

CRITICAL INCIDENT RESPONSE TEAM 60-DAY REPORT

J.M.

April 15, 2010

Executive Summary

This is the update to the initial Critical Incident Response Team (CIRT) report in this case, dated January 15, 2010 and released on January 27, 2010. This report focuses on the work that the Department and the CIRT Team have done since the release of that report.

In summary, since that report was released, the CIRT Team has:

- Consulted initially with the National Resource Center on Child Protective Services regarding the comprehensive screening and assessment of child abuse reports under the policies of the Oregon Safety Model;
- Consulted with medical experts regarding the need for specific guidance to workers with respect to comprehensive assessments when children are being raised without contact by traditional community supports (school, medical, etc.);
- Conducted an audit of a representative sample number of closed at screening and referral determinations where children are above the age of 10 and reviewed specifically whether the child's age inappropriately influenced the decision that was made; and
- Further investigated whether the Department adequately documented all reports of abuse in this case.

Background: Issues Identified in Initial Report

After an extensive file review the Critical Incident Response Team identified the following issues, with an understanding that any personnel issues identified will be handled under a separate process:

Issue #1: The need for the agency to better support the Oregon Safety Model expectation that Child Protective Services (CPS) screening is comprehensive. This includes the need to evaluate – and, as appropriate, strengthen - the sufficiency of supervisor reviews when approving CPS screening decisions.

Issue #2: The need for specific guidance to workers with respect to comprehensive assessments when children are being raised without contact by traditional community supports (school, medical, etc.).

Issue #3: The need to further investigate whether workers are systemically making a child vulnerability determination when screening child abuse reports and/or over-relying upon a child's age as part of their evaluation of child vulnerability in an assessment.

Issue #4: The need to further investigate whether the Department adequately documented all reports of abuse in this case.

Recommendations

Recommendation #1 from the Initial Report

The issue of the comprehensiveness of the Department's response to reports of abuse and neglect is one that has been identified in prior CIRTs. In response, the Department has again reviewed its policies, trained staff in practice and policy, and begun branch-specific case reviews to identify issues and address them. Because the Department continues to struggle in this area, the CPS Program Manager has sought the assistance of the National Resource Center on Child Protective Services regarding the challenges the Department is experiencing with respect to the application of the Oregon Safety Model expectations regarding comprehensive CPS screening and assessments and the timelines by which to complete them. The circumstances of this CIRT will be included in the work with the National Resource Center. By the end of January 2010, the National Resource Center will report back to the Department and its recommendations will be incorporated into the next CIRT report in this case.

Progress Update: The CPS program manager consulted with the National Resource Center regarding the challenges of applying the Oregon Safety Model as well as expectations regarding comprehensive screening and assessments and the timelines in Oregon policy to complete them.

The NRC indicated the following:

First, Oregon has made complex practice changes connected to the Oregon Safety Model, and it is common for that the full implementation of such a change to take approximately five years. In their estimation, Oregon is on track for that five-year implementation timeframe.

Second, the NRC indicated that supervisors are the key to changing practice. In order to support practice change, supervisors must be knowledgeable about the Oregon Safety Model, capable and clearly expected to direct workers toward

conducting comprehensive assessments, and have time to staff cases as the case progresses through the assessment process.

Third, the NRC supported Oregon's development of a quality assurance tool to review CPS assessments. They indicated that using the tool to conduct reviews and provide feedback to branch offices about their practice has been demonstrated in other states as an effective way to support and facilitate improved practice.

Fourth, the NRC indicated that comprehensive safety assessments are more time consuming than incident-based assessments, requiring more information, more mandated contacts and higher levels of critical thinking, analysis and consultation. The NRC confirmed that Oregon's policy requirement for conducting a comprehensive safety assessment (30 to 60 days) is an appropriate timeframe.

In response to this guidance from the NRC the following actions have been taken:

- As a part of Oregon's Program Improvement Plan, the agency has been working with the National Resource Center on Organizational Improvement and the National Resource Center on Data and Technology to develop a strategic plan to support clinical supervision in Child Welfare. This work is specific to assisting supervisors in their work supporting and directing line staff in their application of the Oregon Safety Model. The plan is scheduled to be presented to the Assistant Director April 15, 2010 and to the District and Program managers in May. This plan will then be implemented statewide.
- The department is in the process of developing a new child welfare case management system called OR-Kids. A basic design of the new system is a requirement for greater level of review and approval by supervisors. Additionally, the assessment process in the new system will have more mandatory fields at each step that must be completed before a supervisor can review and approve. The expectation is that these mandates will require more familiarity with the Oregon Safety Model and provide enhanced opportunities for training, teaching and clinical work for supervisors, in addition to providing more accountability.
- The CPS program developed a quality assurance (QA) tool to review screening decisions and CPS assessments. The QA tool was submitted to the NRC for their feedback and recommendations about its design and efficacy. DHS will continue to seek the assistance of the NRC regarding its progress with implementing the OSM.

Recommendation #2 from the Initial Report

The Department will consult with outside medical child abuse specialists to inform the Department's assessment practice when interviewing children who are being raised outside traditional community supports, such as school, medical, faith-based organizations, etc. Those experts will be asked to advise the Department on how to improve its evaluation of information both when screening and assessing calls of suspected abuse involving children who are more isolated. This consultation will be completed by March 1, 2010, and recommendations for improvement will be incorporated into the next CIRT report in this case.

Progress Update: The CPS program manager consulted with Oregon physicians who are specialists in child abuse and with the National Resource Center regarding the assessment of suspected child abuse involving children who are isolated.

The physicians made the following recommendations specific to reports of abuse or neglect involving children who are isolated:

First, CPS workers and screeners should create a more formal partnership with medical experts at the five regional assessment centers in Oregon in order to make better decisions about child safety involving isolated children. Regional centers should identify experts who specialize in specific areas, including mental health, and will be able to provide consultative services to CPS workers in high risk cases. For instance, one expert might best provide consultation on a sex abuse case, whereas another might best consult on a child with developmental delays.

Second, the medical experts recommend that child welfare investigations of reports of abuse or neglect of a child who is more isolated be strengthened by requiring multiple visits over a period of time, for example over a 30 or 60 day period. More contact with a child and family will yield more information, which should result in the ability to more comprehensively evaluate and more accurately determine whether a child who is more isolated is being abused or neglected. Viewing cases longitudinally, in conjunction with consultation from specially designated and trained medical experts, will give the Department a fuller picture of the child and his or her family's circumstances.

The Department also inquired of the National Resource Center whether other states had policies in this area that could inform Oregon's work. The NRC indicated that several states are struggling in this area, but could not recommend a specific policy change that had already been identified by those states to adequately address the issue. The NRC also cautioned Oregon that isolation, by itself, does not indicate

child abuse or neglect, but does increase a child's vulnerability if safety threats or concerns are present.

In response to the recommendations above, the agency will:

- Work with the Oregon Department of Justice to determine ways to increase contacts with and access to the five regional assessment centers in Oregon;
- Work with local Multidisciplinary Teams to explore additional strategies to improve access to medical experts and resources; and
- Clarify in policy the expectation that when the Department has information indicating that a child who is being raised outside traditional community supports is alleged to be abused or neglected, the assessment process should include multiple visits over a 30-day period of time. To facilitate meaningful contact with that child and family during those multiple visits, the Department will develop a practice tool that will assist caseworkers in assessing a child's and family's level of functioning. Once developed, these practice improvements will be sent to the NRC for review and feedback.

These activities will be complete by May, 2010.

Recommendation #3 from the Initial Report

In its training for screening and assessment practice consistent with the Oregon Safety Model, the Department provides materials to staff that specifically highlight several critical determinants of vulnerability *regardless of a child's age*. Most relevant to this case, those determinants include powerlessness and non-assertiveness. Vulnerability and the agency's identification and response to that occurred in two areas of decision-making in this case: screening of abuse reports and assessment after a report has been referred for investigation.

In the first instance, it appears that J.M.'s age was considered as a major factor in the conclusion that she was not vulnerable and, therefore, an assessment of the abuse reports was not warranted. Vulnerability is not possible to evaluate (or assess) in the screening process; assessment of vulnerability requires a face-to-face evaluation (a field assessment). In this case, when a field assessment occurred (Referral 001), it appears that J.M.'s age was also heavily weighted in the determination of vulnerability. While age is one consideration, as noted above, there are specific determinants that presented in this case that should have been considered irrespective of a child's age.

To determine whether these are systemic issues or if these issues are unique to this case, the CIRT team will audit a representative sample of closed at screening and

referral determinations where children are above the age of 10 and review specifically whether the child's age inappropriately influenced the decision that was made. That review will be completed by March 1, 2010. Depending on the outcome of that review, the CIRT Team will consider additional recommendations.

Progress Update: The audit of cases was completed February 25, 2010. The audit confirmed that age is systemically influencing both screening and assessment decisions in cases statewide.

In response to that finding, the CIRT Team is recommending that the CPS Unit convene and facilitate a workgroup charged to do the following: Review the Department's existing policy, practice and training materials regarding screening and assessments of abuse/neglect reports, and make recommendations to clarify and strengthen the Department's child protective services efforts on behalf of children and youth who are older.

The workgroup should consist of stakeholders, such as attorneys and child advocates, with expertise working with older children and youth, as well as child welfare practice experts who focus on older children and youth.

The workgroup should complete its work within 90 days of this report, with recommendations to be released and posted on the website with this CIRT report.

Recommendation #4 from the Initial Report

This case raises two separate issues regarding the Department's recording of and response to calls about the abuse and neglect of J.M. The first is that calls about abuse were made that were not investigated. A second concern raised is that calls may have been made but not documented. If calls were made that did not rise to the level of abuse or neglect, the Department would not have documented those calls. To be certain that the Department did not receive calls of abuse or neglect that it did not record, the CIRT team is recommending further investigation.

Progress Update: The agency completed its investigation in this area and determined that it had documented all calls made about abuse related to J.M. Each of those calls was reported on in the Initial J.M. CIRT Report.

Additional Policy Issue for Consideration

In conversation with communities, advocates and policy-makers about this case, the CIRT Team has identified an additional policy issue for consideration.

This case also highlights the need for a stronger continuum of child safety supports in communities throughout Oregon. Following J.M.'s death, communities statewide — often in partnership with local child welfare offices — had discussions about what they could do to better identify children at risk and better support children and their families before abuse or neglect occurs. In many of those discussions, the conversation turned to the need for the Department to be able to better partner with communities regarding calls it receives that do not rise to the level of abuse or neglect, but that provide an early indication that a child or family may be at risk.

Before the budget challenges that occurred between 2001 and 2003, the Department financially supported a program called the Community Safety Net that did two things: 1) facilitated the sharing of information between child welfare and a contracted community organization regarding at-risk families; and 2) supported the community organization's staff and, in some counties, additional supports for families at risk of abusing or neglecting their child/children.

As noted, that program ended due to budget cuts. A variation of the program, called Family Supports and Connections, exists today in the Temporary Assistance for Needy Families (TANF) program. However, that program is only available to families who are TANF-eligible and identified as at risk for child welfare entry. Moreover, the waiting list for the TANF Family Supports and Connections program is double the capacity of the program itself.

Accordingly, the CIRT Team is recommending that as a result of this case, state policy makers consider again the need to facilitate policy and financial resources to support a community-based, early-intervention child abuse prevention program, like the Community Safety Net and/or an expanded Family Supports and Connections program that better meets the TANF-eligible families' needs and goes beyond TANF-eligible families to include a stronger partnership with child welfare.

The goal of the State, and of the Department, is that families have the ability to safely and appropriately meet the needs of their children. In cases where families have the desire to do so, programs like the Community Safety Net work by promoting child safety and preventing abuse and neglect.

Audit Points

The CIRT Team will identify action items it recommends become audit points for the Department.

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 DHS 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 Review Team.

The ultimate 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.