

CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT

N.W.

October 24, 2014

Executive Summary

On February 24, 2014, the Department of Human Services (DHS) Child Welfare program received a report that 2-year-old N.W. was found deceased in the family home and the cause of death was under investigation.

Since 2009, DHS was contacted fourteen times regarding N.W.'s family, including notification of the fatality that occurred on 2/24/14. Of the fourteen reports, seven were Closed at Screening and seven were assigned for CPS assessment.

On March 21, 2014, DHS Director Erinn Kelley-Siel declared a Critical Incident Response Team (CIRT) be convened, once it was determined that the child's death was the result of neglect. This is a Mandatory CIRT pursuant to Oregon Revised Statute 419B.024. This is the initial and final report of the CIRT.

On March 24, 2014, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On May 9, 2014 the team met a second time and identified one area that requires further action. This issue is similar to other CIRT determinations and highlights the need for a continued focus on analysis of the adequacy of screening decisions.

Summary of Reported Incident and Background

On January 5, 2009, DHS received a report that N.W.'s mother had been assaulted by N.W.'s sibling's father. This report was assigned for assessment as an Immediate Response. The assigned worker contacted mother and father separately and they both denied the incident. The report was closed with an Unfounded disposition. Additional information gathered regarding the family condition may have provided a different picture of what was happening within this family and informed the safety decision at the conclusion of the assessment and may have changed the disposition.

On July 02, 2009, DHS received a report alleging physical abuse of N.W.'s older sibling. The report indicated N.W.'s sibling had been injured after a ceramic plate had been dropped on the child's head accidentally. The child was reportedly lethargic; however medical professionals indicated the injuries were consistent with the description of the

incident. This report was Closed at Screening. The decision to close this report without assessment was correct.

On July 27, 2009, DHS received a report alleging neglect of N.W.'s sibling. The report indicated the home was below minimum community standards for the health and safety of the child. N.W.'s sibling was just starting to walk and there was a lot of clutter on the floors. This referral was assigned for assessment as an Immediate Response. The worker responded and found the home clean and free of safety concerns. This referral was coded as an Unfounded disposition. The assessment activities focused on the condition of the home. Additional information gathered regarding the family condition may have provided a different picture of what was happening within this family and informed the safety decision at the conclusion of the assessment. This may have changed the disposition.

On August 3, 2009, DHS received a call of concern that N.W.'s sibling screams and cries when the child's diaper is changed; N.W.'s mother was concerned about sexual abuse by N.W.'s sibling's father. The behaviors and symptoms that N.W.'s sibling was reported to be exhibiting did not constitute a report of abuse or neglect. This referral was Closed at Screening. The decision to Close at Screening was appropriate.

On August 26, 2009, DHS received a report that the mother was not allowing N.W.'s sibling to visit with the father. The report also alleged the mother had used marijuana and alcohol to excess prior to N.W.'s sibling's birth, and that the mother was not providing sufficient food to N.W.'s sibling, as the child seemed tired and dehydrated when arriving at the father's house for a visit. There was no information that the mother was currently using marijuana or alcohol to excess, or that the child was not being fed properly. This report was Closed at Screening. The decision to Close at Screening was appropriate.

On October 06, 2010, DHS received a report that law enforcement had conducted a welfare check on the mother's home based on a call stating that the home was cluttered and there were people in the home who "liked to party". The police described the home as cluttered but took no further action and closed their report. This report was Closed at Screening. The decision to Close at Screening was appropriate.

On October 19, 2010, DHS received a report that the mother was not providing needed medication to N.W.'s sibling. This report was assigned as an Immediate Response for Neglect. There were additional concerns raised during the assessment that the mother had mental health issues that were not being addressed. The mother explained she left the child's medication at the grandmother's home, however denied she was not appropriately administering medication. The mother reported historical use of marijuana prior to her pregnancy with N.W.'s sibling and reported she now had health insurance and would be seeking mental health services. This referral was coded with a disposition

of Unfounded for Neglect. Additional information gathered regarding the family condition may have provided a different picture of what was happening within this family and informed the safety decision at the conclusion of the assessment. This may have changed the disposition and the level of Agency involvement with the family.

On December 21, 2010, DHS received a report that N.W.'s sibling was being over medicated by the father. The report also indicated concern the mother was inconsistent with providing medication to the child. This report was Closed at Screening. There was a need for a collateral contact to the child's physician prior to closing the referral.

On December 22, 2010, DHS received another report providing information about N.W.'s sibling's need for medication and indicating that the father was providing the correct dosage, but there would be some limitations on when to provide the medication. This report was Closed at Screening. A collateral contact to the child's physician prior to closing the report was needed to determine whether the information constituted an allegation of abuse or neglect.

