# S.G. CIRT Final Report for Publication

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<th>Date</th>
<th>February 1, 2019</th>
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<td>Date of Initial Report</td>
<td>October 1st, 2018</td>
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**Purpose Statement**

Critical incident reports are used as tools for Department actions when the Department becomes aware of a critical incident resulting in a child fatality that was likely 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 recommends which actions should be implemented and which individuals should be responsible for evaluating the implementation. Reports must not contain any confidential information or records that may not be disclosed to members of the public. Versions of all reports are posted on DHS' website.

**Executive Summary**

On 7/30/2018, The Department Director declared a CIRT. The Department had significant history with the family. S.G.’s family are also members of The Confederate Tribes of Grand Ronde.

**Summary of Critical Incident**

In December of 2017, S.G. was six months old and fell ill. Her malaise progressed quickly and at times she experienced a high fever of 104 degrees. S.G. was not taken to a doctor during this time and was found deceased in her bed after several days of being sick. During the subsequent investigation, concerns of ongoing general neglect in addition to failing to access medical care for S.G. were noted as contributing factors to S.G.’s death.

**Evaluation of Department Actions**

- The Department received several reports of neglect that were closed at screening. Each report was considered in isolation though themes of chronic neglect were emerging.
- There was no documentation that Tribal records were reviewed during the DHS assessments.
• The Department may have deferred to the Tribe without working collaboratively in assessing child safety. Further, it is unclear what active efforts were provided to the family by the Department.

**Recommendations for improvements and associated tasks**

**Caseworkers must be able to conduct critical evaluation of case history and collateral information to understand how to recognize signs of chronic neglect within a family.**

Several CIERTS have identified chronic neglect as a systemic issue related to child fatalities. The cumulative impact of neglect and other forms of maltreatment can only be seen through in-depth review of history and the gathering of collateral information in relation to the current reported concern. In-depth review of case history, combined with adequate collateral information, can help to understand the impact of the family condition on current functioning and child safety, leading to more well-informed decisions and appropriate interventions. The Department is moving forward with tasks already identified related to chronic neglect. CPS program has reviewed curriculum from the Butler Institute related to chronic neglect. Collaboration with Butler Institute has begun to address the following:

• Provide coaching and training to CPS caseworkers, supervisors and case aides as appropriate, on critical evaluation of family and case history, to include training on preparing chronologies and presenting information in both individual and group case consultation settings.
  
  o This will be accomplished through child safety program consultants during regularly offered learning opportunities over the next six months.

• Research and develop interactive training related to assessing, intervening and planning in cases with chronic neglect, to
include development of case studies for use as relatable examples.

- This training will be developed in consultation with the Child Welfare Partnership and the CW Training Unit, so as not to replicate training already offered.

- Development of the training will also include assessment of barriers for caseworkers encountering families with problems related to neglect. This will be accomplished through structured exploration with caseworkers and supervisors about the challenges in assessing, identifying, documenting and intervening in cases of chronic neglect.

- Child Safety Program Coordinators will complete research and development of implementation plan. The timeline for development of training is early 2019, with delivery expected in the spring of 2019.

The Department has inconsistent interactions with tribes. The Department should work in collaboration with the tribes to make safety decisions as well as provide active efforts to families who are identified as ICWA.

Districts have been assigned Active Efforts (AE) Specialists to help workers determine how to offer active efforts and work collaboratively with tribes. However, the AE job duties are determined by the districts they are assigned to resulting in different job duties. It is unclear if the intent of these jobs has remained true to their original inception. This could be rectified by centralizing supervision of these positions as well as unifying their job duties.

The Department is not consistent in working with tribes to make decisions related to child safety. Having workers specifically designated to work with Indian families (i.e. an ICWA worker) would offer specialization for ICWA case.
| Methods of evaluating expected outcomes | Recommendations related to chronic neglect will be evaluated through ongoing CPS Assessment Fidelity Reviews, Child and Family Services Review results, as well as regular conversations with local offices about challenges in practice and needed support from program staff. Improvement in case practice with tribes and tribal families will be measured by the Tribal Affairs unit. This unit will create fidelity tools to assess active efforts and fidelity to the child safety model and ICWA OAR rules. These tools will be developed by the end of the 2019 fiscal year. |