

CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT

R.H.

June 27, 2018

Purpose of Critical Incident Response Team Reports:¹

Critical Incident Response Team (CIRT) Reports are used as tools to improve child welfare practice when the Oregon Department of Human Services (DHS) 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. CIRTs are convened by the DHS Director to quickly analyze Department 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 or program areas 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 Department website.

The Department is committed to evaluating its processes and learning how the child welfare system may be improved in order to keep Oregon's children safer. The Critical Incident Response Team's efforts to identify issues are an important component of agency accountability and improvement when tragedies like this occur. In addition to the CIRT, but in a separate process, the Department may address any necessary personnel actions.

Executive Summary:

On April 24, 2017, the Oregon Department of Human Services (DHS) was notified that a child, R.H., was found deceased in the family home and the cause of death was under investigation. At the time of the fatality, it was reported the mother had fallen asleep after feeding R.H. and awakened approximately two hours later to find the child unresponsive. Emergency responders were unable to revive the child and R.H. was pronounced deceased at a local hospital. A Child Protective Services (CPS) assessment had been open since March 27, 2017 in response to a report received regarding R.H.

On September 14, 2017, DHS Director Fariborz Pakseresht declared a Critical Incident Response Team (CIRT) be convened to examine the Department's practice and service delivery to R.H. and the child's family once it was determined that the child's death was due to neglect. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.

On September 19, 2017, the initial CIRT meeting was held and a comprehensive case file review was initiated. On October 12, 2017, the CIRT met a second time to discuss the case file review in order to assist in identifying systemic issues that may have given rise to the incident.

The initial report of the CIRT was submitted to the Department on December 18, 2017. This is the final report of the CIRT.

Summary of Critical Incident:

On March 27, 2017, the Department received a report alleging neglect and threat of harm to R.H. by the mother and the mother's boyfriend. The mother provided information regarding steps she had taken to ameliorate circumstances that had brought her to the attention of the Department. The assessment concluded with an unfounded disposition and a safety threat was not identified. It appears this assessment was closed after learning of R.H.'s death, when an additional assessment was generated.

On April 24, 2017, the Department received a report that R.H. had been transported to the emergency room by paramedics who were performing CPR. Resuscitation efforts were ineffective and exhausted, and R.H. was pronounced dead.

The mother reported waking to feed R.H. at approximately 7:30 a.m. She indicated R.H. had fallen asleep while feeding, so she laid the child down and went back to sleep. When she woke up at approximately 9:30 a.m., R.H. was cold and not breathing. Paramedics arrived shortly thereafter and attempted lifesaving efforts. R.H. was transported to the local emergency department and pronounced deceased. The mother admitted to bed-sharing with R.H., despite knowledge of safe sleeping arrangements. The cause of death was later identified as accidental asphyxiation.

There was no evidence to suggest this fatality was anything other than accidental as law enforcement obtained collateral information negating any concern of current substance use and medical findings concluded no signs of abuse or neglect. The assessment resulted in a founded disposition of neglect of R.H., as the mother knowingly allowed and provided an unsafe sleeping environment for her child, resulting in the death. The law enforcement investigation has concluded and no criminal charges were filed.

Conclusions:

The CIRT found no significant errors in terms of decisions and actions taken by the Department that directly led to the fatality of R.H. However, the CIRT did find instances where additional casework activity may have been beneficial to the assessment of the family situation. While these noted practice areas did not have clear significance to the apparent accidental death, the CIRT identified the following areas that could have been improved during the Department's intervention on this case.

The CIRT noted that the CPS assessments completed prior to the death of R.H. appear to be incident based and lack detail and documentation to fully understand the family situation.

The CIRT discussed workload and caseload size, as well as the general makeup of the office in terms of worker experience and staff turnover. The office had experienced a high turnover in staff, with approximately two thirds of CPS caseworkers having been with the Department for less than one year. The CIRT acknowledged the challenges faced by the Department in maintaining a high level of practice during a time of significant staff turnover and in the ability of supervisory staff to provide consistent clinical supervision.

While the CIRT did not identify concerns regarding screening or assessment of the report surrounding R.H.'s death, the discussion led to the acknowledgement that there is wide variation in

Department practice and response to screening reports, assignment of reports, and disposition of allegations of neglect when the cause of death is positional asphyxiation of an infant.

Recommendations & Process Improvements:

The CIRT did not conclude that the concerns noted regarding this case affected the outcome; however, the following recommendations were identified in order to enhance Department practice and service delivery:

CONTINUE TO INCREASE TRAINING AND COACHING OPPORTUNITIES FOR CASEWORKERS AND SUPERVISORS TO DEVELOP A MORE IN-DEPTH UNDERSTANDING OF ELEMENTS OF OREGON'S PRACTICE MODEL AND HOW TO GATHER, REVIEW AND ANALYZE INFORMATION.

Fidelity to Oregon's practice model has been identified as one of Ten Priority Projects by the Unified Child and Youth Safety Implementation Plan (Child Safety Plan).ⁱⁱ The CIRT recommends the Child Safety Program continue to develop policies and procedure to increase fidelity to the model and implement measures of accountability across the Child Welfare workforce. The Unified Child and Youth Safety Implementation Plan defined the following tasks, deliverables and outcomes regarding the practice model:ⁱⁱⁱ

Tasks & Deliverables:

- Quality review standards.
- A training plan specifically related to Oregon's practice model and a system to review training at regular intervals, adjusting as needed.
- Methods to celebrate success and address areas of need in the use of the practice model.
- Practices to measure competency requirements in the child welfare workforce.
- Integration of research, decision support and Oregon's practice model in child safety decisions.

Outcomes:

- All staff involved in the child safety system understand their role in achieving safe outcomes for kids, according to the practice model.
- Quality reviews address areas of growth and celebrate successes.
- Practice changes among branch or district offices that struggle or misapply the practice model.
- New staff at all levels of the child safety system are trained on practices that are consistent with the practice model, reducing implicit bias in decision-making.

The Office of Child Welfare Programs is working with the Child Safety Plan project team to develop and implement these changes with an estimated timeline for completion between December 2018 and February 2019. Case reviews outlined below will serve as one method of evaluating consistent application of the practice model.

Process Improvements:

The Office of Child Welfare Programs has implemented the following changes to ensure consistent application of the practice model:

- New child welfare caseworker training has been redesigned in order to develop a well-trained, skilled and prepared workforce. The training better supports new caseworkers and provides a more holistic approach in preparing new staff to engage with families and communities. The training includes ongoing professional development and multiple training and learning experiences over the course of the first year. Trainers began delivering the redesigned curriculum to new cohorts in September of 2017.
- In 2017, the Oregon legislature invested in training and professional development of child welfare supervisors and staff by allocating 50 new positions to the Department. These positions, designed to strengthen child welfare practice and improve recruitment and retention of staff, will primarily focus on mentoring, assisting and promoting the success of new staff, but they will also be available to work with experienced staff.
- