

Critical Incident Response Team Final Report

T.R. CIRT

February 26, 2009

Executive Summary

T.R., a 12-month-old child, passed away after drowning in the bathtub of his family's home. Prior to T.R.'s death, the Oregon Department of Human Services (DHS) had worked with the family both on an involuntary and voluntary basis regarding safety issues relating to neglect.

The systemic issue identified by the Critical Incident Response Team (CIRT) review relates to the work of child welfare with families who are also involved with the developmental disabilities system. The CIRT review team recommended steps to improve child welfare and the developmental disabilities' systems' understanding of each others' mutual roles and responsibilities when child safety is an issue.

This is the review team's first and final report.

Introduction

On July 29, 2008, DHS received a referral that 12-month old T.R. had drowned in the bathtub of his family's home. According to the report, T.R. was bathing with his 2-year old sibling when their mother left them alone in the bathtub to check on their nearly 4-year old sibling. When the mother returned, T.R. was face down in the tub. Despite efforts to resuscitate him T.R. passed away. At the conclusion of the assessment it was determined that there was reasonable cause to believe that T.R. and his two older siblings had been neglected.

On August 8, 2008, DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened.

History of Child Welfare involvement with T.R.'s Family

Prior to T.R.'s death, DHS received one logged call, three calls that were closed at screening (CAS) and three Child Protective Services (CPS)

referrals on his family. For the purpose of this CIRT report, the sequence of the first three assigned referrals will be referred to as CPS assessment 001, CPS assessment 002 and CPS assessment 003.

April 14, 2004, Logged call: Reporter stated that mother was five months pregnant and had mental health issues which would make her unable to parent. The report was “logged” as the child was not yet born and there were no children in the home.

Note: “Logged” calls are no longer used to record information received at the Child Abuse Hotline. Based on current rule, this call could have been written up as a “closed at screening” under the same rationale, i.e., there were no children in the home and the child had not yet been born. *See* OAR 413-015-0210.

June 13, 2005, Closed at Screening: Reporter identified concerns regarding threat of harm that existed to a 9-month old (*note:* T.R. was not yet born at the time of this report.) It was reported the child was not gaining enough weight and there was concern about the mother’s low level of functioning. After receiving the initial call, the screener contacted the child’s physician who reported that despite the child’s limited weight gain, the physician was not significantly concerned for the child’s health or safety. The WIC program was also contacted and indicated they were working with the family regarding the child’s weight gain.

CPS assessment 001, received January 03, 2007, completed February 21, 2007, Founded for Neglect: (*note:* T.R. was not yet born at the time of this assessment.) Reporter alleged that three young children (8 yrs old, 2 yrs old and 9 months old) were being neglected. (The oldest child was a half-sibling who did not live in the home on a full time basis but visited the home.) The home was reported to be extremely dirty and was described as unsanitary and unsafe. At the conclusion of the assessment, it was determined that there was reasonable cause to believe that neglect had occurred with respect to the two younger children. The basis for the founded disposition was the condition of the home and the safety threat it posed to the two younger children. The assessment was not founded to T.R.’s older half sibling because of his limited exposure to the conditions in the home. A 60-day, in-home Child Protective Plan was established.

CPS assessment 002, received August 08, 2007, completed September 17, 2007, Founded for Neglect: This is the first referral involving T.R. Reporter alleged that the home which was infested with fleas. A CPS worker went to the home on August 9, 2007, and described the children as being in good health and as having their needs met. However, the description of the home listed several safety hazards to young children, including medication that had fallen onto the floor. At the conclusion of the assessment, it was determined that there was reasonable cause to believe that neglect had occurred. Subsequently, multiple unannounced home visits were made to the home between August 9 and September 17 and no safety concerns were observed. The case was closed.

CPS assessment 003, received November 08, 2007, completed December 7, 2007, Founded for Neglect: Reporter alleged that the home was unsanitary. Due to the history of neglect that included unsafe and unsanitary living conditions, this report was sent out as an immediate response. When the worker arrived at the home, they found unsafe conditions and supervision issues. The safety concerns included a bathtub left one-third full of water with children's toys in the tub. The children were placed into protective custody. At the conclusion of the assessment it was determined that there was reasonable cause to believe that neglect occurred. An out-of-home safety plan (a safety plan for parents whose children are in substitute care) was developed.

