CRITICAL INCIDENT RESPONSE TEAM INITIAL REPORT
G.J.

December 13, 2016

Executive Summary:

On April 28, 2016, the Oregon Department of Human Services (DHS) was notified that a child, G.J.[1], had been hospitalized and died. At the time, the exact cause of death had not been determined. G.J. was in the care and custody of the Department at the time of her death and was placed in a Department certified foster home due to her parents' inability to safely provide care for she and her siblings.

A Child Protective Services (CPS) assessment was assigned to determine if the fatality was the result of child abuse or neglect and if threat of harm applied to the remaining children in the foster home. Concurrently, the cause of death was under law enforcement investigation. On June 8, 2016, as the assessment and investigation were proceeding, DHS Director Clyde Saiki declared a discretionary CIRT be convened to examine the circumstances that led up to the fatality of this child. This is not a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024[2]. A discretionary CIRT may be convened in the case of suspected child abuse or neglect incident where a child has suffered severe harm or death and a review process is likely to impact system change in a manner that increases child safety.

On June 9, 2016, the initial CIRT meeting was held and comprehensive case file reviews were initiated regarding Department history leading up to the child's placement in foster care through the fatality. Because the fatality was regarding a child in foster care, the Department's approach to this Critical Incident Response Team included assigning additional reviews to assess the Department's practice and service delivery throughout this case. Accordingly, case file reviews of the Child Protective Services (CPS) history, certification file reviews of the providers the child resided with, as well as a review of ongoing case management activities were completed.

The Department received the preliminary autopsy report on June 22, 2016. The autopsy report, along with supplemental resource material, including CPS history and medical records, were forwarded to the local Designated

Medical Provider (DMP) for review. The DMP did not find medical neglect on the part of the foster parents, rather indicated "it is my opinion, based on information reviewed to date, that a tragic confluence of circumstances occurred that resulted in the [G.J.'s] death."

G.J.'s cause of death is listed as Complications of Bowel Obstruction and Ischemia. The law enforcement investigation is still pending at the time of publication of this report.

On June 30, 2016 and July 5, 2016, the team met to examine the information contained in the case file reviews. The team raised questions and requested additional information to assist in identifying systemic issues that may have given rise to the incident. On November 28, 2016, the CIRT met a fourth time and identified potential systemic issues regarding the Department's practice and service delivery on this case. Potential systemic issues were assigned to corresponding program areas in order to determine validity and develop actionable methods to address identified concerns. Once systemic issues have been identified and recommendations have been made to address these concerns, an additional report will be published. The CIRT will reconvene in four to six months to ensure necessary system improvements have been made.

Any time a child known to the Department 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 in order to keep Oregon's children safer. The Critical Incident Response Team's (CIRT) efforts to identify issues are an important component of agency accountability and improvement when tragedies like this occur. In addition to the CIRT, but in a separate process, the Department will address any necessary personnel actions[3].

This is the initial report of the CIRT and is issued as an activity report and status update.

Summary of Reported Incident and Background:

Department history with G.J.'s mother dates back to September 2001, when the first report to the child abuse hotline was received involving her as a caregiver[4]. The Department has been contacted twenty eight times

regarding G.J.'s family, prior to the child's entrance into foster care. Of the reports, fourteen were closed at screening, thirteen were assigned for Child Protective Services (CPS) assessment, and one was assigned at the request of G.J.'s mother in order to provide preventative services.

On September 6, 2001, DHS received the first report regarding G.J.'s family. The report alleged G.J.'s mother to be a victim of domestic violence by G.J.'s father. G.J.'s father was arrested and charged with Assault IV and interference with making a police report. As a result, a no contact order was issued against G.J.'s father. According to the report, the mother sustained significant injuries requiring medical attention due to multiple incidents of violence occurring over several days. The report was assigned for CPS assessment with a timeline for response within five days. The CPS worker documented G.J.'s mother as minimizing the domestic violence and admitting only to injuries described to law enforcement by witnesses. She further denied the child was present at the time of the incident.

Documentation delineates the mother was requesting the no contact order with G.J.'s father be vacated, however the worker described a network of family support and the mother's ability to verbalize an understanding of domestic violence and the impact on children in the decision to close the case. The assessment was coded as unable to determine for threat of harm and mental injury, as it was not clear if the child was present at the time the violence occurred. The assessment documented that a voluntary case would be opened in order to provide parenting classes for the mother.

On October 31, 2001, G.J.'s mother contacted the Department to request services that had been discussed in the September 6, 2001 assessment. Although the case was closed, it should have been opened and services provided. Documentation in the case file indicates the case was reopened to provide services, however a closing narrative dated January 16, 2002 indicates the case was closed again, on this occasion due to non-compliance on the part of G.J.'s mother.

On February 7, 2003, DHS received a report alleging threat of harm of G.J. The report alleged substance abuse by G.J.'s mother and father and indicated drug paraphernalia was kept in the home within the child's reach. The report was initially assigned with a timeline for response within five days; however, it was closed with no assessment completed. The decision

was documented as not meeting guidelines for assignment as the caller did not provide information that the child had access to any illicit substances or paraphernalia at the time of the report.

On August 19, 2003, DHS received a report alleging negligent treatment of G.J. The caller stated G.J. has suffered from recurrent head lice and the child's mother had failed to take appropriate steps to rectify the concern. The caller reported having seen "finger type marks" on the child's throat a week earlier. When the caller inquired about the marks the child mentioned having been choked, however reportedly changed the subject, providing no additional detail, nor additional disclosures. The caller reported substance abuse by G.J.'s mother, adding drugs were kept within reach of the child. The caller alleged having observed drugs and paraphernalia in the home approximately two months prior. This report was closed at screening. The screening decision narrative indicated the caller had not reported a safety threat that warranted CPS intervention. The information reported constituted an allegation of physical abuse and would have more appropriately been assigned for CPS assessment. The report involved a very young and vulnerable child who reportedly had abuse related injuries.

