

CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT S.H.

June 7, 2018

Executive Summary:

On August 21, 2016, the Oregon Department of Human Services (DHS) was notified that a child, S.H.,¹ had been transported to the hospital after nearly drowning. The report indicated that S.H. had been swimming with family when located in the water, unresponsive. On August 24, 2016, the Department was notified that S.H. had passed away. Medical personnel raised concerns about possible neglect or lack of supervision leading to the child's death. Reports indicated that S.H. did not know how to swim, was not wearing a life vest and had been under water for several minutes. A law enforcement investigation was conducted regarding the circumstances surrounding the child's death.

On January 27, 2017, DHS Director Clyde Saiki declared a CIRT be convened once it was determined that the child's death was due to neglect. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.²

On February 1, 2017, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On March 2, 2017, the CIRT met a second time to discuss the case file review. The team raised questions and requested additional information to assist in identifying systemic issues. At that time, several areas of concern were noted regarding the Department's practice and service delivery on this case.

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 Team's efforts to identify issues are an important component of agency accountability and improvement when tragedies like this occur. In addition to the CIRT, but in

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>

a separate process, the Department may address any necessary personnel actions.³

This is the initial and final report of the CIRT. This CIRT was declared and completed prior to the passage of Oregon Senate Bill 819 in 2017.

Summary of Critical Incident:

Department history with S.H.'s family dates back to 2011, when the first report to the child abuse hotline was received. Eight reports were assigned for Child Protective Services (CPS) assessments regarding the family, with allegations ranging from unsanitary living conditions, domestic violence, substance abuse, physical abuse and sexual abuse. Of these eight reports, two concluded with founded dispositions, including the fatality.

On August 21, 2016, the Department received a report that S.H. had nearly drowned and was not expected to live. The report indicated that the children were living with their mother, but had been visiting with their father at the time of the incident. It was unknown at the time if lack of supervision resulted in the incident; however, the caller noted that the father had a history of alcohol use.

A second call was received the following day with additional information, indicating that S.H.'s condition had not changed and it was anticipated that the child would not survive. The caller indicated the father reported having lost track of the children momentarily when he observed someone pulling a child out of the water and realized it was S.H. The father reported helping move the child and assisting in administering CPR until paramedics arrived.

The caseworker contacted medical staff and learned S.H. had been under water for several minutes; the child did not know how to swim and was not wearing a life vest. A medical expert stated the drowning was believed to occur due to lack of supervision and could have been avoided. On August 24, 2016, the caseworker was notified that S.H. had died.

The Department received the police report, dated January 23, 2017, indicating law enforcement concluded their investigation and no criminal

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.

charges were being filed. The disposition of the CPS assessment was founded against the father for neglect, lack of supervision for the fatality of S.H. and founded for threat of harm, neglect regarding S.H.'s sibling.

Conclusions:

The CIRT did not identify critical errors that might have led to the death of S.H. However, the team identified overarching themes throughout this case that could have provided greater insight into the family condition.

There was a lack of comprehensive assessment regarding the children's needs and safety throughout this case. Several assessments were incident based and did not consider or analyze the family's history of domestic violence, substance use and criminal behavior in describing the functioning of the parents or the circumstances surrounding the alleged maltreatment. The CIRT believed there were missed opportunities to gather additional clarifying information from collateral contacts that might have assisted in conducting more thorough assessments.

The CIRT noted inconsistencies in application of screening policy and felt several closed at screening reports would have been more appropriate to assign for CPS assessment. The CIRT raised concern surrounding the lack of documentation of review and follow up of reports that were closed at screening. The CIRT also noted inconsistent application of timelines for screening decisions and completion of assessments throughout this case. While caseload and workload may have been factors, several of the screening reports and assessments were well beyond timelines established by policy.

Recommendations and Process Improvements:

While the CIRT did not conclude these identified practice issues directly affected the outcome of this case, the improvements outlined below are underway and will assist in addressing identified practice needs.

- 1) Continue implementation of a centralized Statewide Child Abuse Hotline to ensure consistent and timely responses to reports of abuse.
 - The Department is moving forward with implementation of a Centralized Child Abuse Hotline, designed to improve consistency

in screening decisions and practices, ultimately resulting in more positive outcomes for child safety. The Department is currently working with national experts to develop curriculum for a screening academy to ensure screening decisions are in-line with Oregon's practice model, Oregon Statute and Administrative Rules. A location for the Centralized Child Abuse Hotline has been identified and is expected to begin taking calls in April 2019 with a gradual, planned transition of all Oregon counties to the new system.

2) Continue efforts to increase fidelity to Oregon's practice model and implement measures of accountability across the child welfare workforce.

- Training for new child welfare caseworkers has been redesigned in order to develop a well-trained, skilled and prepared workforce. The training better supports new caseworkers and provides a more holistic approach in preparing new staff to engage with families and communities. The training includes ongoing professional development and multiple training and learning experiences over the course of the first year. Trainers began delivering the redesigned curriculum to new cohorts in September of 2017.
- In 2017, the Oregon legislature invested in training and professional development of child welfare supervisors and staff by allocating 50 new positions to the Department. These positions, designed to strengthen child welfare practice and improve recruitment and retention of staff, will primarily focus on mentoring, assisting and promoting the success of new staff, but they will also be available to work with experienced staff.
- Child safety experts placed in field offices across the state provide intensive coaching, mentoring and training to staff. These experts are also conducting fidelity reviews to inform areas in which improvements are needed. After an initial review is conducted an action plan is created with each field office to address any identified concerns. Additional reviews are conducted at 60 to 90 day and six-month intervals to determine impact on practice and where more support may be needed.

Purpose of Critical Incident Response Team Reports:⁴

Critical incident reports are used as tools for Department actions when there are incidents resulting in the death 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.

⁴ Given its limited purpose, a Critical Incident Response Team (CIRT) should not be construed to be a final or comprehensive review of all 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.