

A.P. CIRT Public Report

Date	6/12/2019
Date of Initial Report	12/14/2018
Purpose of Final Report	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 the DHS' website.
Executive Summary	The Department history regarding A.P. was limited to one prior contact. At the time of A.P.'s death, the Department had an open CPS assessment. A CIRT was declared on 10/31/2018.
Summary of Critical Incident	A.P. was a two month old infant with no noted health concerns born to a teen mother. On 09/17/18 at 8:00 a.m., A.P.s mother went to check on A.P. and found A.P. blue and cold to the touch. There were increased risk factors related to SIDS and A.P.'s mother had been warned against bedsharing. A.P.'s mother suffered from mental health issues which were exacerbated by possible substance abuse. Ultimately it was determined that A.P.'s death was the result of neglect.
Evaluation of Department Actions	A.P.'s mother's ability to successfully parent was predictably poor. Several key factors forecasted failed outcomes including her age, mental health concerns and possible substance abuse. A.P.s mother had little to no reference on how to care for a child. A full understanding of risk factors related to potential neglect were not

	<p>thoroughly assessed.</p> <p>Additionally, DHS history was not thoroughly reviewed. Further, there were four different CPS workers who had been assigned to the case due to work load issues.</p>
Recommendations for improvements and associated tasks	<ol style="list-style-type: none">1. Provide coaching and training to caseworkers, supervisors and case aides to:<ul style="list-style-type: none">• Identifying cases that require a more in-depth critical evaluation of family and case history, to include training on preparing chronologies and presenting information in both individual and group case consultation settings.• Casework staff in both CPS and Permanency programs have been offered a tool for creating detailed timelines on cases. Information about what to include in timelines and how to use them, is being provided at Regional Training Days throughout the spring and summer of 2019. Additional training and coaching is being provided by consultants in local offices through regularly scheduled learning opportunities and case consultations.• Utilization of case aids to help with work load demands to conduct file reviews.2. The issue of neglect has been identified as a systemic problem contributing to the death of children in Oregon and nationally. Significant enhancements to child welfare training regarding neglect are underway and include:<ul style="list-style-type: none">• CPS program collaboration with The Butler institute to create robust curriculum aimed at:<ul style="list-style-type: none">○ Identifying signs of neglect○ Measuring and determining the impact of neglect○ Providing adequate intervention and gauging improvements of family conditions to prevent further

	<p>neglect from occurring</p> <p>This curriculum has been completed and implementation of this curriculum is currently being scheduled by consultants.</p>
Methods of evaluating expected outcomes	<p>Child Safety Program participates in monthly review processes with local branches to discuss local and statewide trends. During these meetings, practice improvement goals are identified through analyzing the results of an assessment fidelity tool, and the review of local and statewide data trends. Consultants will continue to monitor identifiers of chronic neglect, including but not limited to re-abuse rates and report this information back to local branches. Ongoing assessment of the impact of neglect training will occur during these meetings.</p>