On May 25, 2004, DHS received a report of possible abuse of G.J. The child had been examined and interviewed at the local Child Abuse Intervention Center due to vague concerns of abuse, however made no disclosures and the physical exam was normal. This report was closed at screening.

On July 22, 2004, DHS received a call in which the reporter admitted to having used unspecified drugs with G.J.'s mother. The caller denied the child was present at the time, however expressed concern regarding ongoing substance abuse by G.J.'s mother. The caller reported the mother was engaged in a sexual relationship with her own father and suspected G.J. was the result of this relationship. The caller had no evidence of this allegation, nor had they witnessed any sexual interaction, however believed the child resembled the grandfather. This report was closed at screening.

On August 12, 2004, DHS received a report that G.J. was present during a physical altercation between the child's grandfather and another relative. The reporter alleged substance abuse by the grandfather as well as historical sexual abuse of G.J.'s mother. The report was assigned for CPS

assessment with a timeline for response within five days. The worker documented that the relative denied any physical injuries resulting from the altercation with G.J.'s grandfather. The worker attempted to make face-to-face contact with G.J. and the mother, however was unsuccessful. The worker was able to speak with G.J.'s mother by telephone. G.J.'s mother admitted G.J. was present during the altercation, however made no disclosures regarding abuse by her own father. The assessment was coded as unable to determine. The basis for the decision documented that G.J.'s mother did not make any disclosures of abuse; it was unclear where the child was at the time of the physical altercation, and no information had been provided demonstrating the child was at risk of harm.

On October 15, 2005, DHS received a report that G.J. and the mother were residing in a family shelter where the mother admitted to using methamphetamine. This report was initially assigned for assessment with a timeline for response within five days. However, no safety concerns were reported by the caller regarding the mother's substance abuse. The caller was also unable to demonstrate how the mother's drug use impacted her ability to provide care for her child. The referral was closed indicating there was no allegation of abuse or neglect.

On January 23, 2007, DHS received a call of concern indicating G.J. had observed the mother engaging in sexual activity with men. The screening narrative documents a collateral contact to the community correction officer who had recently been in the home. No safety concerns or health hazards were noted and it was reported the mother was in compliance with all conditions of probation. At this time, the Department learned G.J.'s mother had recently given birth and the infant appeared to be healthy and well nourished. The report was closed at screening noting the report did not constitute an allegation of abuse.

On February 20, 2008, DHS received a report alleging G.J.'s mother was using methamphetamine. The caller indicated the mother was also frequenting drinking establishments, leaving the child with unknown caretakers. This report was closed at screening, citing no current safety threats, as the "information was assessed in the closed at screening on January 23, 2007." It is noteworthy that the previous screening report was received by the Department over one year prior to this call.

On April 19, 2010, DHS received a call of concern regarding G.J. having significant absences from school. The report stated that one week prior, G.J. had also expressed concern regarding her parents. According to the reporting party, the child disclosed the mother was four months pregnant. The screener documented no current allegations of abuse or neglect and the report was closed at screening.

On October 4, 2010, DHS received a report that G.J.'s mother had given birth to her third child and both mother and child tested positive for opiates. According to the caller, the mother had a current prescription accounting for the results and the report was closed at screening.

On December 10, 2010, DHS received a report alleging G.J.'s mother was examined at a medical facility and was complaining of pain. The caller indicated the mother had a history of substance abuse and drug seeking behaviors. According to the caller, G.J.'s mother indicated she had fallen down steps in the home while "playing around" with her boyfriend. It was noted the mother could barely stay awake. She initially denied any use of medication however later admitted to having used prescription medication. Additionally, the mother indicated she did not feel safe at home and requested information regarding shelters, however later recanted. This report was assigned for assessment with a timeline for response within twenty-four hours.

While the CPS worker was attempting to make initial contact with the family, law enforcement called and reported they were at the residence and had detained G.J.'s mother and her boyfriend, the father of G.J.'s sibling. Law enforcement located drug paraphernalia, unknown pills, methamphetamine residue and a baby bottle that had been converted into a methamphetamine smoking device in the home. Prior to the CPS worker's arrival, the mother contacted a relative and requested they provide care for the children. The mother and her boyfriend admitted to substance abuse and both were arrested due to outstanding warrants. A protective action plan was implemented allowing the children to stay with the relative selected by the mother. The mother was released shortly thereafter. She informed the CPS worker that she would be entering substance abuse treatment and that she had arranged for the children to continue to reside with family during that time.

G.J. was interviewed and disclosed locating drug paraphernalia in the home as well domestic violence between the mother and the mother's boyfriend, including information contrary to what had been previously reported. The Department discovered the boyfriend had prior founded CPS history, stemming from an incident in 2003 in which he was criminally charged and incarcerated. The boyfriend had completed services related to the 2003 incident while incarcerated, however not all required services related to the crime. During the assessment, the boyfriend admitted to being the primary caretaker for the children at the time of the current incident. According to documentation in the file, the worker informed him that completion of additional services would be required prior to having unsupervised contact with the children. The CPS worker interviewed the boyfriend while in jail, and indicated he would remain incarcerated for approximately one month due to a parole violation.

This assessment appears to have been the first time the Department received information regarding G.J. suffering from medical issues. When the worker inquired about G.J.'s school attendance, the mother indicated the child had "stomach problems" which prevented G.J. from attending school regularly.

