

# L.M. CIRT Public Report

<b>Date</b>	<b>7.29.19</b>
Date of Initial Report	12.21.18
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 DHS' website.</p>
Executive Summary	<p>On 11.4.18, the Department was notified the child, L.M. had been shot in the family home. Early information indicated the child had accessed the firearm in the parents' bedroom and the injury was accidentally self-inflicted. L.M. died later the same day. The investigation revealed both parents were under the influence of controlled substances at the time of the critical incident and it was determined L.M.'s death was likely the result of abuse.</p> <p>On 11.8.18, the Department Director declared a CIRT be convened to examine the Department's practice and service delivery to L.M. and the child's family. This is a mandatory CIRT as L.M.'s death was determined to be the result of abuse and there had been a child protective services assessment in the 12 months prior.</p>

	<p>There is significant Department history with this family spanning several child welfare cases.</p>
<p>Summary of Critical Incident</p>	<p>On 11.4.18, two-year-old L.M. had been shot and was life flighted to the hospital. L.M. died from a gunshot wound to the head and it was determined the child had accessed a loaded fire arm under the father's side of the bed in the home where the child resided with the parents. There had been an open assessment regarding L.M.'s family in both June and September of 2018. The September assessment was pending completion at the time of L.M.'s death.</p> <p>Both parents were home at the time of the incident along with one of L.M.'s siblings. The father was under the influence of methamphetamine at the time of the incident and reported to law enforcement that he did not hear the gun go off. The father told law enforcement he woke up to find L.M. on the floor in a pool of blood with a wound to the eye. Reports indicate L.M. was on the father's side of the bed on the floor and the father was asleep in the bed in direct proximity to the child. Reports also indicate law enforcement observed a hand gun under the bed near the child that had the magazine removed. The father reported he had placed the gun back under the bed after finding L.M., but also reported the gun had been on the headboard the previous night. While law enforcement was at the home, the father asked if he could "get stoned." Multiple other guns, both loaded and unloaded were found in the home by law enforcement. None of the weapons were properly secured.</p> <p>The mother gave conflicting accounts of where she was at the time of the incident. She initially reported she woke up early in the morning with a migraine, took some medication and laid back down. The mother reported the father had gotten up with L.M. earlier that morning and said he was going to lay back down with the child. The mother then reported she woke up mid-morning and went to the garage to find something. When she returned to the home 20 minutes</p>

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later, she observed the father sleeping on the bed, but she did not see L.M. in the bed. The mother reported she began looking for L.M. and could not find the child after looking through several rooms in the home. The mother stated she returned to the bedroom to wake up the father and when she went to his side of the bed, she found L.M. on the floor and bleeding. The mother reported she did not hear a gunshot while she was outside as she is hard of hearing. She also stated she did not see a gun near L.M. but reported the father usually kept several guns on his side of the bed - under the mattress and in his nightstand drawer. The mother reported there were no gun safes in the home. She reported the father kept his long guns in her closet except his new AR-15 rifle which was observed by law enforcement leaning against the wall on the father's side of the bed.

The mother reported a different version of events at the hospital. She reported she was asleep after taking Unisom along with two joints of Marijuana at an unknown time that night. The mother could not recall where she fell asleep in the residence but remembered waking up and panicking that she could not find L.M. The mother stated she heard the father scream and he came out of the bedroom with L.M. in his arms.

The father reported to law enforcement that he had methamphetamine along with paraphernalia in a drawer near the bed. He told law enforcement he and the mother had used methamphetamine within the last couple of days. Methamphetamine and marijuana were found in the home, along with paraphernalia, all within reach of two-year-old L.M.

L.M.'s death was determined to be the result of neglect. In addition, methamphetamine was found in L.M.'s system at the time of death.

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<p>Evaluation of Department Actions</p>	<p>While no specific action or inaction by the Department was directly correlated to the critical incident, there were several areas where the CIRT identified a need to improve child welfare practice at a system level:</p> <ul style="list-style-type: none"> <li>• Difficulty assessing the pattern and understanding the cumulative impact of chronic neglect has been identified as a systemic issue in child welfare and appears to be a factor in this case. There were significant risk factors present over the years that contributed to the neglect of L.M. and the other children in the family system. Support for staff in assessing these complex cases, to include development of processes to facilitate full assessment and appropriate interventions is necessary.</li> <li>• While unclear if more thorough assessment of firearm safety in this home would have prevented the death of L.M., the CIRT recognizes a need to support child welfare workers in having educated conversations with families about this topic</li> <li>• Inconsistent screening practice around information gathering, allegation selection and screening decision-making was identified in the review of case history and has previously been identified as a systemic issue.</li> <li>• Community connections for the family were unclear. The documentation does not reflect if caseworkers understood who else may be working with or supporting the family and asking about safety in the home.</li> </ul>
<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>Continued efforts are needed to support caseworkers and supervisors in assessing complex neglect cases, with a focus on understanding the family condition, presence of danger, and developmental impacts to children. Disposition is rarely the most significant historical</p>

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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. Additionally, evaluation of information and observations 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.

