

L.S. & S.S. CIRT Final Report for Publication

Date	October 18, 2018
Purpose Statement	<p>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 final reports are posted on DHS' website.</p>
Date of Initial Report	10.12.18
Executive Summary	<p>On 11.30.17, the Department was notified there had been a fire at the home where L.S. and S.S. resided with their mother and three older brothers. Initial information outlined concerns about the cause of the fire and care of the children in the home. The case was assigned, and the assessment was completed on 2.2.18, resulting in a founded disposition of neglect. On 2.15.18 the Department director declared a CIRT be convened to examine the Department's practice and service delivery to L.S., S.S. and the family. This is a mandatory CIRT as the deaths of L.S. and S.S. were determined to be the result of abuse and there had been reports assessed by the Department in the 12 months prior.</p>

	<p>The review of case history revealed concerns of neglect, threat of harm and sexual abuse dating back to 2006, though only one report was received in 2006 and the remaining 10 reports occurred between 2012 and the last report, which was from September 2017. In total, there were 8 reports assigned for assessment and 3 reports which were closed at screening. There was one prior founded report in 2015.</p>
<p>Summary of Critical Incident</p>	<p>In the early morning hours of 11.30.2017, a fire broke out in the home where 1-year-old L.S. and 3-year-old S.S. lived with their mother and three older brothers. L.S. and S.S. were asleep upstairs in separate bedrooms when their oldest brother (age 17) heard the smoke alarm. He was also upstairs at the time, along with another brother (age 12). The brothers went downstairs to tell their mother and found the kitchen to be on fire and the house filling with smoke. They observed their 4-year-old brother standing across the living room next to the television. The 17 and 12-year-old brothers and their mother escaped the home to get help. The boys and a neighbor entered the home to rescue the 4-year-old, but were unable to get upstairs to save their sisters. Both L.S. and S.S. died of smoke inhalation.</p> <p>The fire investigation determined the fire likely started on top of a bag of trash that had been placed on the kitchen counter. It was unclear the mechanism which started the fire, however significant concerns were raised based on fire-setting behavior of two of the siblings, one of whom had burned a section of the living room carpet two weeks prior to this incident.</p> <p>The family had been involved with the Department a number of times, most recently through two assessments in June and September of 2017. Both assessments were unfounded but identified concerns about possible ongoing neglect. The assessment that was assigned as a result of the fire was founded for neglect by the mother after it was determined she had failed to meet the needs of her children and</p>

	<p>was aware two children had exhibited fire-setting behavior and had not provided adequate supervision or intervention. Additional concerns were noted regarding the children's unmet physical, developmental and emotional needs.</p>
<p>Evaluation of Department Actions</p>	<ul style="list-style-type: none"> • No significant Department errors led to the fatality • Incident-based CPS assessments – although workers did a sufficient job gathering information related to specific allegations of maltreatment at points in time, lack of evaluation of the family condition over time was evident, including dynamics of domestic violence, substance use and chronic neglect • Lack of sufficient collateral contacts – information was often based on family report and not gathered from outside sources to fully understand the family condition and any present or impending danger • Inadequate identification of safety threats and application of the safety threshold criteria in previous assessments
<p>Recommendations for improvements and associated tasks</p>	<p>1. 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.</p> <p>Work needs to be done to assist staff in evaluating cases with multiple reports over a number of years. Disposition is rarely the most significant historical factor in understanding past and present danger for children. Often, 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. Thorough review of history can be achieved through development of case chronologies as preparation for individual case consultation as well as group supervision. In-depth review of case history, combined with adequate collateral information, can help to understand the impact of the family</p>

condition on current functioning and child safety, leading to more well-informed decisions and appropriate interventions.

Task(s):

- 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.
 - 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
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timeline for development of training is early 2019, with delivery expected in the spring of 2019.

2. Supervisors must be able to assist their staff in identifying appropriate safety threats and correctly applying the safety threshold criteria in all cases.

While all caseworkers receive training related to identification of safety threats and application of the threshold criteria upon employment, the degree to which ongoing training and coaching is provided can vary significantly from branch to branch. Likewise, the level of expertise held by child welfare supervisors can vary significantly. It is important for child safety as well as fidelity to Oregon's practice model, that supervisors have opportunities to enhance their knowledge in this area.

Task(s):

- Develop a plan to assist supervisors in enhancing their expertise around not only the identification of safety threats and application of the threshold criteria, but also their ability to ask the right questions and coach caseworkers through safety threats on any given case.
 - The Department has partnered with Action for Child Protection to develop Oregon practice model expertise and internal subject matter experts (consultants, supervisors and MAPS). This work is scheduled to occur during 2019 in conjunction with the development of a clinical supervision program model.

Methods of evaluating expected outcomes

Both recommendations 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.