March 17, 2008: Children were returned home because DHS no longer had legal authority to keep the children in out-of-home care. DHS began providing services to the family on a voluntary basis.

March 17, 2008, Closed at Screening: Reporter alleged that T.R.'s now 9-year old half sibling had a red mark on his face after a weekend visit with the father and stepmother. The child indicated that he'd been slapped by both of the adults during the visit. This report was closed at screening as the red mark was no longer visible when the referral source called the hotline.

April 01, 2008, Closed at Screening: Reporter alleged that one of T.R.'s siblings was observed to be dressed inappropriately for the weather conditions. The caller also reported that the children were unclean, as was the yard and area surrounding the home. This report was closed at screening, and the information was passed on to the caseworker who was working with the family on a voluntary basis.

May 14, 2008, Voluntary Case Closed: The family requested that the voluntary case be closed. Because there was no new information that would have warranted DHS filing a new petition in court, the case was closed.

CPS assessment 004, received July 29, 2008, completed Sept. 19, 2008, Founded for Neglect: DHS received a referral that 12-month old T.R. had drowned in the bathtub of his family's home. According to the report, T.R. was bathing with his 2-year old sister when their mother left them alone in the bathtub to check on their nearly 4-year old brother. When the mother returned, T.R. was face down in the tub. Despite efforts to resuscitate him T.R. passed away. T.R.'s two older siblings were placed into protective custody. At the conclusion of the assessment it was determined that there was reasonable cause to believe that T.R. and his two older siblings had been neglected.

Current Status

DHS is currently providing services to T.R.'s family and siblings.

Systemic Issues and Recommendations

The CIRT review team found that all DHS policies and procedures were followed in this case, but identified the following systemic issue:

Systemic Issue: In this case there appears to have been confusion about the role of a DD advocate, whose job it is to champion in support of a parent, and the role of a DD service provider, whose job it is to provide an objective perspective on the capacity of a parent with a developmental disability to safely care for his or her children. The CIRT review team concluded that child welfare practice could be strengthened through an improved understanding of the Child Welfare and the Developmental Disabilities systems' respective roles and responsibilities with respect to child safety.

As a result, the CIRT Team made two recommendations:

Recommendation 1: A presentation should be provided to the Child Welfare Program Managers (CWPM) at the statewide CWPM's meeting. The presentation should focus on the role and function of developmental disability programs and, specifically, how the state and local developmental

disability services systems interact with families that are simultaneously served by Child Welfare.

Progress/Status: On November 4, 2008, Janette Williams, Program Manager for Children and Family Supports in the DHS Seniors and Disabilities Division, and an expert on developmental disability programs that serve children and families, presented at the joint District Manager and Child Welfare Program Manager's Meeting in Salem. Child Welfare management staff was provided training regarding the different roles of a DD advocate and a DD service provider, and were provided with contact information for resources at the local level to facilitate improved communication between child welfare and DD services.

Audit points: N/A

Recommendation 2: After the presentation described above, the CWPM for District 12 (Umatilla, Morrow) will relay the information to Child Welfare staff in District 12 at their next all-staff meeting. Of specific focus for staff will be to clearly define the difference in the role of a family advocate through the DD program and the role of a DD case manager.

Progress/Status: On November 7, 2008, and at subsequent unit meetings, the Child Welfare Program Manager and supervisory level staff in District 12 (Umatilla, Morrow) relayed the information provided at the November 4, 2008 District Manager/Program Manager meeting.

Audit points: N/A

Conclusion

After reviewing the facts and circumstances surrounding this incident, the CIRT review team concluded that DHS followed its rules and policies, but identified that child welfare practice could be strengthened through an improved understanding of the Child Welfare and the Developmental Disabilities systems' respective roles and responsibilities with respect to child safety. The recommendations of the CIRT Review Team have been completed.

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 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.