

# **CRITICAL INCIDENT RESPONSE TEAM (CIRT) INITIAL REPORT T.C.**

**August 24, 2015**

## **Executive Summary**

On January 12, 2015, the Oregon Department of Human Services (DHS) was notified that a child, T.C., and T.C.'s mother were involved in a fatal motor vehicle accident. T.C.'s mother died at the scene and T.C. was transported to the hospital and subsequently died. T.C. was in the custody of DHS at the time of death.

Since January 2012, DHS was contacted twenty-two times regarding T.C.'s family, including notification of the fatality. Of the twenty-two reports, ten were Closed at Screening, and nine were assigned for a Child Protective Services (CPS) assessment. Three referrals were addressed as part of already pending CPS assessments.

On April 29, 2015, The DHS Director 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.

On April 30, 2015, the initial CIRT meeting was held and a comprehensive case file review was initiated. On June 1, 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.

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 January 17, 2012, DHS received the first report regarding this family alleging Neglect of T.C. by T.C.'s mother. According to the report, T.C. had set several pieces of paper on fire with the mother's lighter. The mother was reported to have taken appropriate protective action and this report was Closed at Screening. There was no information to indicate the mother was negligent in her actions and/or failed to respond appropriately. The decision to close the report at screening was consistent with policy.

On February 21, 2012, DHS received a report of Neglect of T.C. by T.C.'s mother. The report indicated that T.C. was unable to be transported home from school due to the child's behaviors. T.C.'s mother arrived at the school shortly thereafter. The report

stated that she appeared visibly impaired and smelled of alcohol. This referral was correctly assigned for CPS assessment with a timeline of Within 24 Hour Response.

Law enforcement and two DHS caseworkers responded to the school and observed T.C.'s mother. Given the suspension of the mother's driver's license, the caseworkers transported T.C. and T.C.'s mother home from school. The caseworkers observed that T.C.'s mother did not appear intoxicated or impaired, however they detected a faint smell of alcohol. All individuals in T.C.'s home were observed and interviewed. T.C.'s mother and her significant other reported drinking the previous night with family members; they stated they were casual drinkers and denied any drug use. Multiple, collateral contacts were made, including contact with a community resource the family had recently begun working with. No additional concerns were noted. At the conclusion of the assessment, the disposition was coded as Unfounded. This disposition was consistent with policy.

On September 30, 2012, DHS received a report alleging Neglect and Sexual Abuse of T.C. The report indicated that T.C. was observed with symptoms concerning for sexual abuse. It was also reported that T.C.'s mother smelled of alcohol at the appointment and provided little comfort to the child. This report was correctly assigned for assessment with a timeline of Within 24 Hour Response.

Law enforcement and the CPS worker responded to the home. During the course of the assessment, T.C.'s mother shared information about the child's hygiene and medical history as an explanation for the observations made of the child's physical condition that led to the report to DHS. T.C. was interviewed and made no concerning statements indicative of sexual abuse and corroborated the mother's account of difficulties with hygiene. T.C.'s sibling was also interviewed and did not disclose anything of concern. The mother reported believing that T.C. suffered from multiple, mental health diagnoses; however, none of the reported illnesses were formally diagnosed. The mother admitted to consuming alcohol a few times weekly but denied having a drinking problem or that alcohol had negatively impacted her life; she denied any drug use. The mother's significant other was also interviewed and reported information consistent with mother's statements.

Approximately ten days later DHS received a call reporting concerns about T.C.'s mother's appearance, including observations of unusual bruising on her arms and loss of weight. The caller reported concern about potential substance abuse. The caseworker, familiar with the mother's appearance from an earlier assessment, made contact with the mother and did not observe any bruising or difference in the mother's weight or appearance. The mother reported that she had recently made a decision to stop drinking and had gone through detox, which she believed made her ill, and stated she was now sober. Collateral contacts were made and collateral information was

obtained regarding any use of drugs or alcohol by the mother. The disposition of the assessment was Unfounded for both Neglect and Sexual Abuse. This disposition was consistent with policy.

