

CRITICAL INCIDENT RESPONSE TEAM INITIAL REPORT J.M.

January 12, 2010

Executive Summary

On December 9, 2009, 15 year old J.M. died from what authorities have described as extensive abuse and neglect. The circumstances surrounding the death are currently under law enforcement investigation.

The Oregon Department of Human Services (DHS) had received referrals on the family prior to the report about the fatal injuries, although the number of those referrals is still under investigation.

Any time a child dies or is seriously injured at the hands of a family, our communities suffer. The pain is felt more acutely when the agency has had knowledge of and contact with a child and family before a tragedy occurs. The entire agency grieves this terrible tragedy.

The Critical Incident Response Team (CIRT) team's efforts to identify issues are a critical component of agency accountability and improvement when tragedies like this occur. In addition to the CIRT process, the agency separately addresses any necessary personnel actions involving individual employees and/or their supervisors. Any time a child in Oregon 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 -- and keep Oregon's children safer as a result.

This case raises several issues that can be summarized as follows:

- This was a high-risk family, with a past history with a child welfare agency in another state that included physical abuse and neglect. That information was not adequately considered when evaluating the reports of abuse against J.M.
- The Department received information from credible sources that was not adequately considered when evaluating the reports of abuse against J.M. made several years ago.

- J.M.'s capacity to protect herself and disclose abuse was not appropriately evaluated in determining whether or not to investigate abuse reports received about J.M.

As a result of this review, the CIRT team identified the following areas for further investigation:

- The need for the agency to better support the Oregon Safety Model expectation that Child Protective Services (CPS) screening is comprehensive. This includes the need to evaluate – and, as appropriate, strengthen - the sufficiency of supervisor reviews when approving CPS screening decisions;
- The need for specific guidance to workers with respect to comprehensive assessments when children are being raised without contact by traditional community supports (school, medical, etc.);
- The need to further investigate whether workers are either systemically making a child vulnerability determination when screening child abuse reports and/or over-relying upon a child's age as part of their evaluation of child vulnerability in an assessment;
- The need to further investigate whether the Department adequately documented reports of abuse in this case.

The CIRT team is continuing its investigation into these issues and is seeking additional information to inform its next report, which it expects to complete in March following the results of the work highlighted in this reports' recommendations. As the review of the case continues, the CIRT team will seek to discover whether the issues identified in this case are in fact systemic issues or unique to this case, whether there are any additional systemic issues to address and draft recommendations to address them.

Summary of Reported Incident

On December 9, 2009, the after hours worker in Lane County received a call from Lane County Sheriff requesting assistance at the home of J.M. Responding to a 911 call, paramedics found fifteen year old J.M. non-responsive in the bathtub of her home. J.M. was transported to the hospital, but she was declared dead after attempts to revive her were unsuccessful. Law enforcement identified multiple injuries on J.M.'s body that were consistent with severe physical abuse and neglect. The circumstances surrounding the death are still under law enforcement investigation.

On December 10, 2009, DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened. This is the initial report of the CIRT team.

Background

Before the referral on December 9, 2009, the Department has in its records a total of 4 CPS reports on the family; two reports in 2006, one in 2007 and one in 2009. One report was referred for assessment (referred to in this CIRT document as Referral 001), and three were “closed at screening.” When a report is closed at screening it means that a CPS worker was not assigned to assess the family and no further follow up was done. For purposes of this CIRT document, reports that were Closed at Screening will be identified as Closed at Screening 001, Closed at Screening 002, etc.

REFERRAL 001: Allegation of Mental Injury and Neglect – Disposition: Unable to Determine. The department received its first report on this family in 2006. On April 27, 2006, it was reported that J.M. was being denied food and being punished by being forced to kneel on the tile floor with her nose to the wall and hands behind her back for extended periods of time, that she was being forced to eat chili peppers, and that her hair was being pulled making her head sore. DHS assigned this report for assessment in a 5-day timeline, which was not consistent with policy; it should have been assigned for immediate response (requiring contact within 24 hours). During the assessment, the Department received inconsistent information from J.M.’s mother, father, sister and J.M. about the food deprivation and punishment. The Department concluded that it could not determine whether there was a safety threat to J.M. Given what the Department knew at the time, that may have been the appropriate disposition. The CIRT team believes more could have been done to interview additional, collateral sources about the alleged abuse. In particular, the CIRT team notes that these additional steps were warranted given the family’s history with child welfare in another state and the nature of the allegations in this referral.

CLOSED AT SCREENING 001. The Department received a second report on this family in 2006 . On May 2, 2006, the Department received a second report about J.M. being denied food and having to sit and watch others eat while unable to eat herself. The report was closed at screening because there was a safety assessment already in progress (see Referral 001). The information in this report was provided to the worker assigned to Referral 001. The appropriate protocol was followed in handling this assessment.

CLOSED AT SCREENING 002. The Department received a third report on this family in 2007. On March 16, 2007, the Department received a report that J.M. had a bruise on her chin and refused to state what happened. Later, J.M. told the reporter that the bruise was from “popping pimples”. A third party also told the reporter that J.M.’s mother or stepfather had hit her. The reporter, a credible source, stated that the bruise was not consistent with J.M.’s explanation. Based on J.M.’s age and her denial that abuse had occurred, the report was closed at screening. The CIRT team concluded that based upon the nature of the allegations and credibility of the report, the incident should have been assigned for CPS assessment.

