

CRITICAL INCIDENT RESPONSE TEAM (CIRT) INITIAL REPORT A.M. & R.M.

August 17, 2015

Executive Summary

On May 18, 2012, siblings A.M. and R.M., currently 5 and 4 years old, were placed in an Oregon Department of Human Services (DHS) certified foster home with relatives, J.Y. and D.Y. These relatives were established by the court as the children's legal guardians on August 19, 2013, and at that time, the children's custody and guardianship to DHS was dismissed. A.M. and R.M. resided in the home for approximately 2.5 years.

On December 17, 2014, the court vacated the guardianship of A.M. and R.M. On December 22, 2014, a report was received alleging that A.M. and R.M. had been subjected to starvation while residing with their legal guardians.

On March 12, 2015, J.Y. and D.Y. were arrested and charged with the Assault in the First Degree and Criminal Mistreatment in the First Degree of A.M. and R.M. Their criminal case is pending.

On March 13, 2015, the Oregon Department of Human Services (DHS) Director declared a discretionary CIRT be convened. This is not a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024. A discretionary CIRT may be convened in the case of any suspected or founded child abuse or neglect incident where a child has suffered severe harm and a review process is likely to impact system change in a manner that increases child safety.

On March 16, 2015, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On April 10, 2015, the team met a second time to go over the case file review. The team identified potential issues that require further information and analysis prior to determining if they are systemic issues.

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 Team's (CIRT) 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 a separate process, the Department will address any necessary personnel actions.

This is the initial report of the CIRT and is issued as an activity report and status update.

Summary of Reported Incident and Background

On May 23, 2012, DHS received a report alleging Neglect regarding foster children residing in the foster home of J.Y. and D.Y. Those children are not the subject of this CIRT report. The report alleged concerns around toilet training and excessive discipline of one of the children. The report also alleged that one of the children was hit by the other child resulting in two lost front teeth and that the child who was allegedly hit would be in trouble if the foster mother knew he was speaking to the reporting party. This referral was correctly assigned for assessment as Within 24 Hour Response

The assigned CPS worker made contact with the ongoing caseworker and gathered information regarding the loss of the child's teeth. The CPS worker was informed the child tripped over a box and hit the child's mouth, resulting in the lost teeth, which the child confirmed. The child was seen by a dentist; however the CPS worker did not have collateral contact with the dentist. The CPS worker interviewed the child's sibling, who reported not feeling able to speak honestly when calling the ongoing caseworker because the foster mother would listen to the conversation. The child stated that D.Y. yells and swears at the children and that the younger sibling is not allowed to come out of the bedroom during the day. The CPS worker made contact with the children's school counselor, interviewed both foster parents and made observations of the children in the family home. No concerns were noted. This referral was closed with an Unfounded disposition. The information gathered during the assessment supported a disposition of Unable to Determine.

On June 12, 2012 there was a foster home sensitive case staffing where there was discussion about the concerns regarding inappropriate discipline and ability to meet children's needs, as well as the development of a plan for the caseworker to follow up with the older child to ensure she felt she had safe place to talk away from foster parent as well as explore supports for foster parents.

On July 18, 2012, DHS received a report alleging Neglect of foster children, who are the not the subject of this CIRT report, residing in the home of J.Y. and D.Y. The report alleged that one of the children disclosed that the foster parents were withholding food and verbally abusing the older child. This report was Closed at Screening. The screening decision was based on the completion of the previous

assessment coded as Unfounded. This report met the criteria for assignment for CPS assessment.

On July 26, 2012, DHS received a report alleging Neglect by the foster parents, D.Y. and J.Y. The focus of the report was on the foster children in the home who are not the subject of this CIRT report. The report indicated the foster mother yells and swears at the children, as well as utilizes inappropriate discipline strategies including lack of access to food. A child in the home continued to report fear of retribution from D.Y. and J.Y. This referral was correctly assigned for assessment as Within 24 Hour Response.

Three days prior to this referral, the children's caseworker and the foster parents' certifier had been to the home. The caseworker documented taking the children outside of the home to talk; one of the children indicated feeling safe, denying verbal abuse and indicating not wanting to be moved from the home. During this assessment, a decision was made to move the children to another foster home. The CPS worker interviewed the children in their new foster home. The children made disclosures of inappropriate discipline as well as disclosures consistent with Mental Injury. When contacting J.Y. and D.Y., D.Y. did not deny the allegations, rather explained the need to lock the pantry in order to prevent the children from stealing food or eating food they should not. The foster mother denied swearing at the children and it was noted by the caseworker that disciplinary practices were not intended to humiliate the child. During the assessment, the CPS worker contacted A.M. and R.M. who remained in the foster home. The worker noted that both children appeared to be healthy and well. The referral was closed with an Unfounded disposition. Additional information would be required to determine if another disposition would have been more appropriate.

At this time, an in home safety plan was put in place to support the foster parent in meeting the children's needs with more appropriate strategies. It is inconsistent with policy to have a safety plan in a foster home.

On April 15, 2013, DHS received a report alleging that J.Y. and D.Y. were allowing a former foster child to babysit children in the home. The report alleged the former foster child was using marijuana regularly as well as other substances less often. This report was Closed at Screening. This report qualified for assignment for CPS assessment. The certifier followed up with the foster family and J.Y. confirmed the use of the babysitter, but denied knowledge of the sitter's alleged drug use.

On July 24, 2013, DHS received a report alleging inappropriate discipline of A.M. and R.M. by their foster parents. It was also reported that J.Y. and D.Y. allowed a former foster child with alleged substance abuse issues to reside in their home without

disclosing the information to the Department. The screener appropriately identified Neglect as an allegation. Threat of Harm could also have been identified. This report was Closed at Screening. This report qualified for assignment for CPS assessment.

