

M.H. CIRT Public Report

Date	May 30, 2019
Date of Initial Report	3.11.19
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 final reports are posted on the DHS' website.</p>
Executive Summary	<p>On 8.20.18, the Department was notified the child, M.H., had been transported to the hospital on 8.19.18, after being found unresponsive in the family home. The child died on 9.7.18 as a result of the events on 8.19.18. The CPS assessment was founded for Neglect.</p> <p>On 1.9.19, the CIRT Coordinator was notified of the determination that the death was likely the result of abuse and on 1.11.19 the Department Director declared a CIRT be convened. This is a mandatory CIRT as the child's siblings had been the subject of a CPS assessment in the 12 months prior to the critical incident.</p> <p>The Department had contact with this family due to concerns of neglect prior to the birth of M.H.</p>

Summary of
Critical Incident

On the afternoon of 8.19.18, 3-month-old M.H. was found face down on a plastic bag full of clothing after having been put down for a nap on the parents' bed. The child was cold to the touch, with blue lips. The family called 911 and M.H. was transported by ambulance to the hospital. M.H. was stabilized and flown to the children's hospital. A CPS assessment was assigned on 8.20.18 due to concerns about the condition of the home and the safety of the children.

According to the family, the children had spent the night of 8.18.18 with a relative while the parents spent time with friends. On 8.19.18, the entire family took a nap in the late afternoon. The parents and older siblings slept in the living room and the parents put M.H. in their bedroom, in the middle of their mattress, with blankets bunched around the child as a barrier. Another sibling also slept on a couch in the room with M.H. After approximately one hour, the older children woke up and began playing, waking the parents up. The father reportedly gave M.H. a bottle and put the child back down to sleep. About 30 minutes later, the parents noted M.H. had not been heard awake or crying, although siblings had been in and out of the bedroom playing. The father reportedly went into the bedroom and found M.H. lying face down on the plastic bag filled with clothing. The family called 911 and the child was transported to the hospital.

Once M.H. was stabilized at the local hospital, the child was flown to Doernbecher Children's Hospital. It was soon determined M.H. did not have any brain activity and would not survive. The child was removed from the ventilator on 8.26.18 and on 8.30.18, M.H. was sent home with the parents with hospice care. The child died on 9.7.18.

Photographs taken by law enforcement on 8.19.18 depicted a home in complete disarray and below community standards for the health and safety of children. There was trash piled up on the porch surrounding the entry to the home. The living room was cluttered and

	<p>there was a marijuana pipe within reach of the children. There was also a bottle of Vodka sitting on the kitchen counter, with-in reach of the children. There was food and dirty diapers scattered across the kitchen floor. The bedroom where M.H. had been sleeping was so cluttered with clothes, toys, plastic bags, and trash that one could not see the floor.</p> <p>The condition of the home combined with an unsafe sleep situation directly contributed to the death of M.H. and the CPS assessment was determined to be founded for neglect by both parents.</p>
<p>Evaluation of Department Actions</p>	<p>While there was no prior assessment of M.H.'s safety and no systemic issues contributed specifically to the death of M.H., the history of assessments with the family were Incident-based and led to an incomplete understanding of the family condition and safety threats to the children. Clarity around Present and Impending Danger and appropriate safety planning activities for the older siblings could have changed the trajectory for the family. The case was not recognized as chronic neglect and therefore full understanding of the threats to the safety and well-being of the children were not realized.</p>
<p>Recommendations for improvements and associated tasks</p>	<p>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.</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 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</p>

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

	<ul style="list-style-type: none"> ○ 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.
<p>Methods of evaluating expected outcomes</p>	<p>The recommendation will be evaluated through analysis of maltreatment recurrence data, 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.</p> <p>The recommendation will also be evaluated through review of state child fatality trends.</p>