

# B.P. CIRT Public Report

<b>Date</b>	<b>December 18, 2018</b>
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 reports are posted on DHS' website.
Date of Initial Report	August 24, 2018
Executive Summary	On June 27 <sup>th</sup> , 2018, the Department's Director declared a CIRT regarding the death of B.P. The family did not have extensive history with the Department.
Summary of Critical Incident	<p>In February of 2018 the Department was notified that seven-month-old B.P. had been left unattended in a bathtub and drowned. The Department worked in conjunction with local law enforcement during the initial interviews with the family. B.P.'s mother reported placing B.P. in his bath seat in the tub. The mother ran the water for the bath and went downstairs. While downstairs, the mother reported falling asleep on the couch for an undetermined period. When she awoke, she found B.P. with his bath seat tipped over, submerged and lifeless. After receiving care at the OHSU, B.P. was taken off life support and died three days later.</p> <p>During the Department's assessment of B.P.'s parents, additional information was learned about the family dynamics. The parent's relationship had deteriorated and there were regular conflicts that</p>

	<p>became physical. Additionally, both parents were struggling with substance abuse to the extent that it impaired their ability to provide adequate supervision of their children. These factors contributed to the neglect of B.P. resulting in the parent's inability to provide a safe environment for their children.</p>
<p>Evaluation of actions taken by The Department</p>	<ul style="list-style-type: none"> <li>• The Department's contact with the family was limited and no large systemic issues related the CPS assessment process were identified.</li> <li>• The Department's screening decision to close at screening a previously reported concern of parental substance use a few months prior to B.P.'s death was not supported by Oregon Administrative Rules.</li> </ul>
<p>Recommendations for improvements and associated tasks</p>	<ul style="list-style-type: none"> <li>• The Department noted there can be inconsistent decisions related to when a report of abuse is assigned or if it is closed at screening. In response and in an effort to improve consistency statewide, the Oregon Child Abuse Hotline (ORCA) was created which will provide the following changes to mitigate practice variation around the state: <ul style="list-style-type: none"> <li>○ A central building where all staff receiving reports of abuse are housed.</li> <li>○ Current review and revision of Oregon Administrative Rules and screening procedure to provide more precise language and direction.</li> <li>○ Updated training curriculum to further support consistent decisions related to assigning reports of abuse.</li> </ul> </li> </ul>
<p>Methods of evaluating expected outcomes</p>	<ul style="list-style-type: none"> <li>• The centralized Oregon Child Abuse Hotline (ORCAH) has developed a screening training academy to ensure consistent decision making and adherence to rule and statute.</li> <li>• ORCAH is also establishing a quality assurance/quality improvement program.</li> <li>• In addition, the Office of Research, Reporting, Analytics and Implementation (ORRAI) is developing a safety at screening tool, which evaluates data contained within the Department record to inform decision making.</li> </ul>

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	<p>ORCAH's management team is providing updates regarding the above tasks to DHS Leadership and full implementation of all programs is scheduled by April of 2019.</p>
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