been convened and will meet in June 2008. This workgroup will outline the parameters of the problem and develop action steps to reduce or eliminate barriers and create a consistent process. This project will be ongoing.

Audit points: The administrators reported on their initial findings prior to May 30, 2008. They should submit an action plan with time frames to the DHS director by June 15, 2008.

Purpose of the critical incident reports

Critical incident reports are to be used as tools for the department and the public to improve the department's accountability to the families and public it serves in order to keep children safe and thriving.

The Critical Incident Review Team assesses department actions when there are incidents of serious injury or death involving a child who has had contact with the department. The reviews are launched by the DHS director to quickly analyze DHS actions relating to each child, and are posted on the DHS Web site. Coinciding with the reviews, actions are implemented based on the recommended improvements.

The ultimate purpose of this process is to review department practices and recommend improvements. Therefore, information contained in these incident reports includes information specific only to the department's interaction with the child and family.

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