

Critical Incident Response Team Initial/Final Report

N.B. CIRT

February 26, 2009

Executive Summary

This Critical Incident Response Team (CIRT) resulted after a 15-year old boy, N.B., passed away from a treatable medical condition. N.B. and his parents refused medical treatment on the basis of their religious beliefs. Doctors confirmed that N.B.'s death could have been prevented had medical treatment been sought.

The CIRT review team found that all DHS policies and procedures were followed in this case and did not identify any systemic issues relating to child welfare practice. The CIRT review team did, however, identify an unanswered policy question with respect to the rights of parents and children ages 15 and older to refuse medical treatment under state and federal law.

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

Introduction

On June 17, 2008, N.B., DOB: 9/13/91, passed away at his grandmother's home. N.B. and his family are members of the Followers of Christ church. The Department of Human Services (DHS) and law enforcement were called to the home to assess possible medical neglect.

On June 25, 2008, DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened.

History of Child Welfare Involvement with N.B.'s Family

Prior to N.B.'s death, DHS had responded to two child protective services (CPS) referrals about children in this family. The family are members of the Followers of Christ Church. One child in the community who is related to this family recently died from a medical condition that doctors report she would have survived if she had received medical treatment.

For the purpose of this CIRT report, the first referral is designated as CPS assessment 001 and the second CPS assessment is 002, and the CPS assessment related to N.B.'s death is 003.

CPS Assessment 001; received 3/10/08. The caller in this referral reported concern that K.B., sister to N.B., had been ill most of her life. The reporter had no information that indicated N.B. was currently ill. The caller reported numerous historical medical concerns with respect to K.B. and noted that in keeping with their religious beliefs, the family did not access modern medical treatment but practiced faith healing. At the time of this report it was not known if K.B. had been to a doctor for any of the medical concerns that the caller was reporting.

The CPS worker conducted a thorough assessment, interviewed the child and many others who all denied health concerns. The CPS worker consulted with a physician who concurred that the child did not require medical treatment at this time. This report was determined to be unfounded for medical neglect.¹

The CPS worker was aware of the recent child fatality in the extended family. This fatality was determined to be from a failure to seek medical attention. This information guided the thoroughness of the assessment.

CPS Assessment 002; received 3/31/08: This referral was an assessment of a report that N.B. was ill and had not received medical treatment. N.B. had been ill, but not to the extreme that was reported. He was resting, drinking fluids and staying with a grand parent while he was ill. During this assessment N.B. told the investigating worker that he did not want medical treatment and he was aware that he was "legally old enough to refuse medical treatment". This report was determined to be unfounded for medical neglect.

CPS Assessment 003; received 6/17/08: N.B. died of untreated medical issues related to an illness. The Medical Examiner determined that N.B.'s death could have been prevented with proper medical care. Family members

¹ It should be noted that the team of professionals who reviewed this assessment made a point of noting to the CIRT team the thoroughness of this CPS Assessment. The worker accessed branch management, collateral contacts, and local medical experts to assist in guiding their questions and conclusions.

reported that N.B. felt he had enough faith and did not need to see a doctor. N.B.'s parents did not seek medical treatment for him. The disposition of the report was "founded" for medical neglect because the parents did not seek medical treatment for N.B.

Systemic Issues and Recommendations

The CIRT review team found that all DHS policies and procedures were followed in this case and did not identify any systemic issues relating to child welfare practice.

However, N.B.'s death under these circumstances does raise the following policy issue for consideration:

- Does the fact that Oregon law authorizes children over the age of 15 the right to consent to their own medical treatment also give them authority to *refuse* medical treatment? And if so, under what conditions? In this case, because medical treatment was not sought, one could argue that N.B. did not have the opportunity to make an informed decision about the seriousness of his condition and the consequence for refusing medical treatment. (*See* ORS 109.640 which states that a child 15 years or older can consent to their own medical treatment.)

Conclusion

After reviewing the facts and circumstances surrounding this incident, the CIRT review team concluded that DHS followed its rules and policies and did not identify any systemic issues relating to child welfare practice.

However, every day child welfare workers are charged, within the bounds of the law, to protect and keep safe at-risk Oregon children. This case illustrates the need for clarity regarding the law as it relates to child abuse and neglect and the rights of parents and children over the age of 15 to consent (or refuse to consent), to medical treatment.

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.