

# **CRITICAL INCIDENT RESPONSE TEAM REPORT B.S.**

October 4, 2011

## **Executive Summary**

On August 4, 2011, one year-old B.S. died as a result of injuries sustained two days earlier; doctors determined those injuries were consistent with abuse. The alleged perpetrator was the mother's boyfriend. The Oregon Department of Human Services (DHS) had received one referral on the family prior to the report of the fatal incident in March 2011. That referral related to threat of harm to the child based on alleged domestic violence between the mother and father. Because this child was the subject of a child protective services assessment by the department within the 12 months preceding the fatality, and this death was likely the result of abuse or neglect, it met the statutory requirement for a mandatory CIRT.

On August 5, 2011, Erinn Kelley-Siel, DHS Director, declared a Critical Incident Response Team (CIRT) be convened.

Any time a child in Oregon dies or is seriously injured as a result of abuse or neglect, the Department is committed to evaluating its processes and learning how the child welfare system may be improved, with the goal of making Oregon's children safer. The CIRT team's efforts to identify issues are a critical component of agency accountability and improvement when tragedies like this occur.

***Important note:*** This CIRT report is unusual because the alleged perpetrator was not the subject of prior contact. In this case, the fatality was the result of abuse perpetrated by the mother's boyfriend, and the department's initial investigation involved the biological father, with whom the mother had separated prior to the department's involvement. The subjects of the initial contact were not charged in the death of the child.

The CIRT team identified two main issues in this case:

- (1) The interaction between domestic violence and assessing child safety; and
- (2) The need for the department to conduct comprehensive assessments in cases involving domestic violence.

These issues have been identified in previous CIRTs. Reviews of the audit points associated with those previous CIRTs indicate actions steps were implemented to support the field staff in obtaining additional education and training regarding

conducting comprehensive assessments and assessments involving allegations of domestic violence. However, the CIRT team concluded that further analysis and information is to determine whether those previous efforts to improve practice in cases involving domestic violence have been effective and whether the issues in this case continue to be systemic.

### **Summary of Reported Incident**

It was reported that 1 yr old B.S. had been hospitalized as a result of the injuries sustained on August 2, 2011. The alleged perpetrator was the mother's boyfriend. On August 4, 2011, the Department was notified that the child had been taken off life-support and died.

On August 5, 2011, Erinn Kelly-Siel, the Director of DHS, declared a mandatory CIRT regarding the incident involving this child because this child was the subject of a child protective services assessment by the department within the 12 months preceding the fatality, and this death was likely the result of abuse or neglect.

### **Background**

Prior to the child's fatal injury, the Department received one CPS report on the family. Two additional reports were received concerning the injuries leading to the fatality. Two of the reports were referred for assessment (referred to in this CIRT document as Referral 001, Referral 002, etc.), and one was "Closed at Screening." A Closed at Screening disposition is used when the information reported describes family conditions, behaviors or circumstances that pose a risk to a child but does not meet the definition of child abuse as defined in the Oregon Revised Statutes. For purposes of this CIRT document, that report will be identified as Closed at Screening 001.

**Referral 001:**      **Date:**      **03/30/11**  
                                 Allegation: Threat of Harm  
                                 Response: Within 5 days  
                                 Disposition: Unable to Determine

On March 30, 2011, the department received a report regarding concerns of domestic violence perpetrated by the father towards the mother. According to the report, the mother had been trying to leave the father for a long time, but he was described to have physically restrained her to prevent her from doing so. Given the information obtained from the referral source, the Department appropriately identified the allegation of Threat of Harm because the father's alleged behaviors placed the child at a severe threat of harm. This was assigned as an up to 5 day

response. This was the appropriate screening disposition because the mother had taken steps to protect herself and the baby by staying with relatives.

There was no documentation that collateral sources were contacted throughout this CPS assessment. Therefore, the worker did not appear to have sufficient information to assess the father's relationship with the child, the child's safety while in his care, and to confirm allegations of violence in the home. The CIRT team concluded that this assessment was not comprehensive by Oregon Safety Model standards.

The disposition of Unable To Determine was reached because the worker was not able to determine if violence was occurring since no physical evidence of domestic violence was found. The CIRT team concluded that, had a more comprehensive assessment been completed, the information gathered may have resulted in different disposition.