On August 29, 2011, DHS received a report indicating N.W.'s sibling returned from a visit at the father's home with a bruise on the top of the child's ear. This report was assigned as an Immediate Response for Physical Abuse. The assigned worker contacted the mother and father as well as other collateral contacts. The child's injury appeared consistent with the explanation that the child was hit by a door being opened. Mother reported she was pregnant and she had used marijuana and alcohol prior to becoming pregnant. The home environments were observed to be safe and appropriate. This report was coded with a disposition of Unfounded for Physical Abuse. The report of Physical Abuse was Unfounded Additional information gathered regarding the family condition may have provided a different picture of what was happening within this family and informed the safety decision at the conclusion of the assessment. This may have changed the level of involvement of the Agency with the family.

On September 27, 2012, DHS received a report indicating N.W.'s sibling was now residing full time with the father due to an emergency custody order. N.W. was born on December 18, 2011. The caller reported that law enforcement had been called to the mother's home due to concerns of rape and domestic violence; also that the mother was drinking to the point of passing out. The screener contacted law enforcement who stated that all but one of their calls to the home were due to custody disputes between the mother and the father. The one exception was law enforcement finding mother's roommate intoxicated and mother having an allergic reaction. This referral was Closed at Screening. This report met criteria for assignment for Neglect and Threat of Harm.

On May 22, 2013, DHS received a report of concern regarding N.W.'s mother's home being below minimally adequate standards. This report was assigned as an Immediate Response for Neglect. The worker assigned found the home to be clean and

appropriate during visits. Mother reported struggling with mental health issues and self-medicating with alcohol and marijuana; she reported the children were with a relative when she used. This report was coded with a disposition of Unfounded for Neglect and a Voluntary case was opened with the mother offering support services. It is unclear whether sufficient information was gathered during the assessment to appropriately determine child safety.

On September 23, 2013, DHS received a report that N.W.'s older sibling had disclosed seeing the mother's live-in companion play "the punch game" with the mother. There were also concerns the mother's partner was using methamphetamine. This referral was assigned as an Immediate Response. This case was open for support services at the time this report was assigned and the ongoing worker and CPS worker assigned to this assessment made joint visits to the home during this assessment. The mother denied domestic violence indicating they "play fight" at times. N.W.'s sibling spoke about fighting but did not provide details about it. The workers were unable to confirm violence was occurring in the home, although holes were observed in the walls. Mother acknowledged leaving N.W. alone with her companion or another man, whom she was unable to identify. This referral was coded with a disposition of Unfounded for Neglect and Threat of Harm: Domestic Violence. Services were provided to the family which ended on November 8, 2013. There was information in the assessment that indicated the children were unsafe at the conclusion of the assessment. The reported concern regarding Neglect does not appear to have been assessed.

On February 24, 2014, DHS received a report indicating that N.W. had died. The child was found in the bathtub drowned after reportedly being left unsupervised. The mother and her partner were in the home at the time of the child's death. This report was assigned as an Immediate Response and has been coded with a disposition of Founded for Neglect.

Potential Systemic Issues

As required by CIRT protocol, the first CIRT team meeting convened within 24-hours of the CIRT being declared. The comprehensiveness of some of the assessments was noted as a systemic issue that has been identified in other CIRT reports and has led to a range of actions by the department to address the issue. From October, 2013 through May, 2014, child welfare supervisors and program managers participated in the updated training regarding the Oregon Safety Model including comprehensive assessments, and received intensive field consultation. A second round of training for new supervisors and program managers began the last week of August 2014.

In addition to the OSM training that was developed for supervisors, the CPS program is developing an interactive, OSM computer based training for child welfare caseworkers

and other DHS staff. While some modules of the training are still in production, modules related to comprehensive assessments have been released and are being used by child welfare staff.

Recently, four consultants were added to the CPS program to provide ongoing OSM training and support to child welfare supervisors and program managers throughout the state. These OSM consultants will also assist the field offices to develop district plans for support of the practice of the OSM and establish a program of ongoing quality assurance for the state. The training and support for this branch occurred after the assessments where comprehensiveness was identified as an issue.

Comprehensiveness of the screening process was identified as a possible systemic issue. This has not been identified as an issue in prior CIRTs.

Audit Point

In order to determine if comprehensiveness of the screening process is a systemic issue DHS will review a sample of screening decisions throughout the State and develop a plan to address issues revealed by the review.

Purpose of Critical Incident Response Team Reports

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 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.