

CRITICAL INCIDENT RESPONSE TEAM 30 DAY AND FINAL REPORT

December 4, 2009

Executive Summary

On January 4, 2009 two-year-old L.P. died as a result of multiple serious physical injuries, including injuries to his head and back, which were consistent with abuse. The Oregon Department of Human Services (DHS) had received three referrals on the family prior to the report about the fatal injuries: one for threat of harm, one for physical abuse and one for neglect.

The recommendations in this Critical Incident Response Team (CIRT) report focus on the Department's work to ensure that when assessing a report of child abuse or neglect, that assessment focus not just on the incident that was reported and who caused it, but more broadly look at the conditions overall that could impact the safety of a child or children in a home.

Comprehensive safety assessments are foundational to the Oregon Safety Model, and do represent a shift from previous, incident-based assessment practice. This CIRT report makes clear that Child Protective Services staff need ongoing training to the policy expectation that assessments be comprehensive.

Summary of Reported Incident

On January 2, 2009, two-year-old L.P. was hospitalized after presenting with multiple serious physical injuries which were consistent with abuse. The Department of Human Services and law enforcement responded to assess and investigate for possible physical abuse and criminal activity. L.P. died at the hospital on January 4, 2009, as a result of these injuries.

On January 5, 2009, DHS Director Dr. Bruce Goldberg ordered that a CIRT be convened. This is the 30 day and final report of the CIRT team.

Background

Including the referral at the time of L.P.'s fatal injuries, DHS received and responded to a total of four CPS referrals about the family. For the purposes of this CIRT report, the first referral is designated as CPS assessment 001, the second referral as CPS assessment 002, the third referral as CPS

assessment 003 and the fourth referral, related to L.P.'s death, as CPS assessment 004.

CPS Assessment 001, allegation type - Threat of Harm; received November 29, 2005.

The caller in this referral was concerned about the welfare of L.P.'s siblings because of the mother's concerning behaviors. On November 28, 2005 L.P.'s mother brought her 8 month-old child (L.P.'s sibling) to the hospital and reported that the child had stopped breathing. Her story regarding the length of time the child was not breathing was inconsistent, changing from two minutes to 30 seconds as she explained what happened. L.P.'s mother eventually abandoned the story that the child had stopped breathing, saying instead the child had a seizure. The caller indicated that the child was admitted to the hospital overnight as a precautionary measure. The caller expressed concern about potential mental health issues with mother, as well as bonding issues, between the mother and child. The caller reported that the mother left the child in the hospital overnight and did not return until the following day, at which time the child was released to his mother.

As part of the screening process, the screener made a collateral contact to gather additional information about the mother's current situation. The person the screener spoke with had information that L.P.'s mother may be using methamphetamine. The collateral contact expressed concern that L.P.'s mother could have psychotic break that would result in a tragic outcome and that some type of DHS involvement or intervention was needed.

This referral was assigned as an up to 5-day response for a CPS Assessment for Threat of Harm related to potential drug use and concerns about the mother's mental health issues. The same day that 001 was assigned to a CPS worker; the call about CPS Assessment 002 was received and assigned as an immediate response. The CPS worker kept both assessments open and completed assessments on each report.

CPS Assessment 002, allegation type – Threat of Harm; received November 29, 2005.

The caller in CPS Assessment 002 was concerned for the same sibling mentioned in CPS Assessment 001. The caller reported that L.P.'s mother and sibling were passengers in a vehicle that was stopped by police. The

driver and L.P.'s mother were both arrested, and the sibling was placed into protective custody. L.P.'s mother was arrested for Possession of a Controlled Substance (PCS-meth) and Endangering the Welfare of a Minor.

An out-of-home ongoing safety plan was developed, the child continued in protective custody and multiple services were provided to the family. On August 16, 2006, L.P.'s sibling was returned to the physical care of the mother who was engaged in services at the time. L.P. was born on September 18, 2006 and remained in the custody of his parents. Services were offered to the family during this time and up to the point that the case was closed on August 20, 2007. CPS Assessments 001 and 002 were both determined to be founded for Threat of Harm.

CPS Assessment 003, allegation type – Neglect; received December 20, 2008.

The caller in this referral reported that L.P. had a bruise on his face near his eyes, which was reportedly caused by L.P.'s nearly 4 year-old sibling. L.P. was 2 years old when the call was received. The caller reported that L.P. has a 2 ½ month old sister who has also been hit by the oldest brother. As part of the screening process the screener gathered collateral information that indicated L.P.'s older sibling had been seen being aggressive toward L.P. This referral was assigned as an Immediate Response for a CPS Assessment as an allegation of neglect.

