

CRITICAL INCIDENT RESPONSE TEAM 30 DAY AND FINAL REPORT

December 14, 2009

Executive Summary

A.H., a seven month old child, died in a hospital July 12, 2009 from suspicious injuries. At the time of this report, the Medical Examiner report has not been finalized.

Prior to the injuries that resulted in A.H.'s death, the Oregon Department of Human Services (DHS) received and investigated three abuse and neglect referrals regarding A.H. and her brother. Two referrals were closed at screening. An assessment on the third referral was determined unfounded.

The recommendations in the Critical Incident Response Team (CIRT) report focus on the following three issues:

1. The application of Karly's Law* and the definition and identification of what does and does not constitute a suspicious injury in a child abuse and neglect case;
2. The identification of domestic violence issues and how the guidelines for screening and assessment of abuse and neglect direct the examination and evaluation of domestic violence history when a referral is screened or assessed; and
3. The quality of documentation to accurately record the complete details of the screening and assessment activities and process using the Oregon Safety Model.

Summary of Reported Incident

July 7, 2009: DHS received a report that A.H. was transported by ambulance to Newberg Hospital with life threatening injuries and was then transported to Oregon Health Sciences University and on life support.

*Karly's Law definition: If a person conducting an investigation under ORS 419B.020 observes a child who has suffered suspicious physical injury and the person has a reasonable suspicion that the injury may be the result of abuse, the person shall, in accordance with the protocols and procedures of the county multidisciplinary child abuse team, immediately take pictures and have the child examined by a designated medical professional within 48 hours or sooner if necessary.

July 8, 2009: The boyfriend of A.H.'s mother admitted to causing the child's injuries. At this time, the defendant has been indicted by the Grand Jury on Criminal Mistreatment 1, Murder by Abuse and Manslaughter 1 charges. A trial date has not been set.

July 13, 2009: DHS received a report of the child's death.

July 16, 2009: DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened under the provisions of mandatory CIRT protocol. This is the 30 day and final report from that CIRT Team.

Background

Prior to A.H.'s death, DHS received one CPS referral on her brother and two referrals on her. For the purposes of this Final Report, the first referral is designated "Closed at Screening 001" and the second "Closed at Screening 002." In addition to the screenings, DHS received a third report which is designated "Assessment 001."

CPS Screening 001, completed November 5, 2008

The referral detailed concerns about the mother hitting her six year old son and verbally abusing him. The anonymous reporter observed this incident approximately 2 months prior. There were no current injuries reported. This report was closed at screening as it was not determined to constitute a report of abuse or neglect as the incident occurred two months prior and the child was not currently harmed. However, no follow up investigation was done to elicit more information about the mother's behaviors and interactions with the child or the child's current situation.

CPS Screening 002, completed November 26, 2008

The report identified concerns about the father of A.H. who had returned to the home after serving time in jail for assaulting the mother. Collateral information indicated he had been living in the home and there was no court order prohibiting contact with the mother or the child. It was reported that the father served out his time and was released without completion of any kind of treatment for domestic violence issues. DHS had not received a report of the domestic violence incident. Collateral information indicated the child was not harmed by the domestic violence incident and the father was not on probation for the assault. There was no order prohibiting contact with the victim, the mother. The report was closed at screening

as it was determined it did not constitute a report of abuse or neglect. It was not clear in the screening narrative how it was determined that the mother could protect the child. DHS policy requires the assignment of a referral for investigation when a child's safety is threatened due to domestic violence involving a legal parent.

CPS Assessment 001, received April 23, 2009, completed June 3, 2009

Reported concerns included bruises of various sizes and age on A.H.'s forehead and arms with different explanations from the mother. An additional concern was that the child appeared dirty and unkempt. The report was made four days after the child was seen by medical staff.

The report was appropriately assigned for immediate response assessment. The reported bruises had faded, but the child was found to have a new bruise on the forehead. In addition, the worker observed several small bruises on the mother's arm. The worker interviewed the mother, her live-in boyfriend and the older brother of A.H. The worker followed up with the child's regular physician, who did not report concerns regarding the safety of the child. The worker determined the mother's explanation of cause matched the child's injury and was not suspicious for abuse. The mother explained her own bruises occurred at work. The assessment was unfounded.

The case documentation did not address the application of Karly's Law. Upon investigation, the CIRT Review Team learned that this discussion did occur with the supervisor and a decision was made that Karly's Law did not apply.

The case documentation did not indicate an exploration of possible domestic violence issues in this case which are relevant because of mother's history as a DV victim. Case documentation did not record if the required child welfare record check was completed on the other adult living in the household. A record check would have uncovered that the mother's live-in boyfriend had recently been accused of domestic violence by another woman but the report was unfounded.

Recommendations

Recommendation 1

With respect to CPS Assessment 001, the CIRT Team determined that there was confusion and disagreement over the application of Karly's Law. This included the definition and identification of what constitutes a suspicious injury in a child abuse

and neglect case.

The CIRT Team is recommending that the DHS CAF policy I-AB.4 and OAR 413-015-0400 thru 0485 related to CPS assessment will be updated and training should be conducted at the Supervisor and CPS Quarterlies.

ACTION – This recommendation has been completed by the CPS Unit and the rule change will be effective January 1, 2010, with the effective date of the new legislation.

Recommendation 2

It was not clear that identification of domestic violence issues and guidelines for screening and assessment of abuse and neglect were used to direct the examination and evaluation of domestic violence history when the referrals in this case were screened or assessed.

Members of the CIRT Team identified there may be a systemic issue with how the department is screening reports of domestic violence. Specifically the concern is whether child abuse screeners are closing at screening reports involving domestic violence that should instead be assigned to a CPS worker for a comprehensive assessment.

The CIRT Team completed an audit of sample cases to determine if the Domestic Violence Guidelines are being appropriately applied. A determination was made that a systemic issue exists regarding consistent Guideline application. State wide training to address this issue will be conducted at the Supervisor and CPS Quarterlies.

ACTION – This recommendation will be completed by the CPS Unit March, 2010.

Recommendation 3

The CIRT Team determined there was case information that was not included in the case documentation related to analysis and decision making in the CPS Screening 002 and the CPS Assessment 001.

DHS CAF supervisors will review the quality of case narrative documentation to assure it accurately records the complete details of the screening and assessment activities and process, using the Oregon Safety Model at the completion of

screening or assessment.

ACTION - CPS consultants and OSM Trainers will work with branch staff on an ongoing basis regarding compliance with the child welfare narrative recording policy.

Audit Points

None

Purpose of Critical Incident Response Team Reports

Critical incident reports are to be used as tools for identifying systemic issues 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.