CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT
H.H.

January 24, 2017

Executive Summary:

On October 19, 2014, the Oregon Department of Human Services (DHS) was notified that a child, H.H.[1], was found deceased in the family home and the cause of death was under investigation. On October 21, 2014, former DHS Director Erinn Kelley-Siel declared a Critical Incidence Response Team (CIRT) be convened. On July 31, 2015, DHS Director Kelley-Siel determined the CIRT process was no longer needed due to the child's cause of death having been attributed to natural causes.[2]

On August 2, 2016, after receiving new information regarding the circumstances surrounding the death of H.H., DHS Director Clyde Saiki declared a Critical Incident Response Team (CIRT) be convened to examine the Department's practice and service delivery on this case. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.[3]

On August 3, 2016, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On September 8, 2016, 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. The CIRT identified two areas as potential systemic issues regarding the Department's practice and service delivery on this case.

On November 29, 2016, the CIRT met a third 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 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.[4]

This is the initial and final report of the CIRT. The CIRT will reconvene in four to six months to ensure necessary system improvements have been made.

Summary of Reported Incident and Background:

Department history with H.H.'s mother dates back to 2011, when the child abuse hotline received the first report involving her as a caregiver. The Department was contacted on five occasions regarding H.H.'s family, including notification of the fatality on October 20, 2014. Of the five reports, three were closed at screening and two were assigned for Child Protective Services (CPS) assessment.

On December 30, 2011, the Department received the first report regarding H.H.'s family. The report indicated H.H. was born and the child's mother was a minor at the time of birth. According to the report, the father of the child had reached the age of majority earlier that year and was residing in the home with the mother. The caller had no concerns regarding H.H. or the care the child was receiving. This report was closed at screening. The screening narrative indicates that H.H. and the child's mother and father were residing with the maternal grandmother. There is no documentation that the screener reviewed Department history to determine if additional allegations were warranted.

On May 23, 2012, the Department received a report alleging negligent treatment of H.H. The caller indicated H.H. was underweight and the mother's care and feeding of the child were contributing factors. The caller expressed additional concern regarding the mother's general care of the child. This report was closed at screening. The caller reported that a physician had advised the mother that H.H. was underweight. There is no documentation of a collateral contact being made to the child's physician as part of the screening process.

On October 6, 2014, the Department received a report alleging physical abuse of H.H. According to the caller, the mother and father of H.H. shared

equal parenting time with the child. The caller indicated H.H.'s stepfather had picked the child up following visitation with the father on October 1, 2014. The mother reportedly noticed bruising on the neck of H.H. the next morning and contacted the child's father who denied the child had bruises when the exchange occurred. The screening report documented that the mother contacted law enforcement, who were investigating the concerns. The narrative states, "The child is currently back with the father and there is no injury on the child at this time." The report additionally alleges that in the past the child had expressed not wanting to visit the mother because she "hits" the child and that the mother had admitted to smoking marijuana in the home while in a separate room than the child.

On October 6, 2014, the Department received the police report regarding this incident. The report documented that the mother contacted law enforcement on October 3, 2014, indicating the delay in calling was due to initially believing the child had "ran into something." The mother reportedly became suspicious after speaking with a neighbor. Because the mother alleged the father caused the injuries, the police report was forwarded to the law enforcement agency in the jurisdiction where the father resided. On October 4, 2014, that law enforcement agency responded to the father's home and facilitated examination of the child at the emergency department. According to the police report, the emergency room physician was unable to ascertain the cause of the injuries. The police report indicates the child had bruising on the throat as well marks on the face and shoulder, but did not provide a detailed description of the injuries. Photographs were taken and included with the report. The officer indicated that they "could not tell if the injury was caused from an intentional act." The police report documented a contact and cross report to the Department.

A decision was made to close the report at screening on October 8, 2014. The screening narrative described the child as having no current injuries and the screening decision documented "At this time it is unclear who is alleging who caused the injury in addition, the child is verbal and did not make a disclosure that the bruise was caused by a parent or caregiver." Although the screening narrative indicated there were no injuries, there was documentation that clearly supported the presence of injuries. Lacking any reasonable explanation for the injuries, further investigation may have been necessary to determine their cause. Additionally, while the screening

report listed the stepfather as a household member, there is no documentation that the screener reviewed records to determine if he had criminal history or prior contact with the Department.

On October 13, 2014, the Department received a report indicating H.H. had bruises "all over [the child's] body" after returning from visitation with the mother. The caller indicated that they had observed H.H. on October 6, 2014, and the child had injuries, including bruises on the neck "of an indeterminate cause." The screening summary noted that the report received on October 6, 2014, was closed at screening based on information that the child did not have injuries. The screening narrative indicated that the stepfather had access to the child between parental exchanges and possible opportunity to inflict the injuries. The report was assigned for CPS assessment with a timeline for response within twenty-four hours.

