Critical Incident Review Team Final Report

A Critical Incident Review Team is convened by the Department Director when the Department becomes aware of a critical incident resulting in a child fatality that was reasonably believed to be the result of abuse and the child, child's sibling or another child living in the household with the child has had contact with the Department (DHS). The reviews are called by the Department Director to quickly analyze DHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of DHS or during a child protective services assessment. The CIRT must complete a final report which serves to provide an overview of the critical incident, relevant Department history, and may include recommendations regarding actions that should be implemented to increase child safety. Reports must not contain any confidential information or records that may not be disclosed to members of the public. Versions of all final reports are posted on DHS' website.

<table>
<tr><th colspan="3">CIRT ID: 84B851G16E</th></tr>
<tr><td>Date of critical incident:

Estimated to be July 24, 2019</td><td colspan="2">Date Department became aware of fatality:

July 29, 2019</td></tr>
<tr><td>Date Department caused an investigation to be made:

July 29, 2019</td><td colspan="2">Date of child protective service (CPS) assessment disposition:

September 21, 2019</td></tr>
<tr><td>Date CIRT assigned:

August 5, 2019</td><td colspan="2">Date Final Report submitted:

November 12, 2019</td></tr>
<tr><td>Date of CIRT meetings:

August 28, 2019
September 20, 2019</td><td>Number of participants:

13
11</td><td>Members of the public?

No
No</td></tr>
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Description of the critical incident and Department contacts regarding the critical incident:

Date of report:	Allegation(s):	Disposition:
7.29.19 **Assignment decision:** Assigned, 10-day response	Neglect, Physical Abuse of the child by the mother and father	Founded for Neglect and Physical Abuse by the father Unfounded for Physical Abuse by the mother Unable to Determine for Neglect by the mother

On July 29, 2019 the Department received a report of suspected neglect and physical abuse of the child by the mother and father. It was reported that the body of a child, believed to be the child in this case, was found on July 28, 2019 in a remote area in another state. There was no information at the time of assignment about the cause of death. The child's parents were reportedly killed in a murder/suicide on July 25, 2019.

According to the report, the family left the state of Oregon in June of 2019 and had not been heard from by family or friends. On July 25, 2019, the mother and father fled a traffic stop in another state and led police on a chase. When the vehicle ultimately stopped, both the mother and father were found deceased in an apparent murder/suicide. The mother had a single gunshot wound to her head and the father had what appeared to be a self-inflicted gunshot wound to his head. The child was not in the car at the time and there was no evidence of a child in the vehicle. The events on July 25 led to a search for the child.

The Department assigned the report for CPS assessment on July 29, 2019. The assigned caseworker made contact with law enforcement in an attempt to gather information regarding the identity of the body. On August 2, 2019, the Department received confirmation the body found was that of the child in this case. It was reported the child died of a single gunshot wound to the head and no other injuries were observed on the body.

Through review of police records and conversations with law enforcement personnel, it was determined the mother and father fled Oregon, likely to avoid incarceration for convictions stemming from a 2018 burglary both were involved in.

The mother made arrangements for the child to be cared for and had voiced plans to both her family and her attorney to appear in court for her sentencing on June 11, 2019. Extended family members believed the family may have been camping in the local area in the early weeks of June and did not initially find it unusual not to hear from the couple. When the mother did not appear in court, her family became concerned. A missing person report was filed for the mother and child on June 11, 2019. According to the maternal grandmother, a joint bank account she held with the mother had been drained of all funds during the month of June. The mother had not been heard from since June 4, 2019 and relatives of the father reported he had also gone missing and a warrant had been issued for his arrest.

Law enforcement continued efforts to locate the family throughout June and July 2019. No child welfare case or assessment was open during this time. Family members noted the couple had not disappeared for any length of time since the child was born and no one voiced concern for the child's safety or well-being leading up to this disappearance. Both parents had struggled in different areas of their lives. The mother with mental health and the father with behavioral difficulties. There had been an open child protective services assessment with the family from January 2019 due to concerns of domestic violence, including report of an incident in which the father fired a gun in a tent while caring for the child and also putting a gun in the mother's mouth on more than one occasion. The assessment closed in June 2019 and the department was not aware the family had gone missing.