During the assessment, the CPS worker saw L.P. and documented that L.P. had two black eyes, and significant bruising on his left cheek. The worker also documented bruising and swelling across the bridge of L.P.'s nose. The CPS worker gathered information that L.P.'s older brother was likely the cause of the injuries to his face. The CPS worker learned that L.P. had seen a physician two days earlier, but it was not clear if the bruises were present at that time. The CPS worker documented that they also observed the baby had no bruises or marks. The CPS worker documented that the mother had addressed her son's violent behaviors and had a plan to prevent them from occurring in the future. Law enforcement was present with the worker during the initial contact with L.P., his mother, and the younger sibling. The CPS worker and law enforcement also contacted L.P.'s older sibling at school, and he admitted he hit L.P. with a book. He also admitted to hitting L.P. with the door causing the injuries to L.P.'s face. CPS Assessment 003 was closed with an unfounded disposition, meaning there was no indication of abuse or neglect.

CPS Assessment 004; received January 2, 2009. This was a call regarding L.P. who was brought to the hospital after it was reported by his mother that he suffered from a seizure. LP was critically injured, unconscious and unresponsive and had bruising on various parts of his body, including his head and back. At the time of the report L.P. displayed symptoms of a subdural hematoma, swelling in his brain, broken bones and other injuries. L.P. died in the hospital on January 4, 2009. During the assessment L.P.'s mother admitted to physically abusing L.P. CPS Assessment 004 was founded for physical abuse.

Systemic Issues Identified

Issue: Collateral contacts and interviewing fathers during a CPS assessment. In CPS assessment 003 the CPS worker did not follow up on information provided by L.P.'s mother to confirm it was true. For example, the worker learned that L.P. was seen by a physician two days before the worker contacted the family; however, there was no documentation that the worker contacted the doctor. L.P.'s mother indicated she contacted a local mental health provider to schedule an appointment for L.P.'s sibling, but there was no documentation that the mother followed through with that appointment. After learning that the mother had community service, the CPS worker did not document any attempts to learn why the mother had community service. Finally, there was no documentation in CPS assessment 003 that the CPS worker interviewed L.P.'s father.

A CPS worker's responsibility to make face to face contact with and interview legal parents and make collateral contacts is outlined in *Oregon Administrative Rule (OAR) 413-015-0415 thru 413-015-0420*.

Issue: CPS Assessment 003 was an incident-based assessment and focused only on the bruising to L.P. and how the bruising was caused. Based on the documentation gathered by the CPS worker L.P.'s injuries appeared to be caused by his brother. Once it was determined that the injuries were caused by L.P.'s brother the assessment was basically concluded. It was never clear if L.P.'s injuries were ever seen by a physician. Due to the severity and location of the injuries, as well as L.P.'s young age, the injuries should have been seen by a physician.

There was also extensive information known to the agency about L.P.'s mother prior to CPS Assessment 003. There was no documentation that any

historical information related to the parent's functioning was considered in determining the safety of L.P. or his siblings. The assessment included no information about parenting or disciplinary practices which is mandatory when conducting comprehensive safety assessments.

Recommendation

Over two years ago, DHS Child Welfare implemented the Oregon Safety Model (OSM). One of the fundamental concepts of the safety model is that the CPS worker will conduct a comprehensive safety assessment to determine child safety, as opposed to incident-based assessments which focus almost exclusively on whether or not an incident of child abuse or neglect occurred and who is responsible. Whether a specific incident of abuse occurred or not may have very little to do with the overall safety of a child or other children in the home.

Members of the CIRT Team identified the need for additional, targeted training to the issue of comprehensive assessment for CPS staff and supervisors.

ACTION - Starting in May 2009 and concluding in October 2009, Oregon Safety Model trainers (in conjunction with CPS Program Consultants) provided enhanced training, mentoring and coaching to child welfare supervisors throughout the state. The training specifically focused on supervision as it relates to the OSM and gathering comprehensive, safety related information during assessments.

On October 26, 2009, the CAF Director and Child Welfare leadership de-briefed with the OSM Trainers about the enhanced training outcomes. In that de-briefing, it was clear that on-going training, policy and practice review is needed with respect to this issue.

Currently, leadership across the Child Welfare and Field management structure are identifying quality assurance teams to provide analysis and technical support to field offices with a specific emphasis on the comprehensiveness of CPS assessments and completing assessments within timelines. A plan will be developed by January 2010.

ACTION - The CPS Program in January 2009 developed a review tool for Consultants and supervisors that encompasses the components of the OSM that are specific to the CPS assessment. The review tool also focuses on

decision-making and information gathering from the time a report is received throughout the assessment process.

Beginning in February 2009, the CPS Program began conducting reviews of CPS cases in branches throughout the state using this new review tool. A statistically significant number of cases will be reviewed from each office. At the conclusion of each branch review, a report is generated and the information is then presented during a meeting between the CPS Program Manager, the branch's CPS consultant and the leadership of the local branch. If needed, a training plan is developed to address practice issues discovered through the review process.

Currently, the CPS Program has reviewed cases in 5 CW branches in the State. Two of the branches have received a formal report and a meeting has been conducted.

Audit Points

None

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.