Task(s):

- Provide coaching and training to 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.
  - Casework staff in both CPS and Permanency programs have been offered a tool for creating detailed timelines on cases. Information about what to include in timelines and how to use them, is being provided at Regional Training Days throughout the spring and summer of 2019. Additional training and coaching is being provided by consultants in local offices through regularly scheduled learning opportunities and case consultations.
- Develop and deliver training related to assessing, intervening and planning in cases with chronic neglect.
  - Chronic Neglect overview training is being provided to caseworkers by Child Safety and Permanency Consultants at Regional Training Days in the spring and summer of 2019. This overview training is being offered in preparation for an advanced training that will be developed and made available to program managers, supervisors, MAPS and

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caseworkers with more than two years of service with the Department.

- Child Safety Program Coordinators have partnered with The Butler Institute for Families to modify an existing training curriculum to meet Oregon needs. The first round of development occurred in spring 2019 and final revisions are in process. All Child Safety and Permanency Consultants, as well as select consultants from other program areas will be trained to facilitate the advanced training. The first sessions are being offered to supervisors and MAPS in the fall of 2019, with sessions offered for experienced caseworkers beginning in winter 2019. It is expected the initial training rollout will last through 2020, with a sustainability plan in place for ongoing training by the end of the year.

**2. Caseworkers need to be provided sufficient information about assessing safety in homes where firearms are present. Further, caseworkers must adequately document their observation of the home environment, including how they assessed firearm safety.**

Caseworkers have varying degrees of understanding about firearm safety and varying degrees of comfort in talking with families about the topic. Baseline information and guidance is critical to ensuring caseworkers are addressing access to firearms during CPS assessments and home visits.

Tasks:

- CIRT Coordinators will research information on addressing firearm safety during CPS assessments and home visits and develop guidance for staff.

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- Guidance will be provided by CIRT Coordinators and Child Welfare Program Consultants through regularly scheduled learning opportunities and established avenues of communication.

**3. Child Welfare screening reports and decisions should account for history and patterns of behavior within a family system. Screening decisions should be consistent with Oregon Revised Statute and Oregon Administrative Rules, regardless of geographic area.**

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.

Tasks:

- The centralized Oregon Child Abuse Hotline (ORCAH) was implemented statewide in April 2019. A screening training academy has been developed to ensure consistent decision making and adherence to rule and statute. In addition, Continuous Quality Improvement measures are being established by ORCAH to ensure ongoing quality and consistency.

**4. Active engagement between Child Welfare and partner agencies, particularly Self Sufficiency, is critical to ensuring families have access to resources and supports necessary for child safety and family well-being.**

Oregon Administrative Rule requires CPS workers to contact Self Sufficiency to determine what level of services a family is receiving and to share information and coordinate interventions as

	<p>appropriate. When this happens, families have better access to information and support and duplication of efforts and services is reduced. It is unclear in this case to what degree Child Welfare and Self Sufficiency collaborated. The CIRT recently identified a need for a representative from Self Sufficiency to participate in future reviews to identify barriers to partnership and brainstorm ideas for a more streamlined systems approach to similar complex cases.</p> <p><u>Tasks:</u></p> <ul style="list-style-type: none"> <li>• CIRT Coordinators have partnered with the Self Sufficiency Program and identified individuals to participate in ongoing CIRT reviews beginning in February 2019.</li> </ul>
<p>Methods of evaluating expected outcomes</p>	<p>Recommendations #1 &amp; 2 will be evaluated through ongoing CPS Assessment Fidelity Reviews, results of Child and Family Services Reviews, as well as regular conversations with local offices about challenges in practice and needed support from program staff.</p> <p>Recommendation #3 will be evaluated through ORCAH's ongoing quality assurance/quality improvement program, which is currently being established by the project team.</p> <p>Recommendation #4 will be evaluated through regular contact with the SSP representative and the standing members of the CIRT to determine how partnership can be improved throughout the state and centrally. Recommendations that result from future CIRT reviews with SSP participation will be monitored as required in each circumstance.</p>