

CRITICAL INCIDENT RESPONSE TEAM REPORT

S.I.

March 1, 2012

Executive Summary

On November 5, 2011, four-year-old S.I. was brought to the hospital by his stepfather with serious physical injuries. He died as a result of those injuries on November 7, 2011. The stepfather later admitted to law enforcement that he was responsible for inflicting the injuries to S.I. He was charged with two counts of Murder by Abuse.

On November 8, 2011, Erinn Kelley-Siel, DHS Director, declared a Critical Incident Response Team (CIRT) regarding the incident involving this child.

The Oregon Department of Human Services (DHS) received four child protective service reports on the family prior to the fatality in November, 2011. The most recent report and assessment were in August, 2011. Because this child had been the subject of a child protective services assessment by the Department within the 12 months preceding the fatality, and this death was likely the result of abuse or neglect, it meets the statutory requirement for a mandatory CIRT.

Anytime 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, with the goal of making Oregon's children safer. The CIRT team's efforts to identify issues are a critical component of agency accountability and improvement when tragedies like this occur.

The CIRT team identified the lack of clarity and standardization of the elements of a comprehensive assessment as the systemic issue in this case.

Summary of Reported Incident

It was reported that four year old S.I. had been hospitalized as a result of injuries sustained on November 5, 2011, and passed away as a result of those injuries on November 7, 2011. The stepfather was charged with two counts of Murder by Abuse.

On November 8, 2011, Erinn Kelley-Siel, the Director of DHS, declared a CIRT because this child had been the subject of a child protective services assessment by the Department within the 12 months preceding the fatality, and this death was likely the result of abuse or neglect.

reported to medical staff about the cause of the injury to S.I.'s leg. In addition, the reporter stated the child had said his stepfather hits him. According to the reporter, two weeks prior, S.I. was seen with injuries to his neck. When asked, the mother stated that he was in the bathtub and fell. Four weeks before, S.I. allegedly had a bruise to his forehead and the explanation was he fell off the stairs and landed on the concrete. A year before, he reportedly had broken his arm after falling off a slide.

The reporter had an additional concern that the mother did everything the stepfather told her to do, which the reporter said was unlike her.

The Department appropriately identified the allegations of threat of harm, physical abuse and neglect. The response time was also appropriately assigned with an Immediate Response. The CIRT team decided this appeared to have been an appropriate screening decision

The referral was assigned for assessment on 03/01/11, and the Department responded on this same date, which was appropriate given the response timeline. The worker was accompanied by law enforcement at the time of initial contact with the parents. When they arrived at the home, the stepfather had been sleeping and both children were in the living room. The mother was reported to be at work. While the stepfather went back to the bedroom to clean up, the worker spoke with S.I., who responded in one word answers. He was noted to be three years old and verbal, but not able to hold a full conversation.

The stepfather explained he was in the apartment watching out the patio door while S.I. was riding in his toy car, but did not actually see S.I. get hurt, just that he went outside and S.I. was crying. He stated S.I. was still in the toy car. According to the stepfather, when he tried to get S.I. to come inside, he began crying more and wanted to keep playing; so he thought S.I. was fine. The stepfather reported he told his wife when she arrived home. The following day, they noticed that S.I.'s leg was swollen, so they took him to the hospital.

The worker inquired if S.I. had recently gotten hurt in the bathtub and stepfather said he thought S.I. fell awhile ago in the bath, but he wasn't really hurt. The worker next inquired about S.I.'s broken arm. Stepfather said that he was at the playground and jumped off the slide but that was a while ago too.

A collateral phone call was made to a doctor at a child abuse evaluation center. The doctor advised she had records from both the fractured arm and leg and indicated both were common in children this age and the injuries themselves are not necessarily concerning. Reporter noted when the child was injured in April 2010, the parents

waited three days to bring him in; and with the leg injury, and they waited one day. There was no documentation indicating that the CPS worker requested or reviewed the medical records from the hospital emergency room or from the child abuse evaluation center.

The CPS disposition was Unfounded for child abuse or neglect. The review team continued to have unanswered questions including: 1) whether the parents were questioned about the differing reports of the cause of S.I.'s injury; 2) whether the physicians were advised of the varying descriptions of how the child was injured; and 3) whether the lack of supervision of S.I. at the time of the injury and in previous reports, including the Closed at Screening report from February 24, 2011 and again in Referral 001, were ever addressed with the parents. Additional information gathered from these questions may have provided a different picture of what was happening within this family.

CASE RECORD REVIEW

It should be noted this information was not in the Department's record at the time of this assessment; however, the CIRT team requested a review of the case record following the critical incident. It provides a chronology of events in S.I.'s life.

Records from the Hospital Emergency Room (ER) obtained following the critical incident indicated S.I. was seen at the ER on 03/21/11 (6 days following the closing of Referral 001) for arm pain. Although there was no new fracture diagnosed, the injury was in exactly the same location as his previous buckle fracture (left arm) from a year prior. The mother had no explanation as to how the injury occurred. S.I.'s leg cast had just been removed a few days prior. The treating physician expressed concern that this child had a previous arm fracture, a leg fracture from motor vehicle accident, and now a second arm injury, although the explanation for the other injuries seemed reasonable.

