

M.D. CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT

February 6, 2009

Executive Summary

M.D. suffered a subdural hematoma, a slow bleeding of the brain, consistent with shaken baby syndrome. The Oregon Department of Human Services (DHS) had received two referrals regarding M.D. prior to receiving the report of this injury, one closed at screening, and one assessed but unfounded.

The recommendations in the Critical Incident Response Team (CIRT) report 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 to evaluate information they receive related to the safety of a child.

Summary of Reported Incident

June 11, 2008: DHS received an after-hours call regarding an injured infant: M.D. born 9-18-2007. M.D. was brought to the hospital by ambulance because the child was having seizures. M.D. had symptoms of a subdural hematoma, a slow bleeding in the brain. This injury is consistent with shaken baby syndrome.

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

Context for recommendations to the Department based on the Critical Review to date: Before M.D. was critically injured, DHS received two previous CPS referrals about him. The first referral, in Klamath County, is designated for the purpose of this report as "Closed at Screening 001." The second referral, in Jackson County, is designated as "Assessment 001". The third referral, about M.D.'s critical injuries, led to the current CIRT, occurred in Lane County, and is designated as "Assessment 002".

Background

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. Healthy Start staff reported that 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 now 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, who M.D.’s mother listed as a resource each had 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.

Staff interviews have been completed in relation to this assessment. They were conducted by a CAF Administrator and CPS consultant. The staff interviews focused on three areas of concerns identified in the case file review.

- 1.) Lack of documentation: The staff acknowledged that they had failed to thoroughly document the assessment efforts and findings, but staff members were able to answer interview questions about the case and provide additional information for the record.

ACTION: The supervisor was present for the interview and will follow up with staff regarding the importance of thorough documentation in the case record. This will be done in the course of regular supervisory meetings with the staff.

- 2.) Oregon Safety Model: The caseworker renamed elements of the assessment using new OSM terms and thought they were applying the safety model, but they clearly were not. The supervisor did not have a clear working knowledge of the safety model either. (Note* this is a new supervisor.) This assessment

was completed prior to the statewide OSM training that has been occurring over the past several months.

ACTION: The CPS consultant will follow up with staff in this branch to assure proper application of the OSM. The CPS consultant will review cases and make recommendations as well as provide on-going consultation. This will occur during the consultant's regular, ongoing visits with the branch.

- 3.) **Teen Parent Practices:** The worker expressed surprise when asked about assessing the teen parent's needs as a potential dependent child and was working under the impression that the teen parent and baby should be assessed as a free standing family unit.

ACTION: The issue of assessment of a minor teen parent as a potential dependent child as well as a safe parent is being addressed in a work group. The recommendations of that group will be incorporated into the procedure manual and staff will receive training. The workgroup completed their work in October 2008.

CPS Assessment 002 received 6/11/08- Founded: This referral was assessed by DHS 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. This assessment found that physical abuse did occur. The child is in a medical foster home.

M.D.'s father was arrested in Arizona and indicted on 9/03/08 on Assault II and Criminal Mistreatment charges. On 12/3/08, he was convicted of Criminal Mistreatment in the First Degree and Assault in the Third Degree. The charge of Assault in the Second Degree was dismissed. He was sentenced to one year in jail and a combination of probation and post prison supervision.

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 her 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 completed their work in October 2008 and proposed a draft rule change as well as a “Teen Protocol Outline” to be included in the procedure manual. This outline will guide staff work and decision making when assessing minor teen parents.

Recommendation 2: The role of urinalysis testing in safety assessments

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

The facts of this case support the need to address the role of the UA as a safety factor in a CPS 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.

DHS Internal Auditors completed an audit of UA cases in December 2008 and prepared a final written report. A summary of the audit and the management action response is included in this final MD CIRT report. In addition, the CPS Manager and Oregon Safety Model trainers should meet immediately to insure that Oregon Safety Model training on assessments is clear about the appropriate use of UAs as part of, but not the sole consideration in, a safety assessment.

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 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.

In the recent N.L. CIRT, posted 5/20/08 the issue of information sharing between Self-Sufficiency and Child Welfare was also 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, the same work group has been asked to look at training needs for Self-Sufficiency staff regarding how to read and assess information they receive from other resources that is of importance to a Child Welfare Case, particularly information that would alert child welfare staff to potential safety threats to a child.

MD CIRT Internal Audit Summary

The MD CIRT Internal Audit examined 50 randomly selected Child Protective Services (CPS) assessments completed between April and June 2008 that had urinalysis (UA's) performed while the assessment was open and active. The objective was to determine if the UA results appeared to be a primary factor in the final CPS assessment decision.

Department of Human Services (DHS) CPS management and Internal Audit and Consulting (IAC) agreed that at least five of the 50 randomly selected assessments contained a UA that appeared to be a significant factor in the assessment decision. The concern was that, in some instances, CPS workers appeared to place excessive value and reliance on UA tests in the CPS assessment decision making process.

IAC recommended CPS management reinforce training with field staff that they should take care not to rely too heavily on UA tests when making final child safety decisions on assessments. Further, staff should also connect any UA results to the child safety threats identified during the assessment.

The CPS Program Manager agreed that safety assessors occasionally use UA or Urine Drug Screens inappropriately and may place too much emphasis or reliance on the results. The CPS Program Manager also agreed that some clarification about the UA process was needed, specifically as it related to the limitations of the test and when and how a UA should be used.

As a result of these findings and recommendations, the CPS Program Manager will send an Informational Memorandum (IM) to all Child Welfare staff members who conduct child safety assessments by January 15, 2009. The IM will reinforce with field staff that over reliance on a UA can lead to inappropriately opening or closing an assessment.

The CPS Program Manager will also ensure that training presentations are conducted at Child Welfare Supervisor Quarterlies prior to July 2009. The presentation will focus on the use of UA's during safety assessments, rather than as a component of drug and alcohol treatment. The presentation will include the appropriate use of the UA, how a UA should be interpreted and how a UA should be viewed in the broader context of child safety and the Oregon Safety Model.

Purpose of Critical Incident Response Team Reports

Critical Incident Response Team 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 the 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.