

J.J. CIRT Public Report

Date	October 5, 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 DHS' website.</p>
Date of Initial Report	August 2, 2018
Executive Summary	<p>On 4.14.18, the Department's on-call worker was notified the child, J.J. had been transported to the hospital by ambulance due to cardiac arrest. Initial information indicated the cardiac arrest was due to low body volume as the child was dehydrated and emaciated. The case was assigned, and the assessment was completed on 5.21.18, resulting in a founded disposition of neglect. On 6.7.18 the Department director declared a CIRT be convened. This is a mandatory CIRT as J.J.'s death was determined to be the result of abuse and there had been a report made to the Department in the 12 months prior.</p> <p>The review of case history revealed concerns of neglect and other forms of maltreatment spanning 20 years and four child welfare</p>

	<p>cases. In total, there were 49 reports between the cases, 9 of which were founded for abuse. J.J. was the 8th child for his father and 5th child for his mother. Although J.J. had never been the subject of a child protective services assessment, the family had been assessed by the Department 14 months prior to the child's birth and had also been the subject of a report to the Department 7 months prior.</p>
Summary of Critical Incident	<p>On 4.14.18, J.J., a 47-day-old infant, was transported by ambulance to the emergency department. The family called 911 after the child was pale and blue and having difficulty breathing when J.J.'s mother attempted to feed J.J. Responders found the child apneic and unresponsive. At the hospital, it was determined J.J. was in cardiac arrest and medical staff initially attributed the child's condition to lack of body volume. J.J. was reported to be dehydrated and severely emaciated, weighing less than 6lbs. although the child's birthweight was 6.14lbs.</p> <p>J.J. was transported to Doernbecher Children's Hospital, where the child passed away later the same day. According to medical staff, J.J. was malnourished and noted to have a potential underlying infection, but it was unclear as while at the hospital, the doctors were using all efforts to preserve life.</p> <p>Medical records indicated J.J. had not had any follow-up care by a pediatrician since birth</p> <p>Upon contact at the residence it was determined the home did not have electricity, running water or food. Other children in the home presented with poor hygiene and several were inadequately dressed for the weather. The condition and circumstances of the home were inadequate to ensure safety of the children.</p>

<p>Evaluation of Department Actions</p>	<ul style="list-style-type: none"> • The Department had not had an open assessment with the family since prior to the child’s birth. • The in-depth review of case history of the extended family revealed a pattern of Incident-based Child Protective Services assessments over the course of twenty years, inhibiting the Department from recognizing the cumulative impact of chronic neglect on each of the children in the family. • Finally, a wide variation in response to screening reports across districts was identified.
<p>Recommendations for improvements and associated tasks</p>	<p>1. Caseworkers must be able to conduct critical evaluation of case history and understand how to recognize signs of chronic neglect within a family. Further, caseworkers must be able to articulate concerns that result in threats to child safety in order to seek the appropriate level of intervention.</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 in relation to the current reported concern. While time is often limited for CPS workers, 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 consultation, 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>Tasks:</u></p> <ul style="list-style-type: none"> • 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 over the next six months.
- Research and develop interactive training related to assessing, intervening and planning in cases with chronic neglect, to include development of case studies for use as relatable examples.
 - This training will be developed in consultation with the Child Welfare Partnership and the CW Training Unit, so as not to replicate training already offered.
 - Development of the training will also include assessment of barriers for caseworkers encountering families with problems related to neglect. This will be accomplished through structured exploration with caseworkers and supervisors about the challenges in assessing, identifying, documenting and intervening in cases of chronic neglect.
 - Child Safety Program Coordinators will complete research and development of implementation plan. The timeline for development of training is early 2019, with delivery expected in the spring of 2019.

2. Child Welfare screening reports and decisions should account for history and patterns of behavior within a family system. Screening decisions should be consistent with law and practice, regardless of geographic area.

	<p>Child safety decision making begins the moment a report is received by the child abuse hotline. Current information related to family functioning and behaviors as well as historical information contained in the Department record must be taken into consideration when the decision is made to assign, or not assign, a report for assessment. Such decisions must be made consistently, regardless of the geographic location of the family or reporter. The centralized Oregon Child Abuse Hotline (ORCAH) is scheduled for full implementation statewide by April 2019. Efforts are underway to develop a screening training academy to ensure consistent decision making and adherence to rule and statute. In addition, the Office of Research, Reporting, Analytics and Implementation (ORRAI) is developing a Safety at Screening tool, which evaluates data contained within the Department record to support decision making.</p> <p><u>Tasks:</u></p> <ul style="list-style-type: none"> • Share screening report summaries from this and other recent cases reviewed by the CIRT with the ORCAH project team and training subcommittee chair for use in the development of the training curriculum and training scenarios. This task was completed in October 2018. •
<p>Methods of evaluating expected outcomes</p>	<p>Recommendations #1 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 #2 will be evaluated through ORCAH's ongoing quality assurance/quality improvement program, which is currently being established by the project team.</p>