About one month later on 04/24/11, S.I. was again seen at the ER for an injury to his left arm. He was reportedly playing soccer with the stepfather and got his feet tangled up with the soccer ball and fell over. Doctor's notes indicated he was aware of S.I.'s recent right knee fracture and noted the parents were concerned about bony fragility. There was no mention of the ER visit/injury from 03/21/11. It is possible, if the medical provider had reviewed the ER report from 03/21/11, including the previous physician's documented concern, this report of a second injury to the left arm may have been sufficient to prompt a call to the Child Abuse Hotline.

Referral 002:	Date:	08/23/11
	Allegations:	Physical Abuse, Threat of harm
	Response:	Immediate
	Disposition:	Unfounded

The Department received a report by an anonymous caller that S.I. had marks on his back caused by his stepfather spanking him with a belt for smashing his sister's fingers. The reporter observed S.I. on Sunday (2 days prior to the report) and indicated the injury to be red and about five inches. S.I.'s mother was reported to have said that the stepfather spanked him with a belt after he shut his sister's fingers in a drawer.

The allegations of physical abuse and threat of harm were appropriately identified based on the report. The response time was also appropriately assigned with an Immediate Response. The CIRT team decided this appeared to have been an appropriate screening decision.

The report was referred for assessment on 08/23/11. The worker, accompanied by law enforcement, attempted contact within the 24 hour timeline required for an Immediate Response. The family was not home; that same afternoon, the mother contacted the Department and an appointment was scheduled at the family's home for the following morning. When the family was visited, there was still a mark on S.I.'s back. The worker described S.I.'s injury as a line down his back that appeared to be in the final stages of healing. It looked like a scratch that had healed and no other injuries were noted.

All family members were present at the home. S.I. was interviewed alone in his bedroom by two CPS workers. However, S.I. was not able to give any details surrounding the mark on his back other than it was caused by a toy car. S.I.'s 11 month-old sibling was observed and described as happy and smiling.

Following the interview with S.I., the workers spoke to the mother and stepfather. They indicated they weren't exactly sure when the injury happened. The mother reported that she did not see it happen. The worker informed the mother that S.I. was pretty clear that the injury happened from his car as well. However, it was noted that the interview details were quite limited regarding S.I.

Further discussion occurred with the parents about their work schedules and means of discipline. They stated the younger sibling didn't really need discipline, just re-direction; and with S.I., they usually took things away or didn't let him go to his

appropriately assigned for Immediate Response. The CIRT team decided this appeared to have been an appropriate screening decision. S.I. died on November 7, 2011 due to the injuries sustained.

Issues Identified

In March 2007, the Department of Human Services, Child Welfare implemented the Oregon Safety Model (OSM). The OSM is designed to assist caseworkers in more precisely assessing and managing child safety at all stages of case management, from receiving reports of child abuse and neglect through the closing of a case. The OSM moves workers from incident-based assessments to a model requiring a more comprehensive assessment. Making a determination of child safety requires the caseworker to take into account child vulnerabilities, the willingness and ability of the parent to protect the child, and all identified safety threats. A safety threat is defined as family behavior, conditions or circumstances that could result in harm to a child.

In this case, it is unclear whether collateral contacts were made. Collateral contacts can assist in gathering sufficient information to adequately assess a child protective services referral. The CIRT team identified the lack of understanding by the field workers of what actually constitutes a comprehensive assessment as a systemic issue.

Recommendations

After reviewing the facts and circumstances surrounding this incident and the family's previous contact with the Department, the CIRT team recommends that the CPS Unit review the Procedure Manual to determine whether elements of a comprehensive assessment could be further clarified so that workers and supervisors understand what is expected in a comprehensive assessment. In addition, the CIRT team recommends that the CPS unit consider whether additional training of caseworkers and supervisors regarding the elements of a comprehensive assessment could lead to greater standardization of how CPS assessments are completed and conducted.

In addition to the above recommendations, because of the importance of a comprehensive assessment to the Oregon Safety Model, additional efforts will be made to address this systemic issue.

A review of past CIRT reports, since the implementation of the Oregon Safety Model, indicates 7 of 14 CIRT reports have identified the lack of a comprehensive assessment as a systemic factor in the cases. It is unclear that efforts to date to address this issue have been successful. Given the prevalence of this finding, a more

global evaluation of the factors constituting the incomplete assessments is needed. A workgroup has been formed to address the following:

1. What constitutes a comprehensive assessment?
2. Given what a worker discovers when contact with the family is made, do the elements of a comprehensive assessment change?
3. What barriers are there and to what degree do they impact a worker's ability to complete a comprehensive assessment?
4. What are the concrete actions that are recommended to address this issue?

The workgroup will identify what resources are needed for them to complete this assignment and report back to the Director of Child Welfare and the Chief Operating Officer for Child Welfare and Self Sufficiency by September 30, 2012.

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 Department 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 members.

The primary 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.