The assessment was coded with dispositions of founded for threat of harm, neglect against the mother and her boyfriend and founded for threat of harm, domestic violence against the boyfriend. The safety decision concluded the children were safe as the mother informed the Department that she developed a plan for the children while she engaged in substance abuse treatment. There is a lack of information documented as to how this decision was made and how more formal intervention was not necessary. There was nothing prohibiting the mother or the boyfriend from retrieving the children as the relatives did not have an established legal relationship. While DHS informed the boyfriend he was required to complete additional services prior to having unsupervised contact with the children, the Department did not have the authority to enforce this as the case was closed out at assessment. Based on information documented in the CPS assessment, safety threats appear to have been present at the time of case closure. The Department should have opened a case for safety planning and ongoing case management. Both parents continued to exhibit a pattern of impulsive behaviors, which included active drug addictions and violence in the home. Additionally, the CPS worker missed an opportunity

to gather information from collateral sources that had been identified throughout the assessment process.

On December 14, 2010, DHS received a call of concern indicating G.J. disclosed regularly hearing the child's "parents" fighting, along with throwing and breaking objects. The caller stated G.J. expressed feeling scared and described taking the younger siblings into another room when the parents begin fighting. The caller also expressed concern regarding G.J.'s school attendance. This report was closed at screening, documenting no information was provided that the child witnessed physical violence or had attempted to intervene during verbal altercations. The previous assessment remained open at the time this call was received. The screening decision notes the report was forwarded to the assigned CPS worker. There is no documentation that the CPS worker made any collateral calls in reference to the information reported during the assessment. It would have been appropriate to contact the child's school to gather additional information.

On February 7, 2011, DHS received a report that G.J.'s mother had recently moved into a local shelter however intended to leave the shelter and had failed to remediate concerns identified in the previous assessment. The caller reported that the mother had arranged for the youngest child to be placed with a relative who was using drugs and as a result, the child was moved to a family friend. The reporting party conveyed concerns regarding the needs and wellbeing of the two older children. The caller also stated the youngest child appeared to display symptoms associated with in utero drug exposure and that G.J.'s mother had admitted to substance abuse while pregnant. A second call was received, alleging G.J.'s mother had been asked to leave the shelter due to receiving information confirming drug use. This report was closed at screening, indicating the children were safe and no information was reported that the mother posed a threat to the children. The caller was advised to contact law enforcement if the mother attempted to pick up the children while under the influence.

On April 12, 2012, DHS received a report indicating G.J.'s mother was incarcerated, that the child's father was unstable and had access to the child. The caller indicated the children were residing with the mother's live in boyfriend, the father of the youngest child. The screening narrative also

documents “alleged sexual abuse” to G.J. and the child’s younger sibling by paternal relatives. This report was closed at screening, documenting the children were safe with relatives and the mother’s boyfriend. While the screening report briefly documents previous Department history, there is no indication that these records were reviewed when making the screening decision.

On April 15, 2012, DHS received an additional report alleging threat of harm of G.J. by the child’s father and neglect by the mother. Law enforcement indicated the father of G.J. had requested assistance in picking up his children. The officer indicated the mother was incarcerated and the father appeared to be unstable. The officer reported concerns for worker safety and suggested Department personnel use caution during interactions with the father. This report indicated the children were with the mother’s boyfriend (the youngest child’s father). This report was assigned with a timeline for response within twenty-four hours. The CPS worker made several collateral calls and learned the mother had made arrangements for two relatives and her boyfriend to provide care for the children. The worker documented speaking with the mother who provided history and context regarding G.J.’s father and the father’s family. The mother informed the CPS worker that G.J. was sexually abused by a relative of the father’s several years prior. She stated law enforcement investigated and no criminal charges were filed. She indicated she did not allow the children to have contact with the relative as a result. The report was closed through collateral contacts, documenting there was no allegation of abuse or neglect. This decision was inconsistent with rule, which required a comprehensive assessment be completed.

On March 21, 2013, DHS received a report alleging G.J.’s mother was using drugs while caring for the children, engaging in illegal activity and that the conditions of the home were unsanitary. This report was received from a caller who had not witnessed either the home or the mother using substances, rather had been contacted and provided this information by an individual who was reportedly delusional and threatening. This report was closed at screening.

On October 4, 2013, DHS received a report alleging G.J.’s mother and grandmother have failed to send G.J. to school and have changed the child’s name to “avoid authorities.” The reporter stated the child was not

born in a hospital and is an “unregistered child.” The caller indicated the mother was in a treatment facility and the two oldest children were being cared for by their grandmother and the youngest child by the child’s father. Further, the reporter provided vague information that G.J.’s mother, grandmother and grandfather have a history of substance abuse. This report was closed at screening.

On April 17, 2014, DHS received a call of concern stating G.J.’s mother was pregnant and admitted to using heroin while parenting her youngest child. The caller indicated the two older children continued to reside with relatives. The mother reportedly requested a prescription to manage pain however, this request was denied. This report was assigned for CPS assessment with a response time of within five days.

The mother reported entering treatment in January of 2014, however disclosed continued use of prescription pain medications and to obtaining these from multiple sources. G.J.’s mother reported she was discharged from treatment in March 2014 as a result. At the time of the call, G.J. and the middle sibling were reportedly residing with relatives. The mother reported to the Department that she was visiting her children regularly and again articulated her intention to begin treatment and resume providing care for the children by the end of the summer. The assessment concluded with an unfounded disposition, documenting that while G.J.’s mother admitted to using prescription opiates while pregnant, there was no evidence that use impaired her ability to safely care for the youngest child. The disposition documentation further states the mother reported that she would be entering treatment and that she was in compliance with probation requirements. While the worker contacted the mother’s probation officer, no additional collateral contacts were made. Additional collateral contacts may have assisted in providing a more thorough understanding of this family.

On May 28, 2014, DHS received a report alleging the mother was pregnant, caring for her youngest child, and continuing to seek prescription pain medication at multiple medical facilities. This report was closed at screening. The screening decision indicated “there is no information that [the mother’s youngest child] or the unborn baby are at risk at this time. It is also documented that alert letters had been sent to local hospitals and birthing centers.