CLOSED AT SCREENING 003. The Department received a fourth report on this family in 2009, consisting of two calls from the same individual. On December 1, 2009, the Department received a report that J.M. and her siblings were being “abused and neglected, especially the older one.” The reporter indicated that the two younger children were in school, but that “the older one” had not gone to school for a couple of years. The reporter stated that there were current marks and bruises on the child, but did not know how they occurred, and stated that the child appeared malnourished. The reporter indicated the child was not allowed to speak with her, so there had been no disclosure by the child. The reporter initially would not provide the last name of the children or an address. In a subsequent call that same day, the reporter called back and provided the last name and address for the family. Concluding that the call did not constitute a report of abuse or neglect, the matter was closed at screening. The CIRT team determined that based upon the information provided in the call, this report in fact constituted abuse or neglect and should have been assigned for CPS assessment.

Issues Identified

As required by CIRT protocol, the first CIRT team convened within 24-hours of the CIRT being called. At that meeting, the Team reviewed preliminary information and identified issues of interest in the case. Subsequently, an extensive file review was conducted over the next two weeks and the results were presented to the Critical Incident Response Team at its second meeting. At that meeting, the Team identified the following issues, with an understanding that any personnel issues identified will be handled under a separate process:

Issue #1: The need for the agency to better support the Oregon Safety Model expectation that Child Protective Services (CPS) screening is comprehensive. This

includes the need to evaluate – and, as appropriate, strengthen - the sufficiency of supervisor reviews when approving CPS the screening decisions.

Issue #2: The need for specific guidance to workers with respect to comprehensive assessments when children are being raised without contact by traditional community supports (school, medical, etc.).

Issue #3: The need to further investigate whether workers are either systemically making a child vulnerability determination when screening child abuse reports and/or over-relying upon a child’s age as part of their evaluation of child vulnerability in an assessment.

Issue #4: The need to further investigate whether the Department adequately documented reports of abuse in this case.

Preliminary Recommendations

- The issue of the comprehensiveness of the Department’s response to reports of abuse and neglect is one that has been identified in prior CIRTs. In response, the Department has again reviewed its policies, trained staff in practice and policy, and begun branch-specific case reviews to identify issues and address them. Because the Department continues to struggle in this area, the CPS Program Manager has sought the assistance of the National Resource Center on Child Protective Services regarding the challenges the Department is experiencing with respect to the application of the Oregon Safety Model expectations regarding comprehensive CPS screening and assessments and the timelines by which to complete them. The circumstances of this CIRT will be included in the work with the National Resource Center. By the end of January 2010, the National Resource Center will report back to the Department and its recommendations will be incorporated into the next CIRT report in this case.
- The Department will consult with outside medical child abuse specialists to inform the Department’s assessment practice when interviewing children who are being raised outside traditional community supports, such as school, medical, faith-based organizations, etc. Those experts will be asked to advise the Department on how to improve its evaluation of information both when screening and assessing calls of suspected abuse involving children who are more isolated. This consultation will be completed by March 1,

2010, and recommendations for improvement will be incorporated into the next CIRT report in this case.

- In its training for screening and assessment practice consistent with the Oregon Safety Model, the Department provides materials to staff that specifically highlight several critical determinants of vulnerability *regardless of a child's age*. Most relevant to this case, those determinants include powerlessness and non-assertiveness. Vulnerability and the agency's identification and response to that occurred in two areas of decision-making in this case: screening of abuse reports, and assessment after a report has been referred for investigation.

In the first instance, it appears that J.M.'s age was considered as a major factor in the conclusion that she was not vulnerable and, therefore, an assessment of the abuse reports was not warranted. Vulnerability is not possible to evaluate (or assess) in the screening process; assessment of vulnerability requires a face-to-face evaluation (a field assessment). In this case, when a field assessment occurred (Referral 001), it appears that J.M.'s age was also heavily weighted in the determination of vulnerability. While age is one consideration, as noted above, there are specific determinants that presented in this case that should have been considered irrespective of a child's age.

To determine whether these are systemic issues or if these issues are unique to this case, the CIRT team will audit a representative sample of closed at screening and referral determinations where children are above the age of 10 and review specifically whether the child's age inappropriately influenced the decision that was made. That review will be completed by March 1, 2010. Depending on the outcome of that review, the CIRT Team will consider additional recommendations.

- Finally, this case raises two separate issues regarding the Department's recording of and response to calls about the abuse and neglect of J.M. The first is that calls about abuse were made that were not investigated. A second concern raised is that calls may have been made but not documented. If calls were made that did not rise to the level of abuse or neglect, the Department would not have documented those calls.

To be certain that the Department did not receive calls of abuse or neglect that it did not record, the CIRT team is recommending further investigation.

It should be emphasized that the CIRT team is continuing its investigation into these issues and is seeking additional information to inform its final report. As the review of the case continues, the CIRT team will reach a conclusion as to whether the issues identified in this case are in fact systemic issues (as opposed to unique to the circumstances here), whether there are any additional systemic issues in this case, and draft recommendations to address them.

Audit Points

None at this time

Purpose of Critical Incident Response Team Reports

Critical incident reports are to be 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.