

CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT C.B.

July 19, 2017

Executive Summary:

On January 14, 2017, the Oregon Department of Human Services (DHS) was notified that a child, C.B.,¹ had died. The circumstances surrounding the death are currently under law enforcement investigation.

On January 17, 2017, DHS Director Clyde Saiki declared a discretionary CIRT be convened to examine the circumstances that led up to the fatality of this child. This is not a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.² A discretionary CIRT may be convened in the case of any suspected child abuse or neglect incident where a child has suffered severe harm or death and a review process is likely to impact system change in a manner that increases child safety.

On January 18, 2017, the initial CIRT meeting was held and a comprehensive case file review was initiated regarding Department history leading up to the fatality.

On February 24, 2017, the CIRT met a second time to discuss the case file review. An additional meeting was held on March 10, 2017. The team raised questions and requested additional information to assist in identifying systemic issues. At that time, several areas were identified as potential systemic issues regarding the Department's practice and service delivery. Potential systemic issues were assigned to corresponding program areas in order to determine validity and develop actionable methods to address identified concerns.

Any time a child known to the Department dies or is seriously injured as a result of abuse or neglect, the Department is committed to evaluating its processes and learning how the child welfare system may be improved in order to keep Oregon's children safer. The Critical Incident Response

¹ The child will be referred to by the child's initials in order to maintain confidentiality for the child and the child's family.

² Oregon Revised Statute 419B.024 can be retrieved at <http://www.oregonlaws.org/ors/419B.024>

Team's efforts to identify issues are an important component of agency accountability and improvement when tragedies like this occur. As is the case with any CIRT, any personnel actions will be addressed in a separate human resources process.³

This is the initial and final report of the CIRT.

Summary of Reported Incident and Background:

Due to the ongoing criminal investigation, this report does not include Department history regarding this family. Rather than delay release of the report, pending conclusion of the investigation, a chronology of the Department's history with this family will be published in a subsequent report upon resolution of the criminal case.

CIRT Activity Report and Status Update:

Pursuant to CIRT protocol, the CIRT team has met three times regarding this case. At the first meeting, the team reviewed preliminary information and identified issues of interest in the case. Subsequently, an extensive file review of DHS records was conducted and the results were presented at the second meeting. At the third meeting, potential systemic issues were identified and recommendations were made to address these concerns.

Identification of Systemic Issues:

A review of this critical incident and others has identified the following concerns regarding the Department's practice and service delivery in certain key areas:

1. *Consistently conducting comprehensive assessments pursuant to the Oregon Safety Model.*

The Department has historically made, and continues to put forth extensive efforts in addressing concerns surrounding comprehensive assessments. While comprehensiveness of Child Protective Services (CPS) assessments has been identified as a systemic issue in previous

³ It is not the function or purpose of a CIRT to recommend personnel action against Department employees or other individuals. Nor does the CIRT hear points of view of represented staff.

CIRTs, this CIRT also considered the complexity of the Oregon Safety Model in relation to the stability of the workforce.

Staff turnover, along with high caseloads and heavy workload demands, decrease the ability of the Department to provide effective child protection services and ultimately decrease the ability to ensure child safety. Research demonstrates that high staff turnover affects the quality and consistency of services provided to families as well as case outcomes. Studies have shown a direct correlation between the numbers of caseworkers involved with a child and permanency rates; the more caseworkers involved with a child, the less chance the child will achieve permanency.⁴ The U.S. General Accounting Office conducted analysis of caseworker turnover in relation to measurable outcomes included in the Child and Family Services Review and found a correlation between workload demands and a lack of progress towards achieving federal safety and permanency outcomes.⁵

The Oregon State Legislature recognizes the importance of safety outcomes for children and as a result has increased the Department's staffing allocation, and approved additional funding for caseworker and supervisor training. Further, while the Department is utilizing multiple methods in addressing concerns surrounding staff turnover and workload demands, this CIRT recommends evaluating the correlation between these elements and conducting comprehensive assessments to determine the viability of the Oregon Safety Model and how the Department can strengthen assessments to achieve better outcomes in light of circumstances surrounding workload restraints. In recognition of the investment the Department has made in relation to the safety model, it is apparent that a full analysis will require time and resources.

