

CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT

September 2, 2008

Executive Summary of NL CIRT

N.L., a 2-year old child, died in a hospital March 9, 2008, from non-accidental injuries.

Prior to the injuries that resulted in N.L.'s death; The Oregon Department of Human Services (DHS) received and investigated two abuse and neglect referrals regarding N.L. and her brother. A written safety plan was prepared for N.L. following the second assessment, but a Child Protective Services (CPS) case was not opened. In addition, it was subsequently determined that the individual who had signed the safety plan (in effect taking responsibility for keeping N.L. safe), had previously been referred to DHS for allegedly failing to adequately protect N.L.'s mother.

In reviewing this case, the CIRT team made several recommendations:

1. The CIRT team determined that policies relating to follow up on safety plans need to be clearer.
2. The CIRT team recommended a review to be certain all safety assessors are taking steps to access critical safety-related information (such as prior CPS referrals or criminal records) before executing a safety plan with an individual.
3. The CIRT team recommended additional follow-up as needed based on staff interviews that continued after the initial April 11, 2008 report.
4. The CIRT team recommended that child welfare and self-sufficiency administration should develop an action plan to reduce barriers to information sharing between program areas when serving mutual clients.

To date, DHS has taken the following action on the CIRT team's recommendations:

1) In April, the CPS manager immediately issued instructions to field offices reinforcing DHS' existing policy, which requires a CPS case be opened whenever a safety plan is adopted. In May, the DHS audit team conducted its first audit and made recommendations that DHS is to clarify its safety plan

policy in the field. CPS is acting on those recommendations now, and those efforts will be audited again in November.

2) In August the CPS manager sent a written communication to all safety assessors and their supervisors reminding them of DHS policy requiring safety assessors to access critical safety-related information before executing a safety plan with an individual.

3) At its next scheduled supervisors' quarterly meeting in October, DHS will provide a special practice forum focused on clarifying the information needed (or not needed) to open an assessment.

4) Child Welfare and Self-Sufficiency program administrators submitted an action plan to the DHS director on June 15, 2008, designed to reduce or eliminate barriers to CW/SS information sharing. The group is continuing to work on a plan to implement those actions, and expects to submit that plan by September 30, 2008.

Summary of reported incident

March 9, 2008: DHS received a report that N.L., a 2-year-old child, had died at Salem Hospital.

March 11, 2008: Citing statements from a Marion County prosecutor, the Associated Press reported that an autopsy had revealed N.L. died of "blunt force trauma." The same source reported that the boyfriend of N.L.'s mother had been charged in Marion County with murder and sex abuse of N.L. In addition, the boyfriend had been charged with criminal mistreatment of N.L.'s older brother.

March 11, 2008: DHS Director, Dr. Bruce Goldberg ordered that a CIRT be convened.

April 11, 2008: The initial CIRT report was completed.

May 20, 2008: The CIRT Progress Report was completed. The CIRT file will remain open and progress reports will be completed until all audit points are addressed.

Summer 2008: The Marion County District Attorney's office submitted the case to the grand jury, which returned an indictment against N.L.'s mother's boyfriend for the crimes of murder, murder by abuse, unlawful sexual penetration, sexual abuse 1, criminal mistreatment 1, and assault 4. The case is currently scheduled for trial on October 27, 2008.

August 2008: The final CIRT report was completed.

Background

Prior to N.L.'s death, DHS received two CPS referrals about N.L. and her brother. For purposes of this Final Report the first referral is designated "Assessment 001" and the second "Assessment 002." In addition to the referrals, DHS received a third report. It is designated "Closed at Screening 001."

CPS Assessment 001, completed April 25, 2006: After this referral was received, DHS concluded that the following family risk factors existed in N.L.'s and her brother's household: likely child neglect, teenage mother, young adult father, two young children and parental lack of judgment. This assessment found reasonable cause to believe that neglect occurred. DHS did not open a child welfare case.

CPS Assessment 002, completed April 24, 2007: After this referral was received, DHS concluded that the following risk factors likely existed in N.L.'s and her brother's household: physical abuse of N. L.'s brother; teenage mother; two young children; and that the perpetrator of the physical abuse of N.L.'s brother was the live-in-boyfriend of N.L.'s mother.

Assessment 002 found reasonable cause to believe that third-party physical abuse had occurred, and DHS created a written safety plan for N.L. and her brother. DHS policy requires a safety plan when the agency determines that abuse or neglect occurred, unless DHS determines that with appropriate supports and continued DHS involvement, the risk of future abuse or neglect is minimized. In this case, however, DHS did not open a child welfare case. N.L.'s, maternal grandmother signed the safety plan as the parent/guardian of N.L.'s teenage mother. DHS had previously received CPS referrals concerning this grandmother. The prior referrals included allegations that N.L.'s grandmother had not adequately protected her teenage daughter -- the mother of N.L.