On July 24, 2013, DHS also received a report regarding a foster child who had previously resided in the J.Y. and D.Y. foster home. The report alleged that the child now stated that J.Y. had hit the child resulting in the loss of two front teeth. This report was assigned for assessment as Within 24 Hour Response. A staffing was held with appropriate Department personnel. The assessment was closed as Opened in Error because the allegation had been investigated in two previous assessments resulting in Unfounded dispositions. Continuing to address the current disclosure would have been consistent with policy.

On August 19, 2013, the court ordered guardianship of A.M. and R.M. with J.Y. and D.Y. and the Department's case was closed.

On March 26, 2014, DHS received a report alleging physical abuse of A.M. and R.M. by their now guardians, J.Y. and D.Y. A second caller reported R.M. was observed with a black eye which D.Y. stated was caused when she accidentally hit the child with a door. This report was assigned for assessment as Within 24 Hour Response. This is consistent with policy. The CPS worker requested law enforcement conduct a welfare check. Documentation indicates that the deputy observed injuries on R.M.'s face and spoke with J.Y. and D.Y. who stated the child had been hit by a door. The deputy also indicated that R.M. is developmentally delayed and suffers from poor muscle tone, which may require braces on his feet and ankles due to frequently falling. While the deputy observed and interviewed R.M., there is no information that he observed or interviewed A.M. This report was closed with No Allegation of Abuse. The information from law enforcement did not relate directly to and specifically negate all of the allegations in the screening report and further assessment was needed.

On July 15, 2014, DHS received a report that law enforcement had responded to the home of J.Y. and D.Y. due to concerns the children were not being properly cared for. Officers noted concern with the condition of the home and described the children as very thin and small in stature. The report was assigned for assessment as Within 24 Hour Response. This was consistent with policy.

The CPS worker contacted the children's WIC dietician who conveyed they were significantly failure to thrive, attributing their condition to contact with the children's biological family. When the CPS worker made contact in the home, D.Y. stated that the children were born with Fetal Alcohol Syndrome. A review of the file for this CIRT did not locate documentation of this diagnosis for the children. This case was closed

as Unfounded. Further investigation may have provided additional information about the children's circumstances and may have resulted in a different disposition.

On September 9, 2014, D.Y. contacted DHS to request voluntary services through the Department. This was assigned as a Family Support Services case, which was consistent with policy. While telephone contact occurred with D.Y., face to face contact was not made within the 10-day timeline required by policy. The WIC dietician was contacted and again attributed the children's condition to contact with their biological family. The caseworker had face to face contact with the children on November 19, 2014, and noted the children were small in size and the skin on R.M.'s face and neck looked unhealthy. A.M. was observed to have a similar skin condition on her neck as well, and both children had dark circles under their eyes.

While the family was engaged in voluntary services (FSS), on October 13, 2014, DHS received a law enforcement report, dated September 30, 2014, alleging sexual abuse of one of the children while in the care of D.Y. and J.Y. On October 20, 2014, the report was assigned for an assessment for Within 24 Hour Response. The delay in assigning the report for assessment was inconsistent with screening policy. The FSS caseworker was named in the screening report, however, a review of the file did not locate any documentation that there had been any communication between the workers. When attempting face to face contact at the home, the children were noted to be sleeping, so the CPS worker interviewed only J.Y. and D.Y.

On October 28, 2014, the worker noted having face to face contact with the A.M. and R.M. The CPS worker conducted an interview of the children and they made no disclosures of abuse. It was noted that A.M. was smaller in height than an average five year old but her physical appearance did not raise any concerns. R.M. was described as having an average build and weight for his age. Again D.Y. reported that the children had been diagnosed with Fetal Alcohol Syndrome. D.Y. reported that upon learning of the allegations of sexual abuse, contact between the child and the alleged perpetrator ceased. The Family Support Services Assessment concluded that J.Y. and D.Y. were requesting that DHS take voluntary custody of the children as they were no longer able to care for A.M. and R.M.

On December 22, 2014, DHS received a report indicating that the guardianship of A.M. and R.M. with J.Y. and D.Y. was vacated by the court. The children were placed into foster care with a relative. They were described as being thin and in poor condition. Both children were taken to Randall Children's Hospital and were admitted based on concerns of malnutrition and starvation. This assessment was assigned with an up to 5-day response as the children were no longer residing in the home of J.Y. and D.Y. The assignment of this referral as an up to 5-day response was consistent with policy.

This referral has been coded as Founded for Neglect, Founded for Physical Abuse, and Founded for Mental Injury against J.Y. and D.Y.

CIRT Activity Report and Status Update

Pursuant to CIRT protocol, the CIRT team has met twice 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, the results were presented at the second meeting and potential systemic issues were identified.

The Critical Incident Response Team will reconvene once additional information is gathered in order to inform the decision and identification of systemic issues and make recommendations and plans to address those issues.

Potential Systemic Issues

Additional information and analysis is needed in order to determine if the issues identified by the CIRT are isolated, local issues or statewide, systemic issues. A preliminary review of the files has identified the following potential systemic issues regarding the Department's work in this case:

- The ability of children in foster care to feel safe about expressing concerns, including concerns about a foster home.
- Communication within and between branches on co-managed cases.
- Department interviewing of foster children, including location and method of interviewing.
- Collateral contacts and gathering of relevant records during the CPS assessment process.
- Differentiation between placement support plans and in-home safety plans in foster homes.
- The guardianship approval process and the Department's communication with the court system.

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.