CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT
K.A.

April 17, 2017

Executive Summary:

On March 30, 2015, the Department of Human Services (DHS) was notified that a child, K.A.,[1] was found deceased in the family home and the cause of death was under investigation.

On September 11, 2015, former Acting Department Director Jerry Waybrant declared a Critical Incident Response Team (CIRT) be convened, once it was determined that the child's death was the result of child abuse or neglect. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.[2]

On September 14, 2015, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On October 7, 2015, the team met a second time to discuss the case file review. The team raised questions and requested additional information to assist in identifying systemic issues that may have given rise to the incident.

On January 4, 2016, the CIRT met a third and final time in order to discuss the potential systemic issues in this case and made recommendations to address these concerns.

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 efforts to identify systemic 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]

The Department chose to delay publication of this CIRT report until the criminal charges regarding this case were resolved. Upon final review of this CIRT, Director Saiki requested additional analysis of this case in order to ensure all systemic issues were identified and appropriately addressed.

This is the initial and final report of the CIRT.

Summary of Reported Incident and Background:

Department history with K.A.'s mother dates back to 2013, when the child abuse hotline received the first report involving her as a caregiver. The Department was contacted twice regarding K.A.'s family, including notification of the fatality on March 30, 2015. Both reports were assigned for Child Protective Services (CPS) assessment.

On October 10, 2013, the Department received the first report regarding K.A.'s family. The report alleged ongoing domestic violence in the home that on different occasions had resulted in injuries sustained to K.A.'s mother. The reporting party indicated that the mother does not allow the father to spend time alone with the child due to an incident where he had shaken the child. The caller reported additional concerns regarding the mother's care and feeding of the child, indicating the child had not been examined by a physician in approximately six months, did not appear to have gained weight in that time and may be suffering from failure to thrive. The caller stated that the family was residing in a motel room due to a recent eviction and explained that the mother was four months pregnant and had two older children residing out of state with their father. The screener documented making a collateral contact to the child's physician. This report was assigned for CPS assessment with a timeline for response within twenty-four hours.

The CPS caseworker contacted the family at the motel where they were residing, noting the room appeared to be cluttered yet safe for the child. The mother confirmed she has two older children that reside with their father out of state. She revealed that she left their father due to violence in the home. The caseworker documented discussing the concerns regarding the child's weight with the family. The caseworker requested the family have the child examined by a physician.

The caseworker met separately with the mother and discussed domestic violence and the negative impact of violence on children. The mother admitted to ongoing violence in the home, including a recent incident that occurred in the motel room in which the father assaulted her while she was holding the child. However, the mother minimized the violence and justified the father's behavior. The mother reported feeling isolated since relocating to Oregon and informed the worker that she does not maintain contact with her family of origin. The caseworker then met separately with the father who admitted to having "anger issues" resulting in displaced aggression. The worker discussed participation in services designed to address these concerns and informed him that violence was not acceptable in the presence of the child.

The caseworker documented arranging for the child to see a physician as well as transportation to the appointment. The caseworker further documented confirming the appointment had occurred and consulting with the physician. The physician indicated both parents were amenable to receiving education regarding proper care of the child and were receptive to any suggestions made. The family was referred to community resources and a follow up appointment was scheduled. The caseworker documented requesting and receiving the child's medical records on October 17, 2013. It is unclear if the records were reviewed, if additional records were requested, or if any further contact with the physician occurred throughout the process of the assessment. In consultation with community partners involved in this case, the CIRT was informed that little to no background information regarding the mother's history was shared with the physician. It is unclear what information was shared, however the physician reached a conclusion based on information that these were first time parents who lacked education to provide for the child and has conveyed that a different opinion may have been rendered if all information regarding this family was known. Information regarding the mother having two children whom she was not parenting may have assisted in making a diagnosis and medical determination regarding the ability of these parents to provide care for the child.

On October 18, 2013, the caseworker met with the family who continued to reside at the motel. The caseworker documented that the child's condition had improved significantly within approximately three days. It is not clear from documentation in the CPS assessment how the worker ascertained

the child's condition had improved—if this was reported by the parents, if it was determined by visual observation, or if consultation with the child's physician had occurred yet not been documented. The caseworker noted that the motel room appeared to be "clean and safe with no visible safety threats." As the family expressed concern over finances, the Department provided financial assistance to remain in the motel for an additional week and provided supplies to assist in caring for the child.

