30-Day CIRT REVIEW REPORT  
January 17, 2007

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.

II. CIRT REASON/CASE BACKGROUND

On December 17, 2006, the Douglas County Child Welfare office received a report that Cameron Dabbs, age 18 months, had been critically injured and had been transferred to Dorenbecher Hospital. The child presented with internal injuries and a skull fracture. On Monday, December 18, 2006, Jeremy Lee Wease was arrested and later indicted for first-degree assault and criminal mistreatment. Mr. Wease remains in custody. Mr. Wease was the boyfriend of the child’s mother, Carrie McCullough, and had been staying in the home with her and her children.

III. CIRT RESPONSE/ CASE STATUS UPDATE

The Douglas County Sheriff’s Office is investigating the events surrounding the injuries to this child.

The Douglas County child welfare staff continue to work closely with Law Enforcement (LEA).

The Roseburg News Review has had ongoing, brief coverage of this critical event.
IV. CIRT REVIEW PROCESS

a. Case Review Process:

CAF child welfare program staff reviewed and evaluated all case record information including documents related to prior screening and assessment contacts with or about the family. Areas of focus for this review were compliance with policy, statute and practice focused on child safety.

b. Staff Interview Process:

CAF Administration and HR staff have been assigned to complete interviews of all identified staff and managers involved with this case. Staff interviews are in process and will be completed within the next 30 days.

V. IDENTIFIED ISSUES AND PENDING QUESTIONS

a. Identified Issue: The case review indicated that workers may not have had an understanding of or did not utilize critical historical case and family information prior to responding to new child protective services (CPS) reports.

   Pending Questions:
   • How were case history and family dynamics considered and utilized in responding to new reports of child abuse and neglect?
   • What is the policy expectation related to this issue?
   • How was this issue addressed by supervision?

b. Identified Issue: The file review indicates that response to CPS assessments included a more superficial review of presenting issues, but documentation did not include a comprehensive review of family functioning related to caregiver capacity and child safety. File documentation does not indicate that services were identified and/or offered.

   Pending Questions:
   • How did policy and practice support assessment of caregiver ability and willingness to protect in the CPS assessment?
   • Did local practice differ from statewide practice is this regard?
   • If family functioning was not assessed in a comprehensive way, did this impact the safety of the children in this family? Does this issue have statewide implications?
c. Identified Issue: Assessments that were left open and incomplete because there was a delay in entering the written report in the FACIS system may have contributed to a perception that DHS is involved with a family and providing services and supervision. This may also be the perception when case plans are open but no services are being provided. Both of these issues were identified in the case review.

Pending Questions:
- What are the administrative rule expectations related to this issue?
- How did this issue impact assessment and response to child safety in this case?
- Does this finding have statewide implications?

d. Identified Issue: The case review indicated that there may not have been adequate follow through to make contact with parents, victims and collateral contacts in response to CPS reports. The case review also indicates that assessment documentation did not indicate that children were interviewed and/or observed during assessment activities.

Pending Questions:
- What is the policy expectation related to efforts to make contact on assessments and to conduct interviews of parents, children and collaterals?
- What issues or barriers contributed to lack of follow through to make contact?
- How does the local office address this through management and supervision?
- Is this an actual practice concern or a documentation issue?

e. Identified Issue: The case review indicated that there were numerous contacts with community partners concerning this family over the years. Documentation indicated that the local office did not always respond to protective service concerns by creating and completing a new CPS referral. The case review indicated that community partners may have been placed in the role of monitoring child safety.

Pending Questions:
- Would a review of this case by the local MDT be helpful in improving the DHS and community response to child safety?
- Is this case reflective of current practice in the local office in this regard?
- What are the policy and statutory expectations with regard to creating and completing a new CPS referral in these circumstances?
- Were the policy and statutory expectations with regard to working with community partners to monitor child safety followed?

**VI. NEXT STEPS:**

As a part of the CIRT Protocol, DHS will complete the following activities within this next 60 days:
- Staff and supervisor interviews will be completed and recommendations forwarded to the CIRT review team.
- The local child welfare and central program office will finalize the recommendations and identify action steps and timelines in response to the CIRT findings.

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