

E.G. CIRT Public Report

Date	August 23, 2019
Date of Initial Report	July 2, 2019
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 April 13, 2019, The Department received a call alleging neglect of the child, E.G. It was reported the child died while in the care of the parents and bed-sharing with the mother.</p> <p>On April 30, 2019, a determination was made E.G.'s death was likely the result of abuse. The Department Director declared a CIRT be convened on May 3, 2019.</p> <p>The death of E.G. meets criteria for a CIRT as there was an open CPS assessment at the time of the critical incident.</p> <p>There is moderate child welfare history with the family due to concerns of neglect, though a notable gap in history between late 2013 and the report received in January 2019. There were no founded assessments prior to January of 2019.</p>

<p>Summary of Critical Incident</p>	<p>On April 13, 2019 the Department received a call regarding the death of the child, E.G. According to the report, the child had been brought to the emergency department by the mother after being found unresponsive around 7:00 a.m. The mother and father admitted to using methamphetamine two days prior to the incident and the mother also admitted to using marijuana prior to bed-sharing with the infant the night before. According to the report, the mother expressed concern she may have rolled over onto the infant while sleeping. A child protective services assessment was assigned to follow up on the concerns of neglect. The family already had an open assessment from January 29, 2019, due to concerns of parental substance use.</p> <p>Upon assessment, it was determined the father awoke in the morning and entered the room where the mother and E.G. were sleeping. The father observed only E.G.'s arm, with the mother's body laying over the infant. The father and mother took E.G. to the emergency department.</p> <p>The parents were cooperative with the Department and Law Enforcement and acknowledged struggling with substance misuse and maintaining a safe home environment. The family home was observed to be dirty and cluttered with items and garbage strewn about. There was an infestation of mice and ants in the home. The mother admitted to ongoing methamphetamine use throughout the open assessment from January. The assessment regarding the death of E.G. was founded for neglect.</p>
<p>Evaluation of Department Actions</p>	<p>This was a case of child neglect driven by parental substance misuse. Although substance use had been a concern throughout the family history, there was an incomplete assessment of substance use by parents throughout the January 2019 assessment and a reliance on treatment entry as a means to mitigate possible safety threats in multiple assessments over the years.</p>

	<p>There appeared to be a breakdown in communication between the community and the Department regarding family functioning and child safety. Although conversations occurred, information was not relayed or evaluated timely, leaving gaps that could have impacted decision making in the January 2019 assessment of child safety.</p>
<p>Recommendations for improvements and associated tasks</p>	<p>1. Child Welfare caseworkers need to understand the behaviors, patterns and indicators of substance use and the impact on parenting. They then need to apply this knowledge in each case where substance use is a concern in order to gather adequate information to understand child safety. Further, caseworkers need to access resources available to them to enhance their understanding and assessment of how substance use impacts individual functioning and in turn, the family condition.</p> <p><u>Task(s):</u></p> <ul style="list-style-type: none"> • Caseworkers have access to training upon hire and there are opportunities for more in-depth training offered sporadically, but a long-term plan for ongoing in-depth training is needed and is being developed by the Child Safety Program. This will involve development of curriculum and a plan for statewide delivery of training. This is expected to occur over the next six months. • Child Safety consultants will continue to work with caseworkers and supervisors around adequate assessment in cases involving concerns about substance misuse. Consultants will continue to encourage utilization of resources, such as local Addiction Recovery Teams. This task is ongoing and a regular part of consultant activities. <p>2. Oregon's practice model allows for Cooperative Cases to be opened when a safety threat is identified, and a family is amenable</p>

to safety planning and participating in services to address the safety concerns without the involvement of the Juvenile Court. Cooperative cases can be effective in situations where a parent has a substance use problem that has interfered with parenting but is engaging in treatment and has access to a support system to help manage child safety.

Task(s):

- Provide clarity to the field around the use of Cooperative Cases and appropriateness in families where parents are engaging in services, but child safety must be assured while progress is established. This will be accomplished through child welfare consultants in the course of regular case consultation activities.

3. Further evaluation of barriers in communication between systems is needed, specifically the Department of Corrections and Child Welfare, as well as internally between programs in the Department of Human Services.

Task(s):

- Child Safety Program Coordinators will examine opportunities for relationship building and information sharing with partner agencies. Continued conversations will occur with individuals specific to this community as well as on a state level to identify strategies for improved partnerships.

Methods of evaluating expected outcomes

The expected outcomes will be evaluated through 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.

The recommendation will also be evaluated through review of state child fatality trends.