On June 18, 2014, DHS received a report alleging domestic violence in the family home, ongoing substance abuse by G.J.'s mother and negligent treatment of the youngest child. At the time of this report, it appears G.J. and the middle sibling continued to reside with relatives. This report was assigned for CPS assessment with a timeline for response within twenty-four hours. The CPS worker was notified that a warrant had been issued for the arrest of G.J.'s mother due to noncompliance with conditions of her probation. Upon contact with the Department, the mother stated she had developed a plan to ensure safety of the youngest child by arranging for the child to reside with the father and grandparents. Contact was made with the grandparents who confirmed this information. Both G.J.'s mother and her boyfriend denied any form of domestic violence was occurring in the home. No further exploration of this was documented, despite information domestic violence had been an ongoing issue in their relationship for years. The mother was arrested for absconding and violating conditions of parole. The CPS worker made contact with the mother while in custody and the mother admitted using prescription pain medications. Documentation indicates the child was observed on only one occasion while sleeping. No interview was conducted, which may have offered important information to assist with the child safety decision. The assessment concluded with an unfounded disposition, indicating the mother had made a safety plan for her child. This assessment was incident based and lacked pertinent information regarding child safety and family functioning. It is unclear if the CPS worker was able to gather sufficient information to understand how continued patterns of behaviors by the parents may have contributed to the ongoing physical and emotional safety of the children.

On July 15, 2014, DHS received a call of concern indicating the mother of G.J. had reported the child's father grabbed her while she was attempting to board public transportation with the youngest child. According to the caller, G.J.'s father grabbed the child; however, the mother pulled the child away and successfully eluded him. The caller noted concern regarding the mother's appearance and suspicion she may be using drugs, however was unable to substantiate these concerns. The caller indicated the mother presented as protective of the child and this report was closed at screening.

On August 8, 2014, DHS received a report alleging neglect of G.J.'s sibling. The caller stated that G.J. and the sibling had been residing with relatives

in a guardianship for the previous two years. While visiting the children in the home of the relative, the mother left with the children and failed to return. The caller cited specific concerns regarding the mother's inability to provide care for G.J.'s sibling. The report further alleged the mother had the youngest child in her care and was allowing contact with her boyfriend, the child's father. The caller provided additional information regarding the mother's living situation including she was pregnant and experiencing homelessness. According to the report, the relative contacted local police to assist in enforcing the guardianship agreement, however no record of the guardianship was located in the court system and the mother was allowed to take the children. At the time this report was received, the Department had begun implementation of Differential Response in several counties throughout Oregon[5]. This report was assigned for alternative response with a timeline of within twenty-four hours.

Contact was made with G.J.'s mother, who was residing in transitional housing with both of G.J.'s younger siblings. From case file documentation it appears the mother did not take G.J. when she left the relative's home, rather only the younger sibling. G.J. remained with relatives throughout the assessment however, it is unclear if the child chose to stay with the relatives or if the mother only chose to abscond with the sibling. A collateral contact was made to a relevant provider who had no concern regarding the mother's ability to provide care for the child.

An additional report was received on September 2, 2014, and surrounded the birth of the mother's fourth child. The report stated the mother tested positive for substances she was not prescribed and the child required observation due to exhibiting symptoms of prenatal drug exposure. This report was assigned for assessment on the alternative track for response within five days. This report was appropriately linked to the August 8, 2014 assessment.

The CPS worker documented discussing concerns with the mother involving her history of substance abuse. The mother admitted to substance abuse throughout her pregnancy up until the birth of the child. While the child demonstrated symptoms of withdrawal, the worker noted the child had not been identified as having any specific medical issues. The CPS worker concluded the mother "has the basic parenting knowledge to meet the care needs of her children when not under the influence of

substances." The worker further noted the mother had historically made suitable family plans for her children when she was unable to provide them with safe and appropriate care. The assessment was closed as a Moderate to High Needs case in order to provide services to the mother[6].

G.J. continued to reside with relatives throughout the course of this assessment. The relative reported G.J. was in counseling and prescribed medication for mental health. The relative indicated G.J. was doing well in school and happy. Additionally, it was reported that G.J. preferred living with the relatives due to the stability it allowed and rarely visited with the mother. The CPS worker documented that the mother disclosed that the relative caring for G.J. was using methamphetamine; however, the relative's spouse did not. G.J.'s mother reportedly believed the home remained safe for G.J. and that the relatives were meeting the child's needs.

There were several areas of concern noted in this assessment. Specifically, G.J.'s mother admitted to using methamphetamine, heroin and pain medication and that she had failed to engage in treatment services as recommended. The mother also clearly expressed a desire to have the younger children's father play an active caregiving role in their lives, despite his history of perpetrating domestic violence. The assessment was closed, documenting the children were safe. Based on the mother's pattern of continued impulsive behavior including drug seeking behavior and ongoing drug use throughout her pregnancy, a safety plan should have been developed to manage and ensure the safety of the children.

Additionally, the CPS worker failed to interview G.J. during the course of the assessment, noting the child did not reside with the mother and that no concerns had been reported regarding the child. G.J.'s mother disclosed that the relative providing care for G.J. was using methamphetamine. There was no documentation of further discussion, no call to the child abuse hotline and no assessment conducted regarding this concern or its potential impact on G.J. Additional collateral contacts regarding all children would have been beneficial in providing a greater understanding of family functioning.

