

D.B. CIRT Public Report

Date	April 8th 2019
Date of Initial Report	December 11 th , 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 reports are posted on DHS' website.</p>
Executive Summary	<p>The Department had substantial history with the family regarding concerns of domestic violence, substance use and neglect. The Department concluded abuse occurred on three separate occasions, including the assessment related to D.B.'s death. The Department was notified of D.B.'s death in June of 2018 prompting a CPS assessment. On September 26th, 2018, it was determined D.B.'s death was likely the result of abuse and a CIRT was declared by the DHS Director.</p>
Summary of Critical Incident	<p>On June 2018, D.B.'s mother and mother's boyfriend were intoxicated and took D.B to rural Clackamas County to celebrate the last day of school. The mother's boyfriend was driving erratically and encouraged the other participants in the vehicle to not utilize the safety belts. Other people in the car begged the boyfriend to slow down but he did not listen. Subsequently, he rolled the vehicle which caused D.B to be ejected from the vehicle leading to his death.</p>

<p>Evaluation of Department Actions</p>	<p>The case history highlighted the Department’s struggle to adequately assess child safety in cases where domestic violence and substance abuse are cooccurring. Despite numerous CPS interventions and community referrals for services, these concerns continued to persist. A pattern developed where the family obtained assistance during times of crises; however, sustained positive changes were not maintained resulting in reoccurrence of child abuse.</p> <p>Additionally, provisions set by parole and probation did not always align with the Department’s position. For example, parole and probation removed restrictions that preventing D.B.’s mother’s boyfriend from having contact with her after he was arrested for domestic violence. This left D.B.’s mother unable to prevent her perpetrator access to their shared home resulting in the children continuing to be exposed to domestic violence.</p>
<p>Recommendations for improvements and associated tasks</p>	<ul style="list-style-type: none"> • No systemic issues were identified. However, a lack of understanding related to domestic violence and substance use was noted in the case history. Knowledge regarding these family issues is not developed just through training but also through experience over time. The Department recognized this gap in learned experience and designated special positions called MAPS (Mentoring, Assisting, Promoting Success) to offer support for new case workers. • Coordinated planning for families involved in multiple systems (i.e. substance abuse treatment, parole and probations, mental health services) needs improvement.
<p>Methods of evaluating expected outcomes</p>	<p>NA</p>