According to case file documentation, the mother contacted the Department on October 22, 2013 and informed the caseworker that the father had assaulted her. She reported having asked him to leave the home yet he refused. The mother indicated she did not feel safe therefore the caseworker contacted law enforcement to conduct a child welfare check. The father was arrested for assaulting the mother in the presence of the child. There was no documentation of a report being made to the hotline regarding this incident however, the worker noted making contact with the mother and child at the motel three days later.

Regular contact was made with the mother and child through November 12, 2013. The caseworker noted the child appeared to have started gaining weight, look "much healthier," and was crawling. The mother informed the caseworker that she had not had contact with the father since the arrest.

The next documented contact with the family occurred on April 9, 2014 when the caseworker conducted a home visit after the family had relocated to a different county. At this time, the Department learned that the mother had given birth to K.A. The caseworker also discovered that the mother and father had reunited and he had returned to the family home. The conditions of the home were noted as unsanitary and below community standards. The caseworker advised the family to clean the home by April 11, 2014. The caseworker documented informing the family that if the home continued to "unsafe" the development of a new plan would be required. During the home visit, the mother informed the caseworker that the father had not been physically violent in approximately one month however had begun yelling at the children. The mother indicated she had not been sleeping well due to waking up throughout the night with K.A. She expressed fear that the father would yell at the children if she were to allow him to tend to their needs during the night. The father reported

attending services to address this concern and signed releases of information to contact providers.

On April 11, 2014, the caseworker returned to the home and described the conditions as clean with no evident safety threats. The caseworker discussed working cooperatively with the Department and the mother indicated she had previously worked voluntarily with child welfare in another state. The mother signed a voluntary services application in order to connect with community services and to receive assistance in ensuring the safety of her children. The caseworker documented informing the mother "about the need to protect the children" from the father.

The caseworker documented requesting out of state CPS records from the state where the mother had reported formerly working with child welfare. These records were located in the case file, however it is unclear whether the records were reviewed or considered during the process of conducting the assessment. As part of the CIRT process, the out of state records were reviewed and reveal a pattern and history of neglect including unsanitary living conditions and reports of domestic violence in the home. A risk assessment was conducted and the mother scored an overall high risk for abuse or neglect to occur. At the conclusion of the case, the mother had filed an affidavit requesting the court grant custody of the children to her parents. A review of out of state child welfare records may have provided greater understanding of family dynamics and resulted in more informed efforts surrounding practice on this case. There is no documentation of requesting records from the additional states the mother reported having lived in until after the fatality of K.A.

This assessment disposition was determined to be founded for neglect, lack of supervision and protection against both the mother and father due to the conditions of the home and the failure to meet the health needs of the child prior to Department intervention. The assessment was also founded for threat of harm, domestic violence against the father. At the conclusion of the assessment, the children were determined to be unsafe due to the father's violent behavior. However, there is no safety plan documented in the case file to ensure for the safety of the children. The case was opened and transferred to the county where the family was residing.

On April 16, 2014, the caseworker documented having received a call the day before from a service provider reporting concerns of violence in the home. There is additional documentation on April 16, 2014 of the receiving permanency caseworker and the CPS caseworker who completed the assessment conducting a joint home visit, despite the fact that the case did not formally transfer to the county where the family had relocated until April 17, 2014. The case note indicated that the mother reported the family was doing well and she and the father "had really been getting along lately." There is no documentation clarifying the circumstances reported by the provider, if the information reported constituted a new allegation of child abuse or neglect, or whether the concerns reported by the provider were addressed at the home visit.

The next face-to-face contact was documented on May 9, 2014. The caseworker noted the home was clean and that the children appeared healthy. The mother reported the father had been arrested due to domestic violence the day before and that she was petitioning the court for a restraining order. There is no documentation that the worker contacted law enforcement to gather information regarding the father's arrest.

An additional home visit was documented on June 18, 2014. The mother and children had moved in with the mother's new boyfriend, a neighbor with whom she had recently become involved. The mother reported she had not seen the children's father since his most recent arrest. The caseworker documented informing the mother the Department may be closing the case and that the children appeared to be healthy.

The voluntary services case was closed on July 24, 2014, citing reason for closure as the mother had ended her relationship with the father of the children and both children appeared to be healthy. It is unclear what services were offered to the family, if they participated in services, and how the safety threat had been mitigated.