On January 19, 2013, DHS received a report alleging sexual abuse of T.C. by a five year old neighbor. T.C.'s mother contacted law enforcement and the local Child Advocacy Center. This was a report of third party abuse and the information received by the screener indicated that the mother was willing and able to protect the children. This report was appropriately Closed at Screening. The information was documented and forwarded to the CPS worker conducting the pending CPS assessment at that time.

On February 13, 2013, DHS received a report alleging physical abuse of T.C. by T.C.'s mother. The reporter indicated that T.C. was observed and no injuries were noted. This report was Closed at Screening and the information was forwarded to the CPS caseworker conducting the pending CPS assessment at that time. This report fit criteria to assign for CPS assessment.

On March 6, 2013, DHS received a report alleging historical physical abuse of T.C.'s sibling by the mother's live-in companion. The incident was reported to have occurred between one and three years prior. The report indicated that the sibling denied any other, similar incidents and reported feeling safe with the mother and her live-in companion. It was also reported that mother had not been aware of the incident until now and stated she would speak to her live-in companion about it. This report was Closed at Screening. The decision to close this report at screening was consistent with policy.

On March 8, 2013, DHS received a report alleging physical abuse of T.C. by T.C.'s mother. The report stated that T.C. had two marks on the face that the child reported were the result of the mother. This report was correctly assigned for assessment with a timeline of Within 24 Hour Response.

T.C. was interviewed and stated that T.C.'s mother had scratched the child's face after T.C. accidentally kicked T.C.'s sibling in the eye. T.C. reported being very scared of her mother during the incident and also stated thinking that the child "could just kill" the mother. T.C. also reported being slapped in the face by the mother, which left a bruise, five or six weeks earlier. The CPS worker interviewed the mother who indicated that while T.C. was having a tantrum, T.C. kicked the sibling in the face. The mother stated she grabbed T.C.'s face and told the child to stop and that T.C. kicked her. The mother denied scratching T.C.'s face. The sibling was interviewed separately and stated T.C. had been scratched by the cat. The sibling also reported that one time T.C. had threatened the sibling with a rifle and a knife.

The caseworker went to the home to speak with the mother a second time. T.C. had arrived home from school and bit a neighbor child on the arm and ran away. The caseworker observed the bite mark and assisted in locating T.C.

DHS met with the mother multiple times over several months in an attempt to locate services to assist with T.C.'s behaviors. During the assessment, the CPS caseworker contacted multiple collateral sources. The family began working with a service provider that required a DHS case to remain open. At the conclusion of the assessment, the disposition was coded Unfounded for Physical Abuse. This disposition was consistent with policy. In order for the family to continue to receive services, an ongoing voluntary case was opened on July 11, 2013.

On September 16, 2013, DHS received a report indicating that T.C.'s mother had attended a meeting smelling of alcohol and appeared intoxicated. The report also indicated that T.C.'s behaviors were escalating, including hearing voices, torturing a cat and raising scissors in a threatening manner toward school classmates. The report was correctly assigned for assessment with a timeline of Within 24 Hours.

The CPS caseworker did not conduct an assessment, noting that the mother was following through with treatment recommendations and T.C. was hospitalized at the time. A comprehensive assessment should have been conducted.

On September 28, 2013, DHS received a report alleging Neglect and Sexual Abuse of T.C. The report indicated that while placed in a psychiatric unit, T.C. disclosed possible historical sexual abuse by a friend of T.C.'s mother's. The report indicated that T.C. told the mother about the alleged sexual abuse and the mother did not believe T.C. The report also indicated that T.C. might be discharged back to the mother's care the next day and that the mother reportedly had her own mental health issues. This report was correctly assigned with a timeline of Within 24 Hour Response.

The voluntary DHS case was still open but in the process of being closed at the time this referral was received. The caseworker learned that T.C. had been discharged to T.C.'s mother and had an intake appointment scheduled for day treatment. Assessment activities were conducted and T.C. made inconclusive statements regarding the alleged sexual abuse. This report was coded with a disposition of Unable to Determine for Sexual Abuse and Unfounded for Neglect. These dispositions were consistent with policy.