Assessment documentation indicates the CPS caseworker photographed the child's injuries and contacted the Designated Medical Provider (DMP) at the local Child Abuse Assessment Center for consultation. The caseworker included the photographs along with the screening summary for medical review. The caseworker contacted the DMP the following day and documented that the physician determined H.H. did not need to "be seen for an assessment in result of the consultation." Written correspondence with the center indicated they had requested information regarding where the child received ongoing medical care in order to contact that office directly. It is unclear if this occurred prior to the fatality.

The Department received the police report regarding this incident on October 16, 2014. The report indicated the responding officer had also been involved with the report of suspicious bruising to H.H. the week prior that was "unfounded for abuse or intentional harm." Regarding the injuries on October 13, 2014, the police report noted bruises to the child's bottom and scrapes on the lower back, however stated, "None of the bruises looked suspicious," and "appeared to be normal bruising for an active child." The report further states that the Department took photographs, documented concerns regarding the "lack of care and the environment at [H.H.'s] mother's home." The officer documented that the Department would "follow up."

This assessment was open for seven days prior to notification of the fatality. It is unclear what information was gathered during this time related to safety decisions and regarding family functioning. There were no protective action plans or safety plans implemented during that time to indicate identification of safety threats had occurred.

On October 20, 2014, the Department received a report that officers from two law enforcement jurisdictions were investigating the fatality of H.H. in the family home. The stepfather reported H.H. had been sick with the flu; however, the caller noted that H.H. had what appeared to be non-accidental bruising. The caller stated the sibling of H.H. was taken to the hospital for examination as a precaution, both as part of the investigative process and due to reports the child was also ill. The screener identified Department history regarding the stepfather warranting an additional threat of harm. The screening narrative indicates the Department responded immediately and implemented a protective action plan, placing the sibling of H.H. with the child's father. This report was assigned for CPS assessment with a timeline for a response within twenty-four hours.

The Department received this referral and addressed it in the open assessment dated October 13, 2014. The CPS assessment described that the death of H.H. had gone unnoticed by the family for approximately sixteen hours. The assessment further documented a chronology of the criminal investigation and focused primarily on describing the living conditions of the mother's home. H.H.'s sibling was released from the hospital to the care of the father of both the sibling and H.H., however no description of his home was documented and it is unclear if the Department observed the home environment during the assessment. The assessment disposition was determined to be founded for physical abuse and medical neglect against the stepfather and founded for neglect against the mother.

H.H.'s stepfather pleaded guilty to Manslaughter 2 on September 8, 2016. He was sentenced to 75 months in prison. The mother was charged with Criminal Mistreatment. Per plea negotiations and her cooperation in testifying against the stepfather, the charge against the mother was dismissed.

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. *Compliance with Oregon Administrative Rule surrounding screening duties and decision-making*.

   Several of the screening decisions made on this case raised concerns related to the decision-making process, including:

   - The need for a clear understanding of what constitutes an allegation of abuse and how to recognize multiple allegations of abuse that may be present in screening reports;
   - The need to complete screening duties associated with researching Department history on every identified child, parent, caregiver, and household member;
   - The need to make screening determinations based on the totality of the report;
   - The need to use administrative rules as a guide in determining when it is appropriate to conduct a CPS assessment;
   - The need for clarity between the function of screening and determining the disposition of CPS assessments;
   - The need to accurately apply definitions of what constitutes suspicious physical injury and how to utilize the DMP effectively in applying these definitions.

   The Department has identified comprehensiveness of the screening process as a concern in previous CIRTs and since the incident involving H.H., statewide training was delivered in January 2016 to CPS workers in order to reinforce existing policy and procedure. As a result of continued concern surrounding screening practices, the Child Safety Program also conducted quality assurance reviews of a random sample of screening decisions in three districts throughout the state, including the area in which this fatality occurred. The review revealed comprehensiveness of the screening process continues to be a systemic issue.

As a result of that review, the Department developed multiple methods to address this systemic issue. Until recently, the district where this fatality occurred had access to only one CPS policy consultant on a part-time basis. Due to the current hold on implementation of Differential Response, the Department has had the ability to allocate additional resources to the district. Specifically, two CPS consultants have been assigned to and are currently providing advice to the district.

Following the fatality, a CPS consultant provided training and consultation to the district screening unit and to individual screeners regarding the appropriate use of collateral contacts in screening decisions, as well as in researching and documenting Department and criminal history. In addition, a second supervisor was assigned to the screening unit in order to reduce the supervisor to staff ratio.

The Oregon Department of Human Services currently utilizes a screening model in which local districts conduct screening, with the exception of one district. This model can create a wide variance in process as well as inconsistent application of Oregon Administrative Rule and Department procedure. In 2010, the Department formed a committee to consider implementation of a centralized screening model. The committee recommended moving forward with planning, however the project was placed on hold due to the lack of adequate funding and a staff hiring freeze.