On March 30, 2015, the Department received a report that law enforcement was in the family home investigating the fatality of K.A. under suspicious circumstances. The report was assigned for assessment with a timeline for response within twenty-four hours. At the time of the fatality, the mother had ended her relationship with the intimate partner she had been involved with at the close of the previous voluntary case and had a new boyfriend

who had been residing in the home and acting in a caregiving role to the children for approximately six months. Upon arrival at the home, the CPS caseworker made contact with law enforcement and learned the family reported placing both children to bed at approximately 8 p.m. the night before. The boyfriend reported feeding K.A. between 1 a.m. and 2 a.m. and the child was found unresponsive at approximately 11:45 a.m. K.A. had numerous bruises to the neck and face in varying stages of healing at the time of death that were indicative of having been inflicted by non-accidental means. The child was also described as displaying signs of ongoing, chronic neglect and the conditions of the home were reportedly deplorable, neither safe nor sanitary for young children.

A protective action plan was implemented in regards to K.A.'s surviving sibling allowing no unsupervised contact with the mother and new boyfriend. The child was placed into protective custody on April 9, 2015 with placement in substitute care.

The assessment disposition was determined to be founded for neglect of K.A. and K.A.'s sibling, founded for physical abuse of K.A., and founded for threat of harm of physical abuse of K.A.'s sibling. All founded dispositions were against both the mother and her boyfriend.

K.A.'s cause of death was listed as Sudden Unexplained Death of an Infant (SUDI), despite contradictions that the circumstances of the death did not fit criteria for a SUDI diagnosis due to conflicting information discovered during the criminal investigation. The District Attorney's Office consulted with two experts who indicated the death did not meet criteria for this diagnosis. A diagnosis for SUDI cannot be made if any suspicious findings are located at the crime scene or noted during the investigation. While the cause of death was listed as SUDI, due to the extensive injuries on the child as well as signs of neglect, homicide could not be excluded as a possible manner of death.

On December 18, 2015, a grand jury indicted the mother and her boyfriend on charges of murder by abuse, manslaughter in the first degree, manslaughter in the second degree, criminally negligent homicide, three counts of criminal mistreatment in the first degree and one count of criminal mistreatment in the second degree. Both the mother and boyfriend were arrested on December 28, 2015 and held in custody. On June 15, 2016,

the mother was allowed to enter guilty pleas to two felony counts of first degree criminal mistreatment, one for each child, and was sentenced to 180 days in jail and three years' supervised probation.

On October 3, 2016, the boyfriend entered Alford pleas to charges of criminally negligent homicide and two counts of first degree criminal mistreatment in connection with his involvement in the death of K.A. and mistreatment of the surviving sibling. He received credit for time served and was released from jail. He was sentenced to five years supervised probation. On December 16 2016, he was arrested for assaulting K.A.'s mother and charged with fourth-degree assault, harassment and strangulation. He was convicted of assault in the fourth degree. The arrest violated terms of his probation and as a result his probation was revoked. He was sentenced to 34 months in prison.

Identification of Systemic Issues:

The CIRT identified concerns in this case that required further information and analysis prior to determining if they were systemic issues or isolated to this case. A review of this critical incident and others has resulted in identifying the following concerns regarding the Department's practice and service delivery in certain key areas:

1. *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 significant 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 were noted on this case, require additional field support and will be regarded as systemic issues:

   - When it is appropriate to work cooperatively with families.
   - The need to request and review relevant records in order to make a determination of child safety.

- The need to provide relevant background information to professionals rendering opinions that impact child welfare decision making and intervention.
- Recognizing patterns of chronic neglect.
- The use of sufficient safety plans to manage child safety.
- Conducting monthly face-to-face contacts as required.
- The need to fully assess domestic violence in the home and to understand the dynamics of domestic violence and its impact on children. Additionally, while not identified as a systemic issue, the CIRT discussed the importance of child welfare staff utilizing a holistic framework in conceptualizing trauma in the context of domestic violence. While avoiding labels that can stigmatize and retraumatize survivors, child welfare staff must incorporate an understanding of the intersection between physical health, mental health and domestic violence with knowledge that domestic and intimate partner violence can lead to post-traumatic stress disorder, depression, and other mental health and substance abuse conditions.

While the Department provides ongoing training and utilizes CPS and other program area consultants to provide support and training to field staff, conducting assessments in accordance with the Oregon Safety Model continues to be an area of concern.

The Department will continue in efforts to address concerns that were identified regarding comprehensive assessments as well as staffing shortages that affect the ability of staff to complete required casework activities. In the area where the fatality occurred, both district administration as well as external partners participating in this CIRT noted a lack of resources as a barrier to conducting comprehensive assessments. The district involved in this case struggles to retain tenured staff in both casework and supervisor positions and noted that the CPS worker was assigned approximately twice the number of assessments than the workload model recommends. Inadequate staffing levels, high caseloads and untenable workload demands make it increasingly difficult for child welfare professionals to address child safety both in Oregon and across the nation.

