

# R.B. CIRT Public Report

<b>Date</b>	<b>March 25, 2019</b>
Date of Initial Report	December 6, 2018
Purpose Statement	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.
Executive Summary	On September 26 <sup>th</sup> , 2018, the Department's Director declared a CIRT. The family had significant history with DHS and regarding concerns of general neglect. The CIRT completed their review of the file on November 19 <sup>th</sup> , 2018.
Summary of Critical Incident	R.B was born on May 10 <sup>th</sup> , 2017. In the early morning of October 9, 2017, R.B. had difficulty sleeping and woke up around 2:00 a.m. R.B. was fussy and crying for approximately an hour. R.B. eventually fell back to sleep and was placed face down on a fold out couch. Around 8:30 a.m., the parents went to the grocery store and left R.B. with a family friend. The family friend went to check on R.B. around 9:00 a.m. and discovered the child was stiff and cold to the touch. The family friend immediately contacted paramedics who pronounced R.B. deceased upon arrival. The parents reported to medical personal that R.B. had been on a strict diet of only goat's milk. The parents reported they were told not to feed goat's milk to their older children. Despite this, they believed goat's milk was healthier than formula based on their own research. The autopsy noted R.B. suffered from similar medical complications as another relative with the same diet,

	<p>however, specimen limitations prevented assessment of the severity of R.B.s medical condition and the death was listed as Sudden Unexplained Infant Death.</p>
<p>Evaluation of Department Actions</p>	<p>The CIRT noted the history of Child Welfare involvement highlighted concerns of neglect. Department assessments of the family did not consider all of the family dynamics focusing mostly on specific incidences of alleged abuse. Therefore, the Department did not thoroughly understand the pattern of chronic neglect that was emerging. Interventions with the family did not occur or, if they did, they did not fully address the underlining issues. This resulted in inadequate determinations of child safety. Further, the CIRT identified the Department faces challenges when trying to articulate the impacts of neglect on a family to our judicial partners when seeking court involvement. This can result in an inability to gain legal authority to mandate services or placements for children.</p>
<p>Recommendations for improvements and associated tasks</p>	<ol style="list-style-type: none"> <li>1. The issue of neglect has been identified as a systemic problem contributing to the death of children in Oregon and nationally. Significant enhancements to child welfare training regarding neglect are underway and include: <ul style="list-style-type: none"> <li>• CPS program is collaborating with The Butler institute to create robust curriculum aimed at: <ul style="list-style-type: none"> <li>○ Identifying signs of neglect</li> <li>○ Measuring and determining the impact of neglect</li> <li>○ Providing adequate intervention and gauging improvements of family conditions to prevent further neglect from occurring</li> </ul> </li> </ul> <p>This curriculum will be completed by Spring of 2019. Implementation of this curriculum will begin with training Child Safety Consultants. The consultants will provide ongoing training to management and staff.</p> </li> <li>2. Additionally, the curriculum will be offered to our judicial officers and attorneys in order to provide updated training to legal child welfare system partners.</li> </ol>

Methods of evaluating expected outcomes	<p>The Department's Child Safety Program participates in monthly review processes with local branches to discuss local and statewide trends. During these meetings, practice improvement goals are identified through analyzing the results of an assessment fidelity tool, and the review of local and statewide data trends. Consultants will continue to monitor identifiers of chronic neglect, including but not limited to re-abuse rates and report this information back to local branches. Ongoing assessment of the impact of neglect training will occur during these meetings.</p>
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