Closed at Screening 001: A caller reported information she had heard from another party. The information reported was that the mother was in a “bad crowd” and the mother’s boyfriend “beat them all up.” DHS closed this referral at screening, citing no identifying information regarding the boyfriend and no report of injuries.

Cross-systems information sharing: In CPS assessments 001 and 002, as well as Closed at Screening 001, Child Welfare and Self Sufficiency workers viewed some information about the family from each other’s programs to gain a larger picture of the DHS involvement with this family, but their access was limited. Because some means of communication have not been institutionalized and current technology does not support Self Sufficiency staff viewing pertinent Child Welfare Screens, there are gaps in information sharing.

Recommendations:

Recommendation 1, made in the April 11, 2008, report: The CPS manager should immediately issue instructions to the field offices reinforcing DHS’s existing policy requiring a CPS case to be opened whenever a CPS safety plan is adopted.

Audit points set forth in the April 11, 2008, report: Beginning May 1, 2008, the DHS auditors should sample CPS safety plans in new cases that were closed at the completion of the assessment. These audits should take place on a quarterly basis to determine the degree of compliance with DHS policy requiring every such plan to be accompanied by an open case. The first audit should be completed by July 1, 2008. Auditors should report their quarterly findings to the DHS director and CPS manager.

Progress/Status to date: The auditors reviewed 50 CPS cases opened during the period after the CPS manager notified the field that there should be no safety plan on closed cases. The auditors found five closed cases that still had safety plans. The audit report concludes that confusion remains in the field about what constitutes a safety plan and what constitutes a letter of understanding. It also questions the current policy that requires written notice to families only when the CPS allegation is founded. Cases in which the disposition is “unfounded” or “unable to determine,” do not require written notice. The report recommends that all such notices be written, and entered on a standardized form.

Action Steps still required:

1. In order to clarify the difference between a safety plan and a letter of understanding for the field staff, the CPS manager will revise and clarify the policy and procedure guiding the development of a safety plan. The CPS unit will develop a standardized letter of understanding to be sent to families at the termination of a founded case that will not remain open for services. This letter will be included in policy and procedures.

These tasks will be completed by September 15, 2008. When the revised policy is implemented, the CPS manager will instruct the field staff to stop using any locally developed notification forms. This will ensure consistency.

Sixty days after these policies go into effect; the auditors will conduct a second audit to ensure that workers are no longer keeping open safety plans on closed cases.

2. The CPS manager will revise policy and procedure to instruct Child Welfare field staff to send written notice at the completion of all CPS assessments. This will include all dispositions, whether founded, unfounded or unable to determine. To assist the field with this new requirement, the CPS unit will develop a form letter that can be mailed automatically when the assessment is completed. The CPS manager will provide a draft of the form letter to district managers and Child Welfare managers for their input. Once the form is approved, training will be provided at the supervisors' quarterly meetings and by CPS consultants as they conduct regular branch visits. This will be completed by November 15, 2008.

Recommendation 2, made in the April 11, 2008, report: Relating to Assessment 002, the CPS manager should evaluate whether safety assessors use and have access to sufficient information (such as prior CPS referrals and background or criminal records) to fully assess an individual's suitability to serve as a safety service provider to assure compliance and implementation of the safety plan. If safety assessors do not currently have access to such information, the manager should work with the Oregon Department of Justice (DOJ) to identify and attempt to overcome any legal barriers to providing such information to assessors. If safety assessors currently have access to such information, but do not regularly use it, the manager should clearly communicate the expectation that assessors will use all the information relevant to assessing the proposed safety service provider's suitability to protect the child.

Audit points set forth in the April 11, 2008, report: The CPS manager's evaluation determined that safety assessors do have access to appropriate systems including the Oregon Judicial Information Network (OJIN); Family and Child Information System (FACIS); and Law Enforcement Data System (LEDS) as allowed by law. In addition to reminding safety assessors about accessing this information, the CPS manager will meet with the Child Welfare program managers to determine if there is a need for clearer direction and/or policy clarification regarding when background checks on safety service providers are expected.

Progress/status to date:

In June 2008, CPS manager met with all of the Child Welfare program managers at their regular meeting. He discussed the need for clearer direction and policy clarification regarding background checks for safety service providers. The Child Welfare program managers indicated the current language provides sufficient guidance. Policy revision is not needed.

On August 8, 2008, the CPS manager provided an information memo (IM) to all safety assessors and their supervisors reminding them of the above-named systems, and the expectation that the systems will be used to assist in safety assessments of safety service providers as per the Oregon Safety Model.

These steps complete action required on these two audit points.

