

# K.P. CIRT Public Report

<b>Date</b>	<b>May 29, 2019</b>
Date of Initial Report	3.1.19
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>On 8/15/17, the Department received a report that the child, K.P. had died. The report outlined concerns of neglect due to the mother's behavior and care of K.P. the night leading up to the death. The report was assigned for a CPS assessment.</p> <p>On 6/25/18, the CPS assessment was closed and the death of K.P. was determined likely the result of neglect. There was a delay in the identification and declaration of this CIRT due to the local branch not submitting the required Sensitive Issue Report updating Central Office of the outcome of the CPS assessment. The disposition of the fatality was discovered nearly six months after the assessment was closed by Child Safety Program when reviewing statewide 2018 fatality data. On 12/20/18, the DHS Director declared a CIRT be convened.</p> <p>There were six reports received regarding the family in 2016 and 2017. Three reports were closed at screening and three were referred for assessment, including the report of K.P.'s death. The report of K.P.'s death is the only report with a founded disposition.</p>

<p>Summary of Critical Incident</p>	<p>On 8/15/17, two-month-old K.P. was found deceased in the care of the mother. It was reported the mother had been drinking alcohol the night before and into the morning hours and there was concern for neglect of K.P. and a sibling.</p> <p>While the mother's timeline of events was somewhat unclear, information gathered from multiple sources indicated the mother returned after a night of drinking with friends around 6:00 am and resumed care of her children. She was observed by a collateral to be intoxicated. The mother fed K.P. and then fell asleep in bed with the child on her chest. She awoke between 12 -1 p.m. and found K.P. had passed away. It is believed K.P. aspirated while lying on the mother's chest. In addition to being under the influence of alcohol, the mother reported taking medication that may have increased sleepiness and impaired judgment when combined with alcohol.</p> <p>The CPS assessment was determined to be founded for Neglect of K.P. in June of 2018.</p>
<p>Evaluation of Department Actions</p>	<p>While it is impossible to know if the outcome would have been the same had the mother shared a bed with K.P. when she was not under the influence, there are two elements of CPS assessment and intervention that did not occur in this case that may have changed the trajectory for this family.</p> <p>First, comprehensive assessment of all parents and caregivers did not occur in prior assessments and limited information was gathered from individuals outside of the immediate family unit to fully understand how the mother's substance use was impacting her ability to safely care for the children. While there was some collaboration between other programs and Child Welfare, it appears information may not have been clearly shared or understood between the programs in a manner that would have ensured sufficient service-delivery to the</p>

	<p>mother and children. This was also true in terms of engagement with other community partners, such as housing and education.</p> <p>Second, early engagement of substance use assessment/treatment services did not occur. In the first assessment with the family the mother was known to be abusing alcohol, yet the disposition was unfounded, and the assessment closed. Further exploration and at a minimum a referral to the local addiction recovery team was warranted not only in the first assessment, but in subsequent contacts as well.</p>
<p>Recommendations for improvements and associated tasks</p>	<ol style="list-style-type: none"> <li>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.</li> </ol> <p><u>Task(s):</u></p> <ul style="list-style-type: none"> <li>o Ongoing training and coaching for caseworkers and supervisors in cases where caregiver substance misuse is suspected is in the early planning stages. Caseworkers have access to training upon hire and there are opportunities for more in-depth training offered sporadically, but a clear plan for ongoing training is needed and will be developed by the Child Safety Program. Training will first be offered to the local office in this case, and to other districts identified as needing training more imminently, with the ultimate goal of offering training on a rotating basis throughout the state.</li> </ul>

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2. Collaboration with partner agencies is crucial to ensuring a system response to child neglect. This includes collaboration with DHS partners, but also with community service agencies, such as housing and education programs. The safety of Oregon's children cannot rely solely on the back of Child Welfare Program. How caseworkers understand family dynamics and the ways in which caregivers can manage child safety is reliant upon partners in the community who provide services and see children and caregivers on a consistent basis. No child safety assessment is complete, and no case plan adequately managed without this broader perspective and understanding. Partnerships in the community must be bolstered so caseworkers can make informed child safety decisions.

Tasks:

- Remind local offices about the requirement to share information and collaborate with the Self Sufficiency Program on behalf of families. This will be achieved by the Child Safety Program via the child welfare newsletter, as well as Child Safety Consultants during coaching and case reviews.
  - Continue efforts with caseworkers and supervisors to facilitate creative thinking about information gathering and partnerships with external agencies. This will be achieved through regular coaching, including group supervision, facilitated by Supervisors, MAPS, and Child Safety Consultants on individual cases and in general practice discussions.
3. Supervisors need education and support to provide regular, intentional supervision for staff. This level of supervision would assist with decision-making and case planning as well as provide ongoing support, which aims to reduce secondary trauma and increase staff retention. With the influx of new
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caseworkers entering the CPS field and the increasing complexity of child welfare work, regular coaching to the practice model as well as close supervision for caseworkers is vital in the development of skills needed to ensure child safety.

Task(s):

- The Child Welfare Director has directed supervisors to schedule supervision with caseworkers at specific frequencies depending on worker experience, caseload and circumstances.
  
- The Child Welfare Training Services Unit has developed two Training Specialist positions dedicated to supervisor training and support. These positions have two priority goals:
  - Goal 1: Work with supervisors statewide to create a clinical supervision definition to provide a framework for supervisors new to this role as well as seasoned supervisors.
    - A definition of clinical supervision has been developed as a guideline for supervisor training curriculum.
  
  - Goal 2: Regular communication and support for supervisors in providing clinical supervision to staff. This is being accomplished through:
    - Development and design of multiple supervision tools and communications in all areas of Child Welfare supervision
    - Monthly Supervisor Newsletter with TIPS & Strategies for clinical supervision, which began in summer 2018
    - Design of a dedicated supervisor web page that will have clinical supervision tools.

- The page is under development with numerous tools, documents and activities gathered for posting.
- Supervisor Conferences (scheduled for spring 2019) offer support an education to Child Welfare supervisors, including training on clinical supervision by a renowned speaker in the field.

- A list of competencies has been developed and the current project managers are working with Casey Family Programs and Action for Child Protection to refine the competencies. A framework for training and a list of critical knowledge areas have also been developed and are in the process of being vetted with stakeholders. Training curriculum is expected to be completed within 6 months.

4. Caseworkers must understand what constitutes a safe sleep environment for an infant and have meaningful conversations with caregivers about sleep practices whenever there is a child under the age of one in the home.

Task(s):

- The child safety program coordinators are currently reviewing draft procedure for dissemination in the field. The procedure will be accompanied by training and will cover AAP standards for safe sleep as well as resources available to assist families in creating safe sleep environments. In addition, coordinators will be partnering with multidisciplinary experts in discussion about risk factors and how to engage families in conversations and plans for safe sleep when significant risk factors are present, in particular substance use.

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<p>Methods of evaluating expected outcomes</p>	<p>All recommendations 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>The recommendations will also be evaluated through review of state child fatality trends.</p>
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