**Referral 002:      Date:      08/03/11**  
Allegations: Physical Abuse/Threat of harm  
Response: Assigned, referral sequence 002  
Disposition: Founded

On August 3, 2011, the department received a report on allegations of physical abuse to 1 year old B.S. who was hospitalized on August 2, 2011 and on life support due to significant head trauma. The report indicated that at the time of the injury, B.S. was at home with her mother's boyfriend. The Department appropriately identified the allegation of Threat of harm and Physical Abuse. The mother reportedly left B.S. in the care of her boyfriend. The boyfriend reported that he put B.S. in the bathtub and she slipped back, hitting her head and causing her to become unconscious. B.S. was reported to be critically injured and it was unknown if she would survive. As there were no other children in the home, this was assigned as an up to 5 day response. This was the appropriate screening disposition.

The allegation of physical abuse that resulted to one year old B.S. by her mother's boyfriend was FOUNDED. According to the county Deputy District Attorney, the Medical Examiner found the cause of death to be blunt force head trauma and the manner of death is homicide. This is the appropriate disposition and is in compliance with department policy and rules.

**Closed at Screening 001:      Date:      08/09/11**

Allegations: FATALITY

Response: Closed at Screening

It was reported that 1 yr old B.S. had died in the hospital on August 4, 2011 as a result of the injuries sustained on August 2, 2011. The alleged perpetrator was the mother's boyfriend.

This Closed At Screening was generated to document the fatality and was incorporated into the open assessment, dated 8/3/11. This is the appropriate disposition and is in compliance with department policy and rules.

### **Issues Identified**

The CIRT team identified two main issues in this case:

- (1) The interaction between domestic violence and assessing child safety; and
- (2) The need for the department to conduct comprehensive assessments in cases involving domestic violence.

### **Recommendations:**

After reviewing the facts and circumstances surrounding this incident and the family's previous contact with the Department, the CIRT team concluded that further analysis and information is needed to determine whether previous efforts to improve practice in cases involving domestic violence have been effective and whether the issues in this case continue to be systemic. As noted, the two main issues identified in this case have been identified in previous CIRTs.

The Department's website includes the Domestic Violence Guidelines (<https://apps.state.or.us/Forms/Served/ce9200.pdf>) as a tool for all workers to access and use to improve their understanding and skills when working on these cases. This tool was updated as a result of a CIRT in 2009. Also as a result of that CIRT, all supervisors and CPS workers employed by the Department at that time received additional training specific to domestic violence and the Guidelines. In addition, a workgroup was convened to develop recommendations in an effort to provide additional skills to staff in the dynamics of domestic violence when one or both parents are teenagers. The workgroup recommended further training for screeners with cases that involve teens and domestic violence, as well safety planning with teen survivors was needed.

Comprehensive assessments continue to receive the full attention of consultants in their efforts to affect child welfare practice and increase child safety. Following a

2010 CIRT review, the Department consulted with the National Resource Center (NRC) on Child Protective Services to address the challenges the Department was experiencing with respect to the application of the Oregon Safety Model. From the feedback provided by NRC, the CPS consultants facilitated training to caseworkers and supervisors on conducting comprehensive assessments, as well as practice forums at the CPS Quarterlies for supervisors and workers.

It is difficult to evaluate from just this single case whether the department's efforts to educate and train workers on conducting comprehensive assessments and assessing child safety in cases involving domestic violence have been effective.

Accordingly, the CIRT team recommends that the Internal Audit Unit, in collaboration with the CPS Unit, conduct an audit of sample cases to determine whether the issues identified in this case are systemic, whether the department's efforts have had a positive impact. The CPS Unit will determine if additional or different training and education could assist to improve case practice.

#### **Audit Points**

The department will complete an audit of sample cases to determine if current domestic violence protocols and guidelines are being appropriately applied. A summary of the findings from the audit will be presented in a follow up CIRT report. That report will be completed by December 14, 2011.

#### **Purpose of Critical Incident Response Team Reports**

Critical incident reports are to be used as tools for department actions when there are incidents of serious injury or death involving a child who has had contact with DHS. The reviews are launched by the Department Director to quickly analyze department actions in relation to each child. Results of the reviews are posted on the DHS Web Site. Actions are implemented based on the recommendations of the CIRT members.

The primary purpose 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 that are the subject of the CIRT Review.