2. *Failure to document case planning activities*.

The CIRT required additional information and analysis in order to determine if this concern was a systemic issue. The Child Safety Program conducted quality assurance reviews of a random sample of open in-home and substitute care cases to determine if case plans were documented. The review revealed this concern to be a systemic issue.

Training was delivered to child welfare program managers and district managers in December 2015 regarding application of the Oregon Safety Model beyond the initial assessment. Training regarding the Oregon Safety Model post-CPS assessment was also developed and has been delivered to permanency field staff across the state. The training includes completing protective capacity assessments and developing conditions for return in order to increase timely and safe reunification. The Office of Child Welfare Permanency Program is conducting quality assurance reviews of cases in each branch statewide.

Additionally, between January and March of 2016, training on in home safety planning was provided to CPS workers and supervisors.

The Department will track the impact of these efforts by conducting reviews of case plans that include verification that timely documentation of case planning is occurring. Metrics and information gathered in these reviews will be utilized in working with local offices on improving case planning documentation in OR-Kids.

3. *Effective systems to insure communication to all partners who have responsibilities for the safety of children*.

Review of this case revealed concerns regarding sharing relevant information with professionals that may have provided a more comprehensive analysis of family dynamics and may have resulted in different recommendations. There were also instances when the Department was made aware of additional concerns however did not complete thorough documentation to determine what actions were taken as a result. During the CIRT, the Department was notified that law enforcement had responded to the home on multiple occasions and that service providers indicated having made several “reports” regarding this family. While there is documentation of one call of concern made by a

service provider to the caseworker, there is no documentation that additional reports were made to the child abuse hotline or to the caseworker. Lack of communication between the Department, law enforcement and service providers working with the family created a barrier to connecting information regarding what was occurring in the home and may have assisted in fully assess family functioning and dynamics.

In order to determine if the lack of communication between the Department and community partners is a systemic issue, a statewide workgroup consisting of child welfare program managers was convened in order to examine the issues presented in this CIRT and the impact on the child welfare system. According to the workgroup, this concern is not shared or experienced by other child welfare offices throughout the state. The workgroup further indicated that there are more than adequate systems in place to ensure communication and information sharing occurs under most circumstances. While this was not determined to be a systemic issue, the CIRT recommends local district leadership continue to address these concerns in order to strengthen our partnerships and better serve the children and families of the state. The CIRT will continue to follow up with local administration and community partners to ensure this matter is handled appropriately and sufficiently addressed. In order to increase communication and opportunities for collaboration, the CIRT also recommends utilizing the Multi-disciplinary team (MDT) process to review complex cases that extend beyond the initial CPS assessment.

There appear to have been occasions when community partners and providers contacted the caseworker directly to report concerns regarding this family that may have risen to the level requiring a mandatory report of child abuse or neglect be made to the child abuse hotline. The CIRT recommends that local district leadership work with community partners to assess the training needs of their staff regarding the responsibilities and requirements associated with fulfilling their roles as mandatory reporters. If a need is identified, the CIRT recommends the district provide mandatory reporting training as requested. The district has a protocol in place for responding to requests for this training.

Additionally, the CIRT considered whether barriers existed in transferring this case to the child welfare branch where the family had relocated. The Department has developed a courtesy supervision protocol that defines the process on transfer of voluntary cases between branches. This protocol was developed by a workgroup comprised of Child Welfare Program Managers and sent to staff at central office to review and finalize. From documentation available on this case, it appears that the caseworker from the receiving branch conducted a joint home visit with the sending CPS caseworker prior to the case formally transferring. Therefore, the courtesy supervision protocol as well as a concerns surrounding case transfer were not applicable on this occasion. However, as this concern has arisen on previous CIRTs, the protocol is currently undergoing additional review to ensure the Department is appropriately handling these types of cases. Upon completion, Department District Managers and Child Welfare Program Managers will review the protocol prior to finalization.

Purpose of Critical Incident Response Team (CIRT) Reports:[4]

Critical Incident Response Team (CIRT) reports are used as tools for Oregon Department of Human Services action 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 Department Director to quickly analyze Department actions in relation to each child. Results of the reviews are posted on the Department website. 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 is specific and focused only on 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] 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.