

N.A. CIRT Final Report for Publication

Date	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 DHS' website.</p>
Date of Initial Report	September 17, 2018
Executive Summary	<p>On 11.14.17, the Department was notified of a fire at the residence, resulting in the tragic death of the child, N.A., and her mother. There were allegations of neglect due to the condition of the motorhome and circumstances under which the fire started. The case was assigned, and the assessment was completed on 5.8.18, resulting in a founded disposition of neglect. On 7.25.18 the Department Director declared a CIRT be convened to examine the Department's practice and service delivery to N.A. and the child's family. This is a mandatory CIRT as N.A.'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 Department has history with the family dating back to 2005. This history is encompassed in 17 reports, 9 of which were assigned for assessment. The last face-to-face contact with the family occurred in 2014, three years prior to the critical incident. There were three reports closed at screening during the intervening years.</p>
<p>Summary of Critical Incident</p>	<p>On 11.14.17, the child, 8-year-old N.A., died when fire engulfed the small motorhome she was sleeping in with her four siblings. Upon assessment, it was determined N.A. and her older siblings had been sleeping in the motorhome for some time, using a makeshift wood stove for heat and candles for light. The mother slept in a small trailer home on the property. According to the assessment, the children slept in the motorhome as there was not sufficient space inside the trailer home for the entire family. The mother would remain in the trailer home at night, leaving the oldest sibling (age 17 at the time) to ensure the children went to bed. The fire on the night of November 14th is believed to have been caused by one of the candles lit by another sibling. N.A.'s siblings escaped the fire but N.A. and her mother both perished. The mother ran into the burning motorhome when she realized N.A. was not with the other children when they came to the main residence on the property to inform her of the fire.</p> <p>The assessment was determined to be Founded for neglect as the mother had not ensured safety of the children in the motorhome and was leaving another child to provide care for the younger children in a hazardous environment.</p>
<p>Evaluation of Department Actions</p>	<ul style="list-style-type: none"> • There were no significant errors identified that led to the fatality of N.A. The Department had not had an open assessment with the family since 2014. • While there was notable improvement in information gathering in the 2014 assessment, the in-depth review of case history over time revealed a pattern of Incident-based CPS assessments and lack of adequate collateral contacts, resulting in a failure to recognize the cumulative impact of chronic neglect on each of the children in the family. • The family had limited support and limited access to resources. There was involvement with the Self Sufficiency Program, yet

	<p>connections were not clearly established during assessments to ensure appropriate supports were being offered.</p> <ul style="list-style-type: none"> • Finally, there were a number of reports closed at screening over the life of the case which met criteria for assignment. This included two reports with unrelated concerns received in 2016 and 2017, after the Department's last contact with the family and prior to the critical incident.
<p>Recommendations for improvements and associated tasks</p>	<p>1. Caseworkers must be able to conduct critical evaluation of case history and collateral information to understand how to recognize signs of chronic neglect within a family.</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 and the gathering of collateral information in relation to the current reported concern. 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 collateral information, 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>Task(s):</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/summer of 2019.

2. 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 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 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.

Tasks:

- CIRT Coordinators have reached out to the Self Sufficiency Program and identified a point person to discuss next steps in collaboration. Criteria for SSP participation in CIRT reviews will be established and the identified individual will be invited to review cases which meet criteria beginning in 2019.

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. 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><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. • Consult with ORRAI about this and other recent cases reviewed by the CIRT, in relation to the Safety at Screening tool to provide context for cases with similar history that may or may not impact the risk level. This is underway with a likely completion date of December 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 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> <p>Recommendation #3 will be evaluated through ORCAH's ongoing quality assurance/quality improvement program, which is currently being established by the project team. In addition, ongoing consultation will occur with ORCAH and ORRAI regarding the Safety at Screening tool and application in child welfare.</p>