On February 11, 2015, DHS received a call of concern regarding G.J. health and wellbeing. According to the report, G.J. was residing with the

mother and siblings and was overwhelmed due to the chaotic circumstances in the home. The caller stated that G.J. had expressed suicidal ideation. The report further alleged ongoing domestic violence between the mother and her boyfriend, the father of the two youngest children, often resulting in law enforcement being contacted. The screening report documented the case remained open as a Moderate to High Needs case at the time this call was received and services were being provided to the family. The report was assigned for response within five days, on the alternative track. G.J. was interviewed and denied current suicidal ideation or current domestic violence in the home. The Department facilitated evaluation and follow up services to ensure the G.J.'s mental health needs were being met. The CPS worker notes concerns regarding G.J.'s mental health as significant, however concluded a physician discharged the child to the mother's care, an intake for counseling had been scheduled and a safety plan implemented. The assessment was coded as unfounded based on one documented contact the CPS worker had with the family. The Department received an additional report regarding this family on March 5, 2015. However, it does not appear any ongoing assessment of the family was being conducted prior to the new report coming to the attention of the Department. This is concerning based on significant deterioration of G.J.'s mental health and the mother's ongoing diminished parental capacities. The March 5, 2015 report was not linked to this assessment, which is inconsistent with rule.

On March 5, 2015, DHS received a report that while intoxicated, the mother had driven to the hospital with three of her children in the vehicle. She reported having slipped and fallen, which resulted in breaking her arm. According to medical staff the mother appeared to be intoxicated which was confirmed by blood alcohol testing. Law enforcement responded to the hospital and the mother was arrested for DUII. This report was assigned for traditional CPS assessment with a timeline for response within twenty-four hours, however an after-hours worker responded immediately. The mother disclosed consuming a substantial amount of alcohol and requested the CPS worker contact a relative in order to facilitate a family plan allowing the relative to provide care for the children while she was detained. The relative agreed to provide care for the two eldest children per the mother's request. The Department implemented a protective action plan allowing the two youngest children to reside with their father under the supervision of the paternal grandparents. This plan was implemented

despite information provided by the grandparents confirming their son was experiencing difficulties with methamphetamine, alcohol, and lack of motivation for employment.

During the assessment process, the CPS worker documented concerns regarding G.J.'s mental health and indicated the child was experiencing medical issues, similar to reports received in the past. The worker indicated believing G.J.'s medical issue were a result of stress. The worker documents requesting medical records as well as gathering school attendance records. G.J. was noted to have excessive absences from school.

On March 6, 2015, the Department learned the mother's arm had been broken by her boyfriend, rather than accidentally as she had reported. Consequently, the protective action plan concerning the two youngest children was determined no longer viable. After the mother disclosed this information, the Department implemented a new safety plan, documented as an initial safety plan. The initial safety plan delineated the father was not permitted to "take his children anywhere without the supervision of his parents." The initial safety plan outlined additional restrictions requiring the father to leave the home if he became aggressive or was using drugs. The father was arrested on March 7, 2015 due to the violence he perpetrated on the children's mother.

On March 18, 2015, the Department filed petitions with the juvenile court requesting custody of the children. Three of the children were placed in substitute care with the relative who had previously cared for the older children and the youngest child was placed in non-relative care. It is unclear from documentation as to why the relatives were unable to care for the youngest child; however, it is believed to be due to the child experiencing behavioral issues. The assessment documents that the father attended the court hearing appearing to be "under the influence" and presented as hostile. Jurisdiction was later established on May 13, 2015.

Collateral contacts provided additional information concerning G.J.'s mental health and well-being. The assessment resulted in a founded disposition against the mother and her boyfriend for neglect regarding all four children.

The youngest child was placed with G.J.'s mother on a trial reunification in May 2015; the second youngest sibling was placed with her in July 2015. The two eldest children continued to reside with relatives in substitute care. The conditions of the in-home plan stipulated there was to be no contact between the mother and her children with her boyfriend. The plan also stated there was to be no substance use in the home. The case plan included the older siblings having overnight visits with their mother on weekends.

On September 8, 2015, the Department received information that G.J.'s mother had violated the in-home plan by allowing her boyfriend to be in the home while the two oldest children were visiting. The report further indicated the children disclosed the mother had coerced them into shoplifting food, cosmetics and other items. This report was assigned for CPS assessment with a timeline for response within five days. The ongoing caseworker was made aware of this disclosure and law enforcement was contacted to conduct a child welfare check. The mother was arrested due to outstanding warrants and the two youngest children were removed from the trial reunification and were placed in non-relative foster care.

During the CPS assessment, G.J. and the sibling confirmed their mother forced them to commit theft on multiple occasions while on weekend visits. The youngest two children residing in the home were reported to be present during these occasions, with the second youngest participating in the theft. G.J. and the younger sibling described the home as not having enough food and lacking basic necessities due to their mother purchasing illegal prescription drugs rather than food. The children were able to provide detailed information regarding the person the mother purchased prescriptions from and specified she was purchasing "Vicodin, methadone and oxycodone." G.J. and the sibling expressed fear, sadness and shame regarding these occurrences and G.J. described physical symptoms such as feeling "shaky" and light headed."

The children disclosed the mother was allowing her boyfriend to frequent the home while they were visiting, despite having expressed "extreme fear" of him. G.J.'s mother admitted to having the children commit theft in addition to allowing her boyfriend contact with the children.

In the process of this assessment, the Department learned G.J.'s mother had failed to engage in additional services as recommended. The assessment was coded as founded for neglect.

Certification Summary and Background:

- ***Relative foster care provider***:

Certification summary:

G.J. and the child's siblings were removed from their mother on March 5, 2015 and placed with maternal relatives on a protective action plan. The family was issued a temporary certificate to provide foster care for the children on March 16, 2015, and received a full child-specific Certificate of Approval on October 12, 2015. Concerns had been identified from the certification questionnaires completed by the relatives, however were evaluated and mitigated prior to full approval. Some of the issues were fully or partially addressed in the home study; others failed to show depth of evaluation and mitigation per the SAFE assessment process[7]. The Department has previously identified this as an area where staff need additional training, support and attention. In 2016, the Consortium for Children provided technical assistance and training to certifiers and certification supervisors statewide. Much of the technical assistance training focused on the mitigation and evaluation process, emphasizing the need for outside sources to confirm information, providing additional SAFE tools to enhance practice, and to emphasize the supervisor's role in practicing this assessment model to fidelity.