Action steps still required:

To ensure consistency in this practice, the CPS program manager and the CPS consultants will lead a practice forum on background checks for safety service providers at the next quarterly supervisors' meeting. This will be completed by October 1, 2008.

New Audit point: Practice forum for safety service providers to be completed by October 1, 2008.

Recommendation 3, made in the April 11, 2008, report: The CIRT should continue its examination of the circumstances surrounding CPS Assessment 001, including staff interviews, with completion by May 11, 2008.

Audit points: N/A

Progress/status to date: Staff interviews were completed the week of April 17, 2008. The CIRT team met April 23, 2008, to hear the update. The interviewers reported that the staff kept the referral open for 60 days, confirmed that services were in place and being attended, and consulted with the district attorney (DA) and law enforcement. Therefore, the decision to not open a referral on the child neglect followed DHS policy and was within appropriate decision-making. However, the CIRT team expressed concerns that even though the DA was not pressing charges regarding the underage sexual relationship between N.L.'s parents, DHS did not conduct a safety assessment regarding N.L.'s mother as a "child at risk" herself.

Action steps still required: N/A

Recommendation 4, made in the April 11, 2008, report: The CIRT should continue its examination of the circumstances and decision-making involved in the Closed at Screening referral 001, including staff interviews, with completion by May 11, 2008.

Audit points set forth in the April 11, 2008, report: The CPS manager should poll CPS supervisors across the state to determine their interpretation of the screening rules regarding impending danger. On completion of this work, the CPS manager will report the findings to the DHS director and present a subsequent plan. This will occur on or before June 30, 2008.

Progress/status to date:

Staff interviews were completed the week of April 17, 2008, and the CIRT team met April 23, 2008. Staff was asked what it would have taken for them to have opened an assessment. Staff and their supervisor stated they would have opened an assessment if the report had been more specific than "mother's boyfriend" and if they had been given a name. The CIRT team concurred that, given that two other men in N.L.'s mother's life had injured her children, it didn't matter what the name of the alleged perpetrator was, because there was documented history that more than one man in the mother's life had injured her children.

In August, 2008 The CPS manager conducted a poll of CPS managers across the state to determine their interpretation of the screening rules as they relate to the need for a name to open an assessment. A majority of the supervisors agreed that a protective services worker should have been assigned to assess the safety of the children in this case. A minority agreed that without a name, a worker should not have been assigned.

Action steps still required: CPS manager and program consultants will conduct a practice forum and provide direction at the next scheduled supervisors' quarterly meeting, which is expected to be held in October 2008. Because of the timing of this meeting, the CPS manager will send an e-mail to all CPS supervisors advising of the results of the poll, and providing clarity that, any time a report indicates the potential for impending abuse, a worker should be assigned to conduct a CPS assessment.

New Audit points: Practice forum to be held in October, 2008.

Recommendation 5, made in the April 11, 2008, report: Program administration staff in Child Welfare and Self-Sufficiency should work with DOJ to identify and attempt to overcome any legal barriers to providing information between Child Welfare and Self-Sufficiency staff when serving mutual clients. Additionally, program administration staff in Child Welfare and Self-Sufficiency should work with the Office of Information Systems and FACIS to address and overcome barriers in technology that prevent sharing pertinent information.

Audit points set forth in the April 11, 2008, report: The administrators reported on their initial findings prior to May 30, 2008. They should submit an action plan with time frames to the DHS director by June 15, 2008.

Progress/status to date: The two administrators have met and have reviewed information from staff interviews. They have confirmed that staff lack access to appropriate technology and do not have a consistent understanding of confidentiality, particularly regarding what can and should be shared between Child Welfare and Self-Sufficiency workers when they serve the same clients. A workgroup consisting of Child Welfare field and central office staff, Self-Sufficiency field and central office staff, and DOJ has been established and met in June 2008. This workgroup will outline the parameters of the problem and develop action steps to reduce or eliminate barriers and create a consistent process. This project will be ongoing.

An action plan was submitted to the DHS director June 15, 2008. It is attached.

Action steps still required: The group will continue to meet until it has an implementation plan. This plan should be submitted to the DHS director by September 30, 2008.

New Audit points: Implementation plan to be submitted by September 30, 2008.

Purpose of the critical incident reports

Critical incident reports are to be used as tools by DHS and the public to improve the department's accountability to the families and public it serves in order to keep children safe and thriving.

The Critical Incident Review Team assesses department actions when there are incidents of serious injury or death involving a child who has had contact with the department. The reviews are launched by the DHS director to quickly analyze DHS actions relating to each child, and are posted on the DHS website. Coinciding with the reviews, actions are implemented based on the recommended improvements.

The ultimate purpose of this process 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.