

D.W. CIRT Public Report

Date	8.19.19
Date of Initial Report	5.3.19
Purpose Statement	<p>Critical incident reports are used as tools for reviewing 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 12.30.18 The Department was notified the child, D.W. had died after sleeping on the couch with the mother the night prior. A CPS assessment was assigned with an allegation of neglect of D.W. by the mother.</p> <p>A determination was made the child likely died as a result of abuse on 3.1.19 and the Department Director declared a CIRT be convened on 3.5.19. This was a mandatory CIRT as there was an open CPS assessment at the time of the critical incident.</p> <p>The family had significant child welfare history in another state and recent child welfare contact in Oregon over the 12 months preceding the critical incident. There were no prior founded reports related to D.W.</p>

Summary of
Critical Incident

Emergency response was contacted on 12.30.18 after the mother awoke to find 2-month-old D.W. unresponsive. The mother and child had been sleeping together on the couch in the home of a relative after a family gathering the night prior. A sibling to the child was staying in the home of another relative at the time of D.W.'s death. The death occurred outside the state of Oregon, however there was an open CPS assessment in Oregon at the time.

CPS assessments were assigned in both states due to concerns about the circumstances surrounding D.W.'s death.

At the time of the critical incident, the family had open CPS assessments in Oregon due to concerns surrounding parental substance use and neglect to D.W. and a sibling. There were also concerns the named father to D.W. was a minor.

Department caseworkers had contact with the mother and D.W. on 12.28.18 and spoke with her specifically about safe sleep for D.W.

The assessment of D.W.'s death revealed the mother and children had gone to visit family and attended a family gathering on 12.30.18. While no family members reported observing the mother to be intoxicated, the mother did acknowledge consuming both alcohol and marijuana before going to sleep with D.W. on the couch. Bed-sharing with an infant on a couch is an inherently high-risk circumstance. Substance use further increases the risk.

D.W.'s death was investigated as a Sudden Unexplained Infant Death, with bed-sharing as a factor. Both the out of state assessment and the Oregon assessment found reasonable cause to believe D.W.'s death was the result of Neglect.

<p>Evaluation of Department Actions</p>	<p>A parent's ability to understand and respond to the needs of their child is critical to ensuring child safety. When a parent's functioning is impeded by substance use, impulsivity, violence, or mental health struggles, the impacts to children can be devastating. Chronic neglect is one of the most challenging forms of child abuse to resolve as it can often times seem more benign and less visible than other types of abuse. Because chronic neglect happens on a recurring basis, it can be incredibly dangerous to the physical and emotional safety and well-being of children.</p> <p>In this case in particular, there were missed opportunities to fully evaluate and respond to the circumstances in the home in order to ensure safety of the children. Out of state child welfare history was not adequately evaluated, concerns of substance use were underestimated, and violence and abusive behavior in the household was minimized. This resulted in an incomplete assessment of neglect and the danger posed toward the children in the home.</p>
<p>Recommendations for improvements and associated tasks</p>	<p>The evaluation of Department actions in this case is similar to other CIRTs in recent months. The recommendation around improving practice through advanced learning opportunities for supervisors, MAPS and caseworkers in the area of neglect, in particular chronic neglect, is fitting here.</p> <p>The Department has been partnering with the Butler Institute for Families to modify an advanced training curriculum for Oregon on the subject of chronic neglect. The partnership began in early 2019 and final revisions are currently under way. A number of Child Safety and Permanency consultants have been trained to facilitate the advanced training and the rest of the consultants will be trained in November of 2019. The first round of sessions for supervisors and MAPS are being scheduled beginning in October 2019, with caseworker training to follow in the winter of 2019 and throughout 2020.</p>
<p>Methods of evaluating</p>	<p>The expected outcome of more effective assessment and intervention in cases of chronic neglect will be evaluated through</p>

expected outcomes	<p>analysis of maltreatment recurrence data, ongoing practice model 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>The recommendation will also be evaluated through review of state child fatality trends.</p>
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