While the youngest two siblings were returned to their mother on trial reunifications, G.J. and one sibling remained in substitute care with the relative until their removal from the home on March 18, 2016 due to allegations of abuse by the provider.

The mother resided in and received ongoing case management in a different county than where the relative provider resided. The county where the relative resided assigned a courtesy worker to provide ongoing case management for the children. Certification of the relative provider, as well as the out of home care CPS assessment, were conducted by the county where the provider resided. It is important to note this distinction

due to concerns regarding lack of communication between the counties and the failure to convey critical information.

CPS History:

Since 1996, the Department was contacted five times regarding the relative provider of G.J. prior to the report that led to the removal of G.J. and the sibling with placement in non-relative substitute care. Of the five reports, three were closed at screening and two were assigned for CPS assessment. Of the two reports assigned for assessment, neither was founded for nor indicative of child abuse or neglect. In 2004, a CPS assessment regarding the family concluded with an unable to determine disposition. This disposition required and received a management exception by the certification supervisor in order to proceed with the certification process. The Department received one report regarding this family alleging child abuse or neglect of G.J. and the child's sibling while they were providing foster care for the children.

On March 10, 2016, the Department received a report alleging negligent treatment of relative foster children in the home. According to the report, the relative provider and the provider's spouse were using methamphetamine[8]. The report alleged the children were present while the provider was purchasing methamphetamine. The caller stated the provider has a history of substance abuse and until recently was able to meet the children's needs. The screener documents contacting the ongoing worker who had been suspicious of drug use by the providers, indicating multiple sources had reported concerns regarding drug use. The screening narrative indicated the ongoing worker had been unable to confirm these suspicions and there was not enough information to warrant an investigation. The screening narrative notes the certifier was aware of the ongoing worker's suspicions yet had not been to the home since September 2015[9]. The report was assigned for CPS assessment with a timeline for response within twenty-four hours.

During the course of the assessment, both the provider and spouse denied using methamphetamine or any other illicit substances. On March 18, 2016, the Department obtained collateral information confirming drug use by the provider. G.J. and the sibling were removed from the home and placed in non-relative foster care with their two younger siblings. The

ongoing caseworker submitted a referral to certify another relative of the children.

Following the removal, the provider admitted to taking pills containing methamphetamine and Percocet since September of 2015. The Department made extensive efforts to maintain the children in placement with the spouse; however, this was unable to occur. According to assessment documentation, the spouse denied any knowledge the provider was using drugs and did not believe the provider had or would use drugs, believing the lab had made a mistake. Furthermore, the spouse did not believe drug use impacted the provider's ability to safely care for the children and was unable to recognize the provider's use as a risk to the children. G.J. and the sibling made no disclosures around substance abuse, nor did they describe any abnormal behavior by the provider or spouse.

Upon removal from the home, the provider gathered G.J.'s medication. The CPS worker documented inquiring about specific instructions on administering the medications. The provider was reported as stating that G.J. knew how to take the medication, which was instructed on the prescription labelling. No medication logs were provided to the worker. The spouse indicated G.J. experienced medical issues in the past, which resulted in an emergency room visit. The spouse denied this was a current concern regarding G.J., stating it occurred when the child experienced stress. The spouse also denied the child was experiencing suicidal ideation and reported an antidepressant as the only medication G.J. was taking. Medical records obtained following G.J.'s death, indicate a physician had examined the child in February 2016 due to gastrointestinal issues. According to the records, G.J. shared significant anxiety around the possibility of undergoing a medical procedure similar to one received in the past to address the condition. The physician prescribed a protocol including medication, an abdominal x-ray two weeks later, and follow up with the primary care physician. It is unclear if and when this information was shared with the Department; however the medical records do not reflect these actions taking place as directed.

After removal of children from the provider, G.J.'s mother notified the Department that as a preteen she located methamphetamine in the home of the relative provider. She also disclosed having previously used

methamphetamine with the provider. The CPS worker noted speaking with collateral contacts who advised the worker they had reported substance abuse by the provider to the child abuse hotline. Documentation in the case file demonstrates times where the Department had knowledge of substance abuse by the provider; however, the allegation was not assessed prior to this report.

This assessment concluded with a founded disposition for neglect against the provider and an unfounded disposition against the spouse. The provider agreed to seek counseling and complete an assessment for substance abuse treatment.

The case file review revealed inaccurate information had been used to support the safety decision. The file review concludes that while it was evident the provider was using methamphetamine, there was no specific, describable information regarding the provider's behavior and how the substance abuse impacted the children.

On March 24, 2016, the Department made a decision to move towards revocation of the Certificate of Approval; however, the certified relative caregivers submitted a written request to voluntarily terminate their Certificate of Approval on June 17, 2016.

The providers requested that the Department review the founded disposition. While the reported concerns rose to the level that the children could no longer be maintained in the home, on August 26, 2016 a committee overturned the founded disposition. Although the disposition was changed to unfounded for neglect, the circumstances surrounding the assessment included confirmation of substance abuse in the home. While the Department could not establish a nexus that the drug use had negatively impacted the children, drug use in a foster home is inconsistent with requirements of Department certified providers.

There appears to have been a breakdown in communication between the ongoing caseworker and the certifier. At the time the home study of the provider was conducted, the certifier did not appear to have any concerns regarding self-reported past substance abuse negatively impacting parenting. Concerns about current use appear to have been brought to the attention of the certifier on August 20, 2015; several months after the

ongoing caseworker began receiving information about these concerns. The certifier conducted further assessment of these concerns and was unable to locate information corroborating the concerns or demonstrating the children were unsafe. The family was approved and issued a full Certificate of Approval. Critical information was not shared with the certifier in a timely manner potentially impacting the certifier's ability to complete the provider home study, monitor certification compliance, and in confirming child safety during home visits.