In April 2015, the Department decided to revisit this concept and formed a steering committee to examine the benefits and risks associated with centralized screening. The steering committee noted multiple considerations regarding implementation. The Department recently appointed a new Child Welfare Director and Deputy Child Welfare Director who are in the process of examining the cost-benefit analysis to determine the value of implementing centralized screening in Oregon. The steering committee has been asked to develop formal recommendations regarding implementation of a centralized screening model. Once the steering committee has finalized their recommendations, the Department will move forward accordingly.

2. *A system-wide need for clarity surrounding Karly's Law[5] and the statutory requirements imposed on Department staff, law enforcement*

and Designated Medical Providers concerning the handling of child abuse cases involving suspicious physical injury.

While it appears that Karly's Law was followed in this case, it is unclear why the decision was made that H.H. did not need to be seen by a DMP for medical evaluation. The CIRT was unable to identify a method to determine if this concern is a systemic issue. However, the team believes that a clear administrative interpretation of Karly's Law is critical to ensuring the safety of Oregon's vulnerable children and as such will address this concern accordingly.

It is not the purpose of Critical Incident Response Teams to identify errors or inconsistencies in decision-making and/or practice of external agencies. However, the CIRT discussed several overarching, system-wide concerns regarding Karly's Law including but not limited to the following:

- Review of photographs by a DMP without medical assessment may not be sufficient and does not allow for a more comprehensive review of the child and circumstances surrounding the injuries.
- Capacity of Oregon Child Abuse Intervention Centers to conduct medical assessments of children who have suspicious physical injuries within 48 hours of identification of injuries.
- Adequate amount of medical professionals serving as DMPs across the state who are trained in the evaluation, diagnosis and treatment of child abuse.
- Whether there is confusion by caseworkers concerning how to consult with a DMP and when a conclusive determination of abuse is made.
- Whether the Department's interpretation of Karly's Law can be expanded beyond the primary focus of a suspicious physical injury to better address potential for abuse.

There are many existing tools to ensure Department staff are in compliance with Karly's Law. Oregon Administrative Rule and the DHS Child Welfare Procedure Manual provide guidelines surrounding Karly's Law and the handling of cases involving suspicious physical injury. Currently, there is comprehensive training explaining the importance of Karly's Law as well as the core requirements. While this training is

mandatory for child welfare staff, members of this CIRT recommend requiring staff to complete the available computer based training on Karly's Law annually. The Department is also currently in the process of redesigning CORE training provided to child welfare staff. This concern has been clearly communicated to Department staff involved in the redesign in order to ensure Karly's Law will continue to be adequately covered in training.

The Department's information system contains a checklist for completing comprehensive CPS assessments that includes Karly's Law and reminds the caseworker to photograph and document suspicious physical injury. The CIRT recommends creating a tool for Department staff that will emphasize the requirements of Karly's Law while not impeding other necessary components involved in conducting comprehensive CPS assessments. If a caseworker does not believe a case meets Karly's Law criteria, the tool may provide prompting to provide supporting documentation.

Additionally, the CIRT recommends the Department pursue opportunities to discuss concerns surrounding Karly's Law with relevant stakeholders and community partners to ensure consistent interpretation of the law. The Child Safety Program Manager will discuss this issue with the Child Abuse Multidisciplinary Intervention (CAMI) Advisory Council. CAMI advises the Oregon Crime Victims' Services Division regarding the allocation and administration of funding for a coordinated community response to the intervention, assessment, and investigation of child abuse. This issue will also be raised with the Child Welfare Advisory Committee and Children's Justice Act Task Force in consideration of their role in making recommendations to the Department and in creating priorities for future allocation of funding resources.

3. *Child welfare workforce stability and the Department's ability to recruit and retain staff.*

   The CIRT raised concerns regarding workforce dynamics that have been and are increasingly affecting child protection agencies nationwide. Branch leadership participating in this CIRT discussed high employee turnover, high caseloads and lack of experienced staff as well as the

potential impact of these factors on the work force. While it is unclear if this issue played a role in this fatality, the Department is concerned about the ability to recruit and retain child welfare staff and is committed to continued efforts in improving working conditions and stabilizing the workforce. This concern will not be identified as a systemic issue at this time; however, the CIRT recommends continued and deeper exploration into this topic in order to determine if a causal effect exists in relation to case outcomes.

Purpose of Critical Incident Response Team Reports[6]:

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

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] The CIRT report can be retrieved at https://www.oregon.gov/DHS/CHILDREN/CHILD-ABUSE/CIRT/H.H.%20CIRT%20Initial%20and%20Final%20Report.pdf
[3] Oregon Revised Statute 419B.024 can be retrieved at http://www.oregonlaws.org/ors/419B.024
[4] 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.
[5] Requirements of Karly's Law can be retrieved at http://www.oregonlaws.org/ors/419B.023
[6] 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.