On October 21, 2013, DHS received a report that T.C. had made additional statements regarding the sexual abuse allegation from the previous report. This information was

in the process of being assessed and therefore this report was Closed at Screening. The decision to close this report at screening was consistent with policy.

The next assessment includes four separate reports received regarding this family over a six month time frame that were linked into one assessment. Prior to the first of these reports being received, on December 2, 2013 the Voluntary In-Home Services Agreement closed. According to documentation, there were no current safety threats and the family had engaged in services.

On December 6, 2013, DHS received a report concerning possible substance abuse by T.C.'s mother. This report was correctly assigned for assessment with a timeline of Within 24 Hour Response. The mother and children were all interviewed and collateral information was obtained regarding any use of drugs or alcohol by the mother. Collateral contact was made with a service provider for T.C. who reported no concerns regarding the mother's care of T.C.

On April 2, 2014, DHS received a report concerning possible physical abuse of T.C. by T.C.'s mother. The child did not have any reported injuries. This report was correctly assigned for assessment with a timeline of Within 24 Hour Response. T.C. was interviewed and reported being placed in a cold shower by T.C.'s mother's roommate as a form of discipline. The child made no additional disclosures.

On April 21, 2014, DHS received a report that T.C. had disclosed possible physical abuse by one of T.C.'s family's roommates. There were no injuries reported from the incident. This report was correctly assigned for assessment with a timeline of Within 24 Hour Response. Shortly thereafter the child was voluntarily placed into an emergency psychiatric ward, with plans to be moved to residential treatment when a bed was available. T.C.'s mother's roommate was interviewed and indicated that he had put his hand on the back of T.C.'s neck when the child was holding another child in the home up by one arm. He also stated he had placed T.C. in a cold shower during one of the child's episodes to calm the child down.

On June 24, 2014, DHS received a report alleging physical abuse of T.C. by T.C.'s mother. This report was correctly assigned for assessment with a timeline of Within 24 Hour Response. A review of the file does not indicate that this report was assessed.

These assessments (December 6, 2013, April 2, 2014, April 21, 2014 and June 24, 2014) were resolved with one dispositional finding and were coded Unfounded for Neglect and Physical Abuse and closed. The documented information is insufficient for the CIRT to determine if the dispositions were consistent with policy.

On February 3, 2014, DHS received a call of concern for T.C. and the child's behavior. According to the report, T.C. discussed inappropriate "pranks" involving the child's sibling. It was also reported that T.C. had pulled down the child's own pants, exposing the child in public. T.C.'s mother was contacted by the reporting party and indicated a similar incident happened in the community. This report was Closed at Screening and forwarded to the ongoing caseworker. The decision to close this report at screening was consistent with policy.

On February 25, 2014, DHS received a report indicating that T.C. disclosed that T.C.'s mother had put duct tape on the child's mouth several years prior. The child did not report any injury or provide further information. This report was Closed at Screening and forwarded to the ongoing caseworker. The decision to close this report at screening was consistent with policy.

On February 25, 2014, DHS received a report alleging that T.C. had convinced the child's sibling to show the child the sibling's genitalia. It was reported that the incident was brought to the attention of T.C.'s mother who articulated a plan to enhance supervision. Both children were engaged with service providers who were made aware of the incident. This report was Closed at Screening and forwarded to the ongoing caseworker. The decision to close this report at screening was consistent with policy.

On March 11, 2014, DHS received a call of concern that T.C. had stated the child hated T.C.'s mother because the mother slapped the child on the head. No additional information was provided and no injuries reported. This report was Closed at Screening and forwarded to the ongoing caseworker. The decision to close this report at screening was consistent with policy.

On April 10, 2014, DHS received a report that T.C. first disclosed physical abuse by T.C.'s mother and then recanted, stating no abuse occurred. It was also reported that later the same day, T.C. began screaming and stating the child did not want to go home because of abuse by T.C.'s mother. It was reported that when the inconsistency in the child's statements was brought to the attention of T.C., the child began tearing the car apart, kicking windows. It was further reported that the following day T.C. apologized for the child's behavior. Shortly thereafter the child began kicking windows of the car and indicated a desire to be hospitalized. This report was Closed at Screening and forwarded to the CPS caseworker conducting an assessment at the time. The decision to close this report at screening was consistent with policy.