When contacted by law enforcement about the death of the mother, her stepfather stated the mother said this would happen. She had reportedly commented when she learned of their criminal convictions, that the child's father would never let the family be separated and their lives would be over. The mother's stepfather did not believe she was serious at the time of the comments. It is unknown if the mother left the state with the father voluntarily.

The assessment was founded for physical abuse against the father resulting in the death of the child. It was also founded for neglect of the child by the father. The family was living off the grid and were on the run from a prior crime. They lived with no electricity, no running water, and lacked toilet facilities for an unclear amount of time. The child had not been seen by the doctor since 2017 and there were concerns the child was not properly supervised. The assessment was unfounded for physical abuse of the child by the mother and unable to determine for neglect by the mother. It is believed the mother was the victim of ongoing domestic violence by the father and may have had limited ability to protect or provide for the child as a result.

Description of relevant prior Department reports:

Date of report: 2.18.16 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition:** Not applicable

A caller reported concerns for the unborn baby. The mother was reported to be 16 weeks pregnant, diagnosed with a mental health condition and living on the street. The mother stated to the reporter she did not want prenatal care and did not plan to seek any. The reporter was concerned the mother did not have the ability to parent a child due to her mental health.

The information was documented as closed at screening as the report did not meet the statutory definition of child abuse as there was no child and high risk alerts were sent to area hospitals.

Date of report: 11.4.16 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition:** Not applicable

A local review of the high risk pregnancy records showed the mother gave birth to the child.

The screener reviewed records and found the mother had been seeing a contracted provider. The provider was contacted and relayed that the mother was doing well and living at home with her mother and siblings. The maternal grandmother was helping her care for the child and sometimes allowed the mother to go out and do things without the child. The provider stated the mother was working with a local parenting support program and a nurse home visiting program. The mother had been seeing a therapist, but when that therapist left the agency, she chose not to see another one. The provider was encouraging the mother to re-engage in therapy due to concerns about post-partum depression. The mental health provider stated she would have a concern if the mother were to move from her mother's home and parent on her own but was not concerned while she was in the home with support from her mother.

The report was closed at screening as there was no allegation of abuse.

Date of report: 9.5.17 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition:** Not applicable

The caller reported concerns for the child. The caller reported the family has moved back and forth between Oregon and Washington. The caller stated while the family lived in Washington, they had an open CPS assessment due to the parents leaving the child with the couple they were renting a room from without clear plans for care.

The caller stated services for the family were ending in Washington, and everyone decided it would be best for the family to move back to Oregon to be where they had support from family and friends as they still had not found stable housing in Washington. The caller stated there were no significant concerns with the parents other than they were very young and made some poor parenting choices.

The report was closed at screening as the concerns had been addressed in Washington and did not require an assessment in Oregon.

Date of report: 1.22.19 **Assignment decision:** Assigned, 24-hour response	**Allegation(s):** Threat of Harm, Neglect	**Disposition:** Unfounded

DHS received a report alleging domestic violence, including death threats against the mother and child by the father; possible developmental delays as to the mother; mother's lack of understanding of the threat posed by the father; and family's lack of appropriate housing as they were living in a van. Caller reported the father had put a gun into the mother's mouth and threatened to blow her head off several times. Per the caller, the father's behavior also included becoming frustrated when the child would not hold still while being changed and shooting his gun through the tent near his child. Father also brandished a knife and attempted to break into the grandmother's house by cutting the
screen of the door.

DHS and law enforcement made contact with the mother and child in the home of the maternal grandmother the day the report was assigned. The father was not contacted as he was at work.

The mother reported about six months prior the father was intoxicated and shook a gun in front of her face. The mother reported she didn't truly believe he would shoot the gun at her. She was asked by the officer if she was worried about the father seriously injuring her and she said she didn't think he would ever shoot her but maybe shoot around her but commented it was hard to know what he may do if he was mad. The mother confirmed the incident of the father shooting a gun inside a tent with their child. She stated she confronted the father about shooting the weapon and asked him not to do it again. He then then apologized to her and the child.