Within the past year, approximately, the Department has implemented a Certification Staffing and Well-Being Staffing Protocol across the state. This protocol assisted in enhancing and creating a more consistent process for discussing and documenting concerns with certified families. Branches that had not previously conducted similar staffings have been attending to this practice.

- ***Department certified foster home***:

Upon removal from the relative provider on March 18, 2016, G.J. and the child's sibling were placed in the same Department certified foster home where their younger siblings were residing.

Certification summary:

This family initially applied for certification to provide foster care as general applicants. Prior to completion of their full SAFE home study, a request was made for placement of two specific children and they were issued a temporary certificate on February 27, 2015[10]. On August 20, 2015, the family was issued a full Certificate of Approval to provide general foster care for capacity of three children, ages 0-5. The certificate was updated to increase capacity to four children on November 2, 2015 when G.J.'s two youngest siblings were placed in the home. Oregon Administrative Rule requires the Department to obtain child abuse history background checks for every adult member of the household from each state where the individual resided in the five years preceding the application prior to issuance of a full Certificate of Approval. While there is documentation of a request made to another state where the provider resided, it is unclear if this information was received. Other policy requirements appear to have

been met regarding certification of this family. The Department had no prior CPS contact with the family.

On March 18, 2016, G.J. and her sibling were placed in this home with their younger siblings "on an emergency basis," per documentation by the certifier. The Certificate of Approval was updated to increase capacity to six children in the home, for ages 0-20 accordingly. Documentation indicates the Department was seeking an alternative placement for the children.

On April 28, 2016, the Department was notified that while on a visit with a relative, G.J. had been taken to the doctor and later admitted to the hospital due to internal distress. Prior to this visit, the Department had initiated emergency certification of this relative. According to the screening report, G.J. suffered from severe gastrointestinal issues and had been experiencing complications for approximately six days, resulting in the child's hospitalization. While undergoing a medical procedure, G.J.'s system failed. G.J.'s condition was so acute that physicians could not save the child. G.J. died later that day.

The screener documents gathering additional information including that G.J. was taking medication for depression and on March 1, 2016 had been prescribed medication due to gastrointestinal complaints. The screener documented that although the medication was newly prescribed, "Historical records already in the system seem to indicate this was not a new issue for [G.J.]." Further, the screening report states that upon placement with the provider the CPS worker did not provide any direction regarding dosage or administration of the medication. According to the screening narrative, the foster parent had asked G.J. about the medication. G.J. reportedly described taking the medication as needed and denied requiring assistance with administration. The medication was refilled during the child's placement with the provider. The provider indicated G.J. had a stomachache, however declined to see a physician on more than one occasion. Prior to visiting with the relative on April 26, 2016, G.J. was described as staying mostly in her bedroom due to not feeling well. To complicate matters, the provider reported having been ill and suffering from influenza, and attributed G.J.'s behaviors to possibly having the flu.

The assessment documents the provider having noted G.J. experiencing depression; however, the symptoms were attributed to grief associated with having been removed from the relative placement. The CPS worker documented concern that the removal had an emotional impact on G.J. that could potentially affect the child's physical health. The assessment further documents G.J.'s depression worsening and the worker's belief that the child may be more successful if placed with a relative.

According to the assessment, multiple sources indicate that when the children were removed the relative provider placed the children's medications in a plastic bag and handed them to the CPS worker, stating the children were responsible for their medication and take them regularly. When placing the children with the non-relative provider, the CPS worker told the provider the children take the medication as needed. The providers were not given any information regarding why the medication was prescribed or how to they were administered. The CPS worker was unable to provide the family with DHS Placement Information forms, however the ongoing worker initialed that she provided these to the family on April 6, 2016. G.J.'s placement form listed depression under behavior considerations, and indicated the child was taking an antidepressant medication. While there were no pending appointments listed, it was noted G.J. "needs lab work done." No further explanation was provided. The form is notable for its lack of reference to any gastrointestinal issues.

The assessment documents the provider believing the child was taking the medication as they would see the "daily pill tray get filled up and then emptied." The providers reportedly purchased additional over the counter laxative medication for G.J. when the supply provided by the relative provider was exhausted. No medication logs were completed for G.J. while the child was residing in the home. The providers indicated they were unaware they were required to distribute the medication and track it on medication logs. The ongoing caseworker later indicated they were unaware G.J. had been prescribed medication for gastrointestinal issues, as the relatives had been providing care and supervision of the children.

The assessment revealed that G.J. suffered from embarrassment due to gastrointestinal problems and went to great lengths to avoid intrusive medical treatment. G.J.'s younger sibling indicated G.J. began feeling ill the week prior to the child's death, particularly in the three days prior to

visiting with the relative. The sibling confirmed attempts made by the provider to have G.J. examined by a physician as well as G.J.'s refusals. The sibling described that G.J. hid the medical condition from the provider due to fear of requiring intrusive medical treatment and trauma associated with previous treatment. The sibling believed G.J. had taken medication for gastrointestinal symptoms during this time.

The Designated Medical Provider (DMP) reviewed the case postmortem and concluded that no adult in the home could have predicted or prevented the fatality, as they were not provided adequate information regarding G.J.'s medical and mental health history, how these concerns intersect, and how significant stress made the child vulnerable to severe complications. While the provider attempted to monitor medication and seek intervention, the child was resistant. The assessment concluded with an unfounded disposition for Neglect of G.J.

CIRT Activity Report and Status Update:

Pursuant to CIRT protocol, the CIRT team has met four times regarding this case. At the first meeting, the team reviewed preliminary information and identified issues of interest in the case. Subsequently, extensive file reviews of DHS records were conducted, the results were presented 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.