The next assessment documented by DHS includes two separate reports regarding the family which were dealt with as one assessment. On June 5, 2014, DHS received a report alleging that T.C.'s sibling had bruising and scraping around the eye. According

to the report, the sibling had no memory of receiving the injury. The report was correctly assigned for assessment with a timeline of Within 24 Hour Response. When interviewed, the child reported the injury was from climbing a bunk bed and hitting the child's eye. A medical examination of the child did not identify the injury being abuse-related.

On August 4, 2014, DHS received a report alleging physical abuse of T.C. by T.C.'s mother. According to the report, T.C. had torn a photo and the mother spanked T.C. leaving a small mark on the child's thigh. This report was correctly assigned for assessment with a timeline of Within 24 Hours. During the assessment, T.C.'s mother stated that while restraining T.C. due to the child's behavior, T.C. had "head butted" the mother on purpose, leaving a bruise. The mother described her frustration with T.C.'s behaviors and needs. T.C. mother's reported that T.C. hit her in the face with a closed fist and the mother responded by hitting T.C. in the back of the head with an open hand. When T.C. was interviewed, the child stated, "I will do anything to get my mom arrested." During the interview, in the presence of the CPS caseworker, T.C. hit a 2 year old child in the head. T.C. reported physical abuse by mother including picking the child up by the hair, pulling the child's hair and hitting the child on the head. T.C. denied having any marks or injuries; none were observed by the caseworker. A service provider was in the home during the reported incident and described T.C.'s behavior as belligerent.

Several service providers were contacted who described T.C.'s difficulties. T.C. had received multiple mental health diagnoses at that time, however the child's mental health team did not feel the child would meet the criteria to be placed in a residential treatment program.

On August 12, 2014, T.C.'s mother requested placement of T.C. as she could no longer manage the child's needs. On August 14, 2014, DHS took protective custody of T.C. and the child was placed in a Behavioral Rehabilitation Services (BRS) placement. During the assessment, the caseworker had contact with numerous collateral sources working with the family. The assessment disposition was coded as Unfounded for Physical Abuse by the roommate, which was consistent with policy, and Founded for Physical Abuse of T.C. by the child's mother. There was insufficient information in the assessment to support a founded disposition against the mother. The information supported an Unable to Determine disposition.

Between August 14, 2014, and January 12, 201, T.C. remained in the legal custody of DHS. T.C. had ten separate placements ranging from regular foster care to a psychiatric residential treatment facility, where the child was placed at the time of the child's death. The child had multiple hospitalizations for stabilization during this time.

On January 17, 2015, DHS received a report that T.C. and T.C.'s mother were involved in a motor vehicle accident. The mother died at the scene and T.C. was transported to a local hospital where the child subsequently died. T.C. was in the custody of DHS and placed in a psychiatric residential facility at the time of the child's death. The child's mother had picked the child up from the facility that morning to transport the child to a medical appointment. This report was assigned for assessment with a timeline of Within 5 Days. T.C.'s sibling was left in the home without an available caregiver. An assignment with a timeline of Within 24 Hour Response would have been more appropriate.

Based on information obtained as part of the assessment, including but not limited to, information regarding the mother's condition at the time of the accident, this assessment was coded with a disposition of Founded for Neglect of T.C. by T.C.'s mother.

### **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 analysis is necessary 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:

- Navigating the mental health system to determine the most appropriate placement for children with significant mental health and behavioral needs.
- Lack of adequate training for field staff on how to appeal or challenge decisions by Coordinated Care Organizations and Mental Health providers.

- Assessing parental capacity to determine child safety when the child has challenging behaviors and behavioral needs.
- Joining several referrals into one assessment and the potential impact on the thoroughness of assessing each referral.
- The appropriate use of voluntary cases by the Department.

### **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.