30-Day CIRT REVIEW REPORT

I. Introduction

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

- 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 and procedures, practices, training and personnel matters.

The following is a 30-day report as required by the protocol, which includes initial findings, preliminary recommendations and next steps. During the next 30-day period, DHS will continue a comprehensive review of these preliminary findings and assess the degree to which these findings have statewide implications. The CIRT team will then assign specific tasks, identify time frames and desired outcomes.

II. CIRT Reason: 15-month-old child in DHS custody died as a result of inflicted injuries.

On 12-14-04, Ashton Parris, age 15 months, was transported by Life Flight to Oregon Health and Science University. Ashton died on 12-16-04 due to inflicted injuries resulting in a skull fracture, infracted brain, retinal hemorrhaging, and subdural hematomas. Ashton was a medically fragile child who had been in foster care since 12-21-03. Ashton was returned home on 10-21-04.

III. CIRT Response and Case Status Update:

Criminal Investigation and CPS Assessment:

Sgt. Alan Alderman was identified as the law enforcement representative on this CIRT team and Clackamas County Sheriff's Office (CCSO) is leading the criminal investigation in this case. LEA is continuing a process of interviews and review of pertinent information. No arrests have been made at this time. Child Welfare staff will continue to coordinate closely with LEA in the completion of the Child Protective Services Assessment.

b. Children:

The four surviving siblings of Ashton are in foster care.

c. Media Response:

Pursuant to the protocol, the CIRT lead designated a local media lead. Joel Manley of the Clackamas County Sheriff's Office (CCSO) served as the initial point of contact for media inquiries. Patricia Feeny was the DHS lead.

IV. CIRT Review Process:

a. Case Review Process:

The case file review was conducted at the St. Johns child welfare office by technical staff from Central Office. The CIRT team developed a list of questions and areas of focus for this review related to child protective services referrals, service planning, casework contacts and supervision. Actions of DHS staff were reviewed for compliance with administrative rule and policy as well as approved practice. The review process was used to assist in the development of questions for subsequent staff interviews.

b. Staff Interview Process:

Staff interviews were completed with the caseworkers for the case, the CET (consultant, educator, trainer), the social service assistant and the supervisor.

Additional interviews are being scheduled with the probation officer, the public health nurse, the Court Appointed Special Advocate, the foster parent, and the child's attorney.

Completion of the interviews and analysis of the results will be accomplished within 30 days.

V. Initial Findings and Preliminary Recommendations:

• **Finding**: The father's probation officer was not consulted before critical child safety decisions were made by DHS.

Recommendation: Central office will revise the administrative rule and procedure to ensure that all appropriate partners are included in critical child safety decisions.

• **Finding:** Review of calls made to CPS intake indicated that allegations were not properly assessed for face-to-face contact.

Recommendation: Central office program staff will develop an emergency temporary rule to revise the intake screening process. Training will be provided for screeners pursuant to the rule.

• **Finding:** Communication between the caseworker and social service assistant (SSA) was neither well documented nor coordinated.

Recommendation: Central office program staff will work with Multnomah County child welfare to strengthen and reinforce communication between the caseworkers, social service assistants and others assigned to provide service on a case. This is being reviewed as a statewide issue.

• **Finding:** Issues in this case, related to child safety, included substance abuse, domestic violence, criminal behavior and the parents' lack of follow through with recommended services. There is no documentation that there was adequate evaluation of the parents' protective capacity or ability to benefit from services and provide safe parenting for their children. Documentation was not clear that historical information was considered in this regard.

Recommendation: CAF staff are being notified that any reunification plan for a foster child with his/her family, must be reviewed with the casework supervisors to ensure that parental protective capacity has been adequately addressed and that known safety threats have been resolved. This supervisory review must occur and be documented in the case record prior to the return of the child.

• **Finding:** There were numerous family decision meetings held in this case, but the focus of the meetings was more on family reunification than child safety. This raises issues of concern about whether there is a proper balance between strengths/needs based planning and child safety and parental protective capacity.

Recommendation: Central office will review state law and DHS administrative rules related to the use of family decision meetings in the safety planning process to determine the impact of statutory and administrative rule mandates on current practice.

VI. Next Steps:

- Human Resources and Administration will continue interviews with staff and evaluate personnel related information. This will be completed within the next 30 days.
- Multnomah County child welfare staff will continue to coordinate with the Clackamas County Sheriff's Office on the completion of the criminal investigation and child protective services assessment.
- DHS will examine the information shared by child welfare with other parties to the case and how this information impacted the recommendation made to the juvenile court.
- Expert consultation from National Resource Center for Child Protective Services is scheduled to examine how critical decisions regarding safety of children are being made in Oregon's child welfare cases.