The family was living in their car at the time of initial contact. The mother stated the father no longer had possession of the gun. She commented the father was schizophrenic but was controlling his anger and things were going better. The assessment documents the child was observed to be a physically healthy child with no notable delays. She was observed with possible developmental delays and appeared limited in her understanding of the dangerous nature of the father's behavior. She was easily frustrated during contacts.

The maternal grandmother's significant other confirmed the details of the incidents reported.

The caseworker attempted contact with the father on January 24, 2019, two days after initial contact with the mother and child.

Additional contact was made with the family April 22, 2019 and again May 8, 2019, when the caseworker learned the parents had been arrested on burglary charges. The mother reported she and the father were not permitted to have contact as a result of being co-defendants. The crime occurred in 2018 and the mother was working on making arrangements for the child's safe care if she were to face incarceration. She reported she had not seen the father since April 10, 2019 and was not concerned for her or her child's safety.

A final attempt was made to contact the father on May 28, 2019, without success.

The assessment was completed using the Overdue Assessment Protocol and approved on June 25, 2019. The Department was unaware the family had gone missing at the time the assessment was approved. The disposition was determined to be unfounded and the child was identified as safe in the care of his mother.

Description of concerns regarding actions taken or not taken by the Department or law enforcement agencies in response to the critical incident or events that led to the critical incident:

The father's behavior in this case was unstable and he regularly threatened the mother and others. Limited information was gathered to understand the mother's ability to remain safe while in a relationship with the father and no contact was made with the father to understand the severity of his behavior and whether or not he was amenable to intervention. There was a reliance on family support and a no contact order to ensure safety, without a full understanding of how the father may exert his parental rights to the child as well as his power and control over the mother.

Despite information reported about the father's lethality, the Department did not fully assess the violence occurring in the family and child safety decisions were made based on incomplete information. The lack of comprehensive information gathered led to the use of the Overdue Assessment Protocol which would not have applied to this situation.

When considering what factors played a role in the assessment and decision making in this case, a few observations were discussed. The parents' limited child protective services history and criminal history in conjunction with the mother's denial of her fear of the father likely contributed to the inaccurate depiction of the severity of the circumstances. Additionally, the assigned caseworker received a significantly high amount of new CPS assessments during the time this assessment was open and also experienced a change in supervisors during that time, moving to a supervisor with less experience supervising CPS. Workload and supervision are significant factors in a child welfare professional's ability to prioritize efforts and exercise diligence where it is most needed.

Recommendations for improvements in the administration and oversight of the child welfare system that are specific to the critical incident and any historical information reviewed by the team:

There are tools, resources and guidance available to child welfare staff when assessing cases of domestic violence, though it has been recognized those providing direct service to families at times struggle to understand the scope and impact of domestic violence. Efforts are underway to support expansion of learning and improvement in practice by providing training on the Safe & Together Model. The Department has long recognized Safe & Together and the associated tools as complimentary to Oregon's child welfare practice model however incorporation into practice has not been

consistent. Child Welfare supervisors, MAPS and consultants participated in week-long training from the Safe & Together Institute during the summer of 2019. This training was aimed to enhance supervision and coaching efforts across the state in cases with domestic violence as a part of the family condition. The CIRT recommends continued support of these efforts by the Department.

Additionally, CIRT Coordinators are undertaking efforts to better understand what systemic factors may be influencing the work of Child Welfare. These efforts include the application of safety science and the Safe Systems Improvement Tool (SSIT). The use of safety science to evaluate child fatalities is a national movement supported by the Commission on the Elimination of Child Abuse and Neglect Fatalities, Children's Bureau Capacity Building Center, Child Welfare Workforce Safety, Dr. David Sanders and Casey Family Programs. The CIRT supports current efforts by the Department to team with innovators at Chapin Hall Center at the University of Chicago and Casey Family Programs to evaluate how to best implement this system.