

# E.H. CIRT Public Report

<b>Date</b>	<b>February 11, 2019</b>
Date of Initial Report	November 16, 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 final reports are posted on the DHS' website.</p>
Executive Summary	<p>On 3.23.18 the Department was notified of the death of the child, E.H. A CPS assessment was conducted and on 5.3.18 it was determined founded for neglect of E.H. by the father, resulting in the child's death.</p> <p>On 9.25.18 the Department Director declared a CIRT be convened to examine the Department's practice and service delivery to E.H. and the child's family. This is a mandatory CIRT as E.H.'s death was determined to be the result of abuse and there had been a child protective services assessment in the 12 months prior to the critical incident.</p>
Summary of Critical Incident	<p>On 3.23.18, 4-month-old E.H. was found unresponsive after sleeping on a futon couch with the father while the child's siblings slept in a bed in the small travel trailer the family shared. The mother was out of state at the time. E.H.'s father contacted 9-1-1 when he was unable to rouse the child. E.H. was transported to the hospital and pronounced dead soon after arrival.</p>

	<p>A CPS assessment was assigned at the time of E.H.'s death and was ultimately Founded for Neglect by the father after it was learned he had consumed alcohol, marijuana and Kratom prior to sleeping on the futon with the child. Additionally, there had been a recent assessment, that was not yet closed at the time of the critical incident, with concerns of neglect to the children.</p>
<p>Evaluation of Department Actions</p>	<p>At the time of the last assessment in November of 2017 there had been several reports on this family in Oregon as well as multiple reports in two other states, all related to concerns of neglect due to lack of parenting skills, parental substance use, and domestic violence. The CIRT noted a lack of comprehensive information gathering and critical evaluation of information available to fully understand the threat to child safety in the November 2017 CPS assessment, which was assigned just after E.H.'s birth.</p>
<p>Recommendations for improvements and associated tasks</p>	<p><b>1. Caseworkers must be able to conduct a critical evaluation of case history and collateral information to understand how to recognize signs of chronic neglect within a family and make appropriate safety decisions.</b></p> <p>Work needs to be done to assist staff in evaluating cases with multiple reports over time. 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. This can be achieved through development of case chronologies as preparation for individual case consultations as well as group supervision.</p> <p>Thorough review of case history, combined with adequate collateral information about substance use, domestic violence, and other complex issues, can help to understand the impact on current functioning and child safety, leading to better informed decisions and appropriate interventions.</p>

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Task(s):

- 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.
  - This will be accomplished through child safety program consultants during regularly offered learning opportunities in 2019.
- 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 research and development of a training 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 implementation 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.

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Methods of  
evaluating  
expected  
outcomes

This recommendation will be evaluated through ongoing CPS Assessment Fidelity Reviews, results from Child and Family Services Reviews, as well as regular conversations with local offices about challenges in practice and needed support from program staff.

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