I. Introduction

Oregon Department of Human Services adopted the Critical Incident Response Team (CIRT) protocol on November 1, 2004. This protocol was developed for the following purposes:

- To specify the Department of Human Services, Child Welfare procedures that will be used when a critical incident occurs;
- To increase the Department’s accountability to the public;
- To ensure timely responses by the Department with respect to any critical incident in Child Welfare; and
- To increase the Department’s ability to recommend necessary changes to statutes, administrative rules, policies and procedures, practices, training and personnel matters.

The initial findings of the Critical Incident Response Team in the case involving Ashton Parris were reported in a 30-Day Report on January 20, 2005. The protocol requires that, within 30 days of completing that report, if system issues are identified, the Critical Incident Response Team must:

- Develop recommendations to address the system issues;
- Identify action steps. The action steps will be specific as to time lines, tasks and parties responsible for the tasks; and
- Communicate recommendations, action steps and progress to the public and stakeholders as appropriate.

As per the protocol, the above-identified areas are covered in this report. DHS has completed a comprehensive review and analysis of all child welfare involvement with the family that was the subject of this report and specifically the activities related to the injury and death of Ashton Parris. The findings and actions described in this report are reflective of both local office actions as well as statewide efforts to address concerns and improve practice.
II. CIRT Review Progress and Actions Taken:

1. **Finding:** The father’s probation officer was not consulted before critical child safety decisions were made by DHS.
   
   **Recommendation:** Central office will revise the administrative rule and procedure to ensure that all appropriate partners are included in critical child safety decisions.
   
   **Action Taken:**
   
   a. As documented in a memo to the field dated January 28, 2005, Multnomah child welfare staff will be required to obtain written reports and input from treatment providers and appropriate partners such as probation officers at all critical decision points including court hearings, citizen review boards, and prior to reunification. Caseworkers will also be required to have written reports or updates from providers and critical partners included in 6-month narrative reviews (147’s).
   
   b. CAF program staff will revise the Safety Plan Review Administrative Rule to require information from partners be considered and documented when making safety decisions. The temporary rule on Safety Plan Review will be completed by April 2005. Policy changes will be implemented by September 2005.

2. **Finding:** Review of calls made to CPS intake indicated that allegations were not properly assessed for face-to-face contact.
   
   **Recommendation:** Central office program staff will develop an emergency temporary rule to revise the intake screening process. Training will be provided for screeners pursuant to the rule.
   
   **Action Taken:**
   
   a. Within the last year, the Multnomah County Hotline supervisors identified the following key practice areas for improvements in the screening process and these areas continue to be reinforced through practice discussion at screener meetings and individual supervision time with staff:
      
      - Law Enforcement Agency contact may inform screening decisions, but does not replace the CPS safety assessment.
      - Screener review of history is critical to the screening decision.
      - Screening protocols have been developed to guide screening decisions regarding reports on open cases, specifically reports of abuse in foster
care. Effective February 10, 2005, Multnomah screeners are required to consult with screening supervisors on all reports on open cases.

- Effective December 2004, Multnomah County Hotline screening supervisors are required to review all reports that are “logged.”

b. Effective February 11, 2005, CPS screening supervisors statewide are required to review all screening decisions, including “logged calls” to assure the appropriate response, communication and notification. This information has been shared in meetings with all SDA managers and Child Welfare Managers. A memo was sent to all child welfare staff on February 10, 2005.

c. CAF program staff will provide an interim training for screeners and screening supervisors in Multnomah. The focus will be the revised policy related to screening decisions with emphasis on how to handle subsequent reports of abuse and neglect on open cases. This training will be completed by May 2005.

d. CAF program staff will convene a work group by March 1, 2005, to revise policy to eliminate “logged” as a category and to clarify screening decisions. Revised policy will be reviewed by and coordinated with the findings of the national experts.

3. **Finding:** Communication between the caseworker and social service assistant (SSA) was neither well documented nor coordinated.

**Recommendation:** Central office program staff will work with Multnomah County child welfare to strengthen and reinforce communication between the caseworkers, social service assistants and others assigned to provide service on a case. This is being reviewed as a statewide issue.

**Action Taken:**

a. Multnomah child welfare is developing a plan to reassign Social Service Assistants to smaller units to work with a limited number of caseworkers. This will improve communication and provide more direct access to caseworkers. This action is to be completed by March 2005.

b. CAF program staff have requested that the national experts review how Social Service Assistant staff are used to support caseworkers. This review will be completed in April 2005.
4. **Finding:** Issues in this case, related to child safety, included substance abuse, domestic violence, criminal behavior and the parents’ lack of follow through with recommended services. There is no documentation that there was adequate evaluation of the parents’ protective capacity or ability to benefit from services and provide safe parenting for their children. Documentation was not clear that historical information was considered in this regard.

**Recommendation:** CAF staff are being notified that any reunification plan for a foster child with his/her family, must be reviewed with the casework supervisors to ensure that parental protective capacity has been adequately addressed and that known safety threats have been resolved. This supervisory review must occur and be documented in the case record prior to the return of the child.

**Action Taken:**

a. In response to the January 28, 2005, memorandum to the field, Multnomah child welfare is developing a checklist to be used by all supervisors to assure there has been adequate evaluation of parental protective capacity or parental ability to benefit from services and provide safe parenting for the child (ren). This form will be used to document review of this information in reunification planning. Caseworkers will be required to have supervisory review and signature on this form prior to reunification. The form will be completed by February 18, 2005.

5. **Finding:** There were numerous family decision meetings held in this case, but the focus of the meetings was more on family reunification than child safety. This raises issues of concern about whether there is a proper balance between strengths/needs based planning and child safety and parental protective capacity.

**Recommendation:** Central office will review state law and DHS administrative rules related to the use of family decision meetings in the safety planning process to determine the impact of statutory and administrative rule mandates on current practice.
Action Taken:

a. CAF program reviewed state law and DHS administrative rule regarding the use of Family Decision Meetings.
   - A position paper was completed identifying key issues related to the use of family decision meetings in ensuring child safety.
   - By March 4, 2005, CAF Program Managers and local child welfare managers will review and provide feedback on rule and practice changes related to family decision meetings.
   - CAF will request Attorney General review and concurrence by March 10, 2005.

b. If appropriate, CAF program staff will draft rule revisions by April 2005 with implementation by September 2005.