Identification of Systemic Issues:

The events and circumstances surrounding the Department's practice and service delivery regarding this case have raised significant concerns requiring further exploration. The CIRT is concerned about the Department's ability to recruit and retain child welfare staff as well as the limited number of appropriate foster care placements. It is unclear how these factors may have influenced this case; however, these concerns have significantly impacted child welfare agencies nationwide. The Department is making concerted efforts to address the foster care shortage

in order to increase capacity and oversight. However, regarding staffing levels, it may be beneficial for the Department to conduct a workload study of child welfare staff. Rather than requesting a snapshot of day-to-day activities conducted by workers, the study should utilize Department procedure and rule to determine all requirements of workers, per family and per child. This study may assist in gaining a full understanding of expectations placed on Department staff and the estimated time to complete these duties.

This impact of this fatality on Department staff was widespread and evident. The Department recognizes how trauma exposure and secondary traumatic stress affect staff, which can in turn influence case practice and decision-making. While there are resources available to staff, the Department will continue to make efforts to address this concern by revitalizing trauma response teams that have been initiated in the past and exploring additional ways to manage vicarious trauma.

It is crucial that the Department utilize quality assurance measures and consider efforts that have been successful in recognizing risk factors that contribute to child fatalities nationwide. On March 17, 2106, the Commission to Eliminate Child Abuse and Neglect Fatalities released their final report containing recommendations regarding innovative efforts and strategies to reduce and prevent death of children due to abuse or neglect.[11]

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 review of this critical incident and others has identified the following concerns regarding the Department's practice and service delivery in certain key areas:

1. Consistency regarding the regular use and submission of medication logs for children placed in the care and custody of the Department as required by Oregon Administrative Rule.

2. Sharing complete medical information with foster care providers in order to meet the ongoing medical and mental health needs of children placed in their care.

3. Determining whether it is appropriate to rely on foster parents to share necessary information with medical and mental health providers regarding children placed in their care; and in turn, to communicate information regarding appointments, outcomes and recommendations with the Department.

4. Clarifying the roles and responsibilities of caseworkers and other Department staff when courtesy supervision agreements are in place between branches.

5. Adherence to certification policy when placing children in the custody of the Department with relative providers.

6. Requirements regarding the number of times a certifier must have face-to-face contact with providers and children when certifying a child specific placement.

7. Need to clarify whether the Department should conduct CPS screening and assessment, review and address certification violations, or both when allegations of abuse or neglect in a foster home are received.

8. Consistently conducting comprehensive assessments pursuant to the Oregon Safety Model. Comprehensiveness of assessments has been identified as a systemic issue in previous CIRTs. The Department has made extensive efforts to address this concern, however high caseloads and lack of additional resources create a real barrier to completing comprehensive assessments in every case. Rather than identifying an overarching concern regarding comprehensive assessments, the following elements of the Oregon Safety Model require further analysis:

    - Allowing families to make plans to manage the safety of their children in order to avoid Department intervention, without thorough assessment of the sustainability of the plan.

    - Fully assessing ongoing domestic violence in the home.

- Ensuring only accurate information is used in determining impending danger safety threats in both Traditional and Alternative Response Assessments.

9. Need to request and review comprehensive medical records of children placed in the custody of the Department and the need for caseworkers and foster parents to seek input when attempting to interpret diagnostic information and understand the full impact of ongoing medical and mental health needs for children in their care.

Purpose of Critical Incident Response Team Reports[12]:

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 Department web site. Actions are implemented based on the recommendations of the CIRT.

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.

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[1] The child will be referred to by the child's initials in order to maintain confidentiality for the child and the child's family.

[2] Oregon Revised Statute 419B.024 can be located at http://www.oregonlaws.org/ors/419B.024

[3] It is not the function or purpose of a CIRT to recommend personnel action against Department employees or other individuals. Nor does the CIRT hear points of view of represented staff.

[4] The family composition includes the following participants, who will be referred to as the following throughout this CIRT report:

- G.J.'s mother
- G.J.'s father
- G.J. siblings: The mother has had a total of four children, G.J. being the eldest. G.J. and the immediately younger sibling share the same father. The two youngest children were fathered by a man other than G.J.'s father.
- Mother's boyfriend: father of G.J.'s two youngest siblings

[5] The purpose for Differential Response can be located on the Department's website at http://www.dhs.state.or.us/policy/childwelfare/manual_1/i-ab412.pdf and http://www.oregon.gov/DHS/CHILDREN/DIFFERENTIAL-RESPONSE/Pages/index.aspx.

[6] Information of Moderate to High Needs cases can be located in the Oregon DHS Child Welfare Differential Response Procedure Manual at:

http://www.dhs.state.or.us/caf/safety_model/differential_response_pm/assessment/ch2-assessment-section14-dr.pdf.

[7] Information regarding the use of the Oregon SAFE home study can be retrieved at https://www.dhs.state.or.us/caf/safety_model/procedure_manual/ch07/ch7-section3.pdf

[8] Both the relative provider and spouse were certified to provide care for the children, however in order to differentiate between the couple this report will refer to them as the provider and spouse.

[9] Certification rule requires minimum visits by a certifier every 90 days while a temporary certificate is in effect. The certifier had not been in the home for approximately five months prior to the visit documented in August 2015.

[10] The specific children placed in the home have no relation to G.J. or the child's family.

[11] The Commission to Eliminate Child Abuse and Neglect Fatalities final report can be retrieved at http://www.cwla.org/wp-content/uploads/2016/03/CECANF_Final-Report_Embargo-until-3.17.16-1.pdf

[12] Given its limited purpose, a Critical Incident Response Team (CIRT) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CIRT review is generally limited to documents in the possession of or obtained by the Department. The CIRT is not intended to be an information gathering inquiry and does not include interviews of the child's parents and relatives, or of other individuals associated with the child. A CIRT is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of the child fatality.