

# **Initial 30-day Critical Incident Response Team (CIRT) Report**

**September 25, 2008**

## **Executive Summary**

M.D. suffered a subdural hematoma, a slow bleeding of the brain, consistent with shaken baby syndrome. Prior to receiving those injuries, DHS had received two prior referrals regarding M.D., one was closed at screening, and one was assessed but unfounded. The recommendations in this CIRT focus primarily on issues relating to how the department evaluates the safety of minor teen parents, how to ensure the appropriate consideration of a single urinalysis as part of a child's safety assessment, and how to be certain self-sufficiency staff are prepared evaluate information the receive that might relate to the safety of a child.

## **Summary of Reported Incident**

**June 11, 2008:** The Oregon Department of Human Services received an after-hours call regarding an injured infant; M.D. born 9-18-07. M.D. was brought to the hospital by ambulance because he was having seizures. M.D. had symptoms of a subdural hematoma, a slow bleeding in the brain. This is consistent with shaken baby syndrome.

**June 14, 2008:** DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened; this is the first report of the CIRT team.

## **Context for recommendations to the Department based on the Critical Review to date**

Before M.D. was critically injured, DHS had received two previous CPS referrals about him. One was in Klamath County, the other in Jackson County. For the purpose of this interim CIRT report, the first referral is designated as "closed at screening 001", the second referral as "Assessment 001". The Lane County referral about M.D.'s critical injuries, which led to this CIRT, is referred to in this report as "Assessment 002".

**Closed at Screening 001, received 9/19/07: This referral detailed concerns about one day old M.D. and his minor teen parents. The hospital staff expressed concerns about the 17-year-old father acting domineering, controlling and argumentative with staff.**

The CPS screener made collateral calls to the Healthy Start program and learned they had been providing services to the young couple for 8 months prior to the baby's birth. They saw the father as a "typical defiant teen" and did not have concerns about domestic violence with the couple. The young couple planned to take the infant and reside with the maternal grandmother. This referral was closed at screening due to "no protective service concerns at this time."

**CPS Assessment 001 received 4/09/08; completed 4/22/08:** This referral was assessed in Medford, Oregon where the family was currently residing. The referral detailed multiple concerns of potential child neglect for 7-month-old M.D. Reported concerns included the following: 1) residential instability (the family had reportedly moved multiple times, had reportedly been repeatedly "kicked out" of where they were residing, including residential home for mothers and babies); 2) leaving the child with multiple and inappropriate caregivers; 3) potential drug use by both parents; and 4) the fact that the maternal grandparents, whom M.D.'s mother listed as a resource, each have open child welfare cases themselves.

This referral was appropriately assigned as an immediate response for assessment. The assessment, however, was unfounded for neglect based on the child appearing clean, healthy and attached to the mother. In addition, the mother's urinalysis did not indicate current drug use.

**CPS Assessment 002 received 6/11/08 – Founded:** This referral was assessed by DHS in Lane County, where the family was residing when M.D. was injured. This referral details the current concern of physical abuse of 8-1/2 month old M.D. due to having been shaken. The child continues to receive medical care at Doernbecher Children's Hospital in Portland. This assessment found that physical abuse did occur.

### **Recommendations:**

#### **Recommendation 1: Assessment of minor teen parents.**

Relating to Closed at Screening 001 and Assessment 001: In Closed at Screening 001, no assessment was conducted on the 16-year-old mother regarding her own protective service needs, even though her plan was to move in with parents who had previous and current child welfare cases with protective service issues. Similarly, in Assessment 001, although an assessment was conducted, that assessment did not include an evaluation of

the teen parent's safety needs as a child herself, even though she intended to live with her father who reportedly had a long history of substance abuse and an open child welfare case.

The facts of this case support that assessment of minor teen parents is a systemic challenge for the agency. Prior to this CIRT, the CPS Manager convened a workgroup to evaluate and make recommendations about how to conduct a CPS assessment when the parent is a minor teen. The workgroup is assessing the need to make recommendations for policy and procedure changes when assessing parents who are minor teens. This workgroup will have a final report by October, 2008.

**Recommendation 2: The role of UAs in safety assessments.**

Relating to Assessment 001: The Medford referral listed numerous allegations of possible child neglect. The assessment appears to have relied primarily on the mother's clean urinalysis (UA) to conclude that the child was safe.

The facts of this case support the need to address the reliance on a single UA as a safety determinant in an assessment. A UA is only a point-in-time snapshot. Instead, a UA may appropriately be used as an assessment tool, along with consideration of the totality of the circumstances in assessing child safety and the risk of impending danger.

The CIRT team needs additional information to determine how frequently UA information is used to complete safety assessments to determine whether this is a systemic issue, or an issue that is isolated to this case. Accordingly, the CIRT team recommends that the CPS Manager work with DHS Auditors to do a random sample of cases to determine how often UA results are used as an assessment tool in CPS dispositions and safety planning.

**Timelines:** The DHS Auditors should complete their audit of cases by October 30, 2008. In addition, the CPS manager and Oregon Safety Model trainers should meet immediately to ensure that Oregon Safety Model training on assessment is clear about the appropriate use of UAs as a part of, but not the sole consideration in, a safety assessment.

**Rationale:** Additional information is needed to determine whether this is a systemic issue.

**Status as of date of report:** CPS manager and auditors are meeting before the end of September to discuss and schedule the audit.

**Audit points:** CPS manager and auditors should conduct the audit and have a report to the Assistant Director of CAF by October 30, 2008.

**Recommendation 3. Cross-Systems information sharing about issues relating to a child's safety.**

In both Klamath and Medford, DHS Self-Sufficiency was involved and working with this teen mother and her child. The Self-Sufficiency file review in Medford contains information that indicates Child Welfare and Self-Sufficiency were sharing information about the family. However, it does not appear that Self-Sufficiency workers understood the importance of information they were obtaining from the parents regarding the safety of the young child. For example, information from someone applying for self-sufficiency services that their parent has been violent in the past, and they plan to take their infant and live with that parent.

In the recent N.L. CIRT, posted 5/20/08, the issue of information sharing between Self-Sufficiency and Child Welfare also is raised. As a result of the N.L. CIRT, a work group was formed to examine opportunities to strengthen information sharing between the two program areas.

As follow-through to the issue identified in this CIRT, that same work group has been asked to also look at training needs for Self-Sufficiency staff regarding how to read and assess information they receive from Child Welfare, and what kind of information received from other resources is important to a Child Welfare Case, particularly information that would alert child welfare staff to potential safety threats to a child.

**Purpose of critical incident 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 recommended improvements.

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