

# C.M. CIRT Public Report

<b>Date</b>	<b>2.5.19</b>
Date of Initial Report	10.8.18
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 the DHS' website.</p>
Executive Summary	<p>On 4.24.18, the Department received a report when the child, C.M. was transported to the hospital after the father woke to find her unresponsive. The father and child had been bed-sharing during a nap. The child was pronounced deceased shortly after arriving at the hospital.</p> <p>The report of C.M.'s death was assigned on 4.24.18 and determined to be founded for neglect on 6.27.18. On 8.6.18, the Department Director declared a CIRT be convened to examine the Department's practice and service delivery to C.M. and the child's family. This is a mandatory CIRT as C.M.'s death was determined to be the result of abuse and there had been an open child welfare case in the 12 months prior to the critical incident.</p> <p>There is significant child welfare history with the family. There was an open case at the time C.M. was born, but that case closed in March of 2018, just one month prior to the child's death.</p>

<p>Summary of Critical Incident and Relevant Events that Led to the Critical Incident</p>	<p>On the morning of 4.24.18, law enforcement responded to the home where 5-month-old C.M. resided with the parents and siblings. C.M.'s father had been sleeping when the mother placed C.M. in bed with him and left to run errands. The father later woke up and C.M. was face-down and the father's arm was over the child's back. C.M. was blue and unresponsive. Her father began CPR and called 911.</p> <p>Upon assessment, it was determined the father had worked a graveyard shift the night before and was in and out of sleep throughout the morning. According to the family, when the father returned home, he smoked marijuana and went to bed. The mother took C.M. and a sibling out of the home for about an hour and a half and when they returned the father woke up and shared a meal with the family. He then went back to bed and when the mother and sibling left again about two hours later, the mother placed C.M. in bed with the father who had returned to sleeping. Approximately one hour later, the father woke up to C.M. not breathing.</p> <p>C.M. was transported to the hospital and later flown by Life Flight to Portland. The child was pronounced dead on 4.27.18.</p> <p>C.M.'s death was determined to be caused by accidental suffocation while bed-sharing and no criminal charges were filed. The CPS assessment was determined to be founded for neglect of C.M. by both parents, resulting in the child's tragic death.</p>
<p>Evaluation of Department Actions</p>	<p>While the CIRT determined there were no significant Department errors that contributed to the critical incident, there were areas identified in which Department practice and service delivery to C.M. and the family could have been improved.</p> <p>Historical assessments of child safety were limited in scope and did not fully explore the complex family dynamics. Thorough evaluation of history and consistent application of the safety threshold criteria with regard to children in the home did not occur. An understanding of the chronicity of neglect and the cumulative impact it may have had on the children was not evident from the documented case history.</p>

	<p>Although C.M. was born shortly before the family's last CPS assessment in December of 2017, thorough assessment of the child's safety was not documented. It is unclear in the file documentation if the child's birth was considered when looking at family stressors during the CPS assessment or the open permanency case.</p>
<p>Recommendations for improvements and associated tasks</p>	<p><b>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.</b></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 condition on current functioning and child safety, leading to more well-informed decisions and appropriate interventions.</p> <p><u>Task(s):</u></p> <ul style="list-style-type: none"> <li>• 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. <ul style="list-style-type: none"> <li>○ This will be accomplished through child safety program consultants during regularly offered learning opportunities in 2019.</li> </ul> </li> </ul>

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- Research and develop intermediate/advanced level training related to assessing, intervening and planning in cases with chronic neglect.
    - Child Safety Program Coordinators have partnered with the Child Welfare Training Unit on training research and development of an implementation plan. The Department will work with The Butler Institute to modify an existing training curriculum to meet Oregon needs. The timeline for development of training is spring 2019, with delivery expected in the summer/fall of 2019.
      - Consultation with The Butler Institute will include a plan to support the comprehensive assessment and understanding of complex child neglect cases, to include expectations around clinical supervision, parameters for group supervision, and work with community partners to support collaboration around intervention and service delivery in conjunction with or outside of DHS when appropriate.

**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.

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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.

**3. Caseworkers must be able to evaluate the impact of the addition of a new child to a family under the purview of the Department.**

New babies may add stress to an already overwhelmed family. When a child is born during an open assessment or open case, there is an expectation the safety of the new baby will be evaluated by the assigned caseworker(s).

Task(s):

- The Department updated practice guidelines for addressing pregnancies and new babies on open cases in 2017. The information was shared with supervisors via quarterly meetings at that time. Additional distribution and training regarding the guidelines has occurred informally through supervisors and consultants. Renewed attention is needed to ensure caseworkers and supervisors are referring to available guidelines when babies are born on open cases or open assessments.

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- This will be accomplished through communication with staff in quarterly meetings, newsletters, policy communications and/or regularly scheduled learning opportunities with permanency and safety consultants in field offices. A Child Safety Program Coordinator will be responsible for reaching out to individuals in the best position to share guidance over the next three months.

**4. Caseworkers must understand what constitutes a safe sleep environment for an infant and have meaningful conversations with caregivers about sleep practices.**

Caseworkers have a unique opportunity to engage in conversations with families about what they do to keep their children safe. This extends to all areas of safety, including while asleep. Caseworkers are guided to view and describe a child's sleeping environment as part of a child safety assessment, but limited additional guidance is given regarding what constitutes a safe sleeping environment and how to talk about it. It is important for caseworkers to be comfortable having conversations with caregivers about safe sleep in order to provide unbiased information and education.

Task(s):

- The Department will develop specific guidance for child welfare staff when contacting families caring for infants. This guidance will include specific parameters for when and how to discuss sleep practices at home, daycare and any other environment where a child may sleep. The guidance will also include expectations for documentation of observations and conversations and will include a training component. Considerations for when parents are using substances or have otherwise compromised faculties will also be included.
  - Child Safety Program Coordinators are reviewing information compiled by a previous work group as well as

	<p>examples of policy and training from other states. Training materials and guidelines are expected to be complete by March 2019, with implementation by late spring/early summer.</p>
Methods of evaluating expected outcomes	<p>Recommendations #1 through #3 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.</p> <p>Recommendation #4 will be measured similarly to #1-3 as well as through review of state child fatality data to determine if the public health efforts are having an impact.</p>