2. Consistent application of Oregon Administrative Rule regarding screening reports of child abuse and neglect.

⁴ Flower, McDonald & Sumski. (2005). *Review of Turnover in Milwaukie County Private Agency Child Welfare Ongoing Case Management Staff*. Retrieved from: http://www.uh.edu/socialwork/_docs/cwep/national-iv-e/turnoverstudy.pdf

⁵ The U.S. General Accounting Office. (2003). *Child Welfare: HHS Could Play a Greater Role In Helping Child Welfare Agencies Recruit and Retain Staff*. Retrieved on March 21, 2017, from: <http://www.gao.gov/assets/240/237373.pdf>

The Oregon Department of Human Services currently utilizes a screening model in which local districts conduct screening of child abuse and neglect reports. This model can create a variance in process as well as inconsistent application of Oregon Administrative Rule and Department procedure. In 2015, Governor Kate Brown requested an independent review of child and youth safety in Oregon's substitute care system. The independent review, completed in September 2016, found that child abuse reporting was inconsistent across Oregon and the "local variation in screening and assessment protocols makes it difficult to eliminate bias and ensure consistent safety decisions are made statewide."⁶

As a direct response to findings from the Child Safety in Substitute Care Independent Review, the Department is implementing a project to centralize hotline operations to standardize screening for allegations of child abuse across Oregon.⁷ Further, in conjunction with Casey Family Programs, Portland State University, Tribes and community stakeholders, the Department is redesigning its core training curriculum for new child welfare caseworkers with implementation scheduled to begin in September 2017.

3. *Adequately addressing child safety in CPS assessments assigned as alternative response.*

This CIRT revealed a concern that staff may perceive that reports assigned for alternative response do not pose safety threats and are less serious than reports assigned for traditional response. As of result of concerns regarding alternative response, along with the Oregon State Legislature's passage of Senate Bill 942, the Department is no longer assigning reports of child abuse or neglect for alternative response CPS assessments. Child Safety Program consultants are providing technical assistance to field offices to ensure practices are followed and to assist in this transition.

4. *Management of cases across counties.*

⁶ The Public Knowledge Independent Review final report can be retrieved at: <http://www.oregon.gov/DHS/DHSNEWS/CWIndependentReview/Child%20Safety%20Substitute%20Care%20Independent%20Review%20Final%20Report.pdf>

⁷ Background regarding the Child Safety in Substitute Care Independent Review can be retrieved at: <http://www.oregon.gov/DHS/DHSNEWS/Pages/Child-Safety-FC-Review.aspx>

As a result of previous CIRTs, the Department developed a protocol defining how shared cases are managed between child welfare offices. As every CIRT faces unique circumstances and challenges, this particular case raised concerns regarding the management of cases across counties that had not yet been considered. This CIRT reviewed the draft protocol and made recommendations to address concerns that were noted in this case. As a result, The Department has incorporated the recommendations of the CIRT and completed a new protocol that outlines clear direction for cases involving more than one child welfare office, including the following types of cases: Cross County Case Supervision, CPS Assessments and Interviews, Out-of-County Placements, Transfer of Jurisdiction and Foster and Adoptive Home Studies. The protocol will be available on the Department's website by the end of July 2017. Publication of the protocol will be followed by communication to the field and incorporation into Oregon Administrative Rule and/or child welfare procedure as appropriate by September 1, 2017.

Purpose of Critical Incident Response Team Reports:⁸

Critical incident reports are 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 Department web site. Actions are implemented based on the recommendations of the CIRT.

The ultimate purpose is to review Department practices and recommend improvements. Therefore, information contained in these incident reports include information specific only to the Department's interaction with the child and family that are the subject of the CIRT Review.

⁸ Given its limited purpose, a Critical Incident Response Team (CIRT) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CIRT review is generally limited to documents in the possession of or obtained by the Department. The CIRT is not intended to be an information gathering inquiry and does not include interviews of the child's parents and relatives, or of other individuals associated with the child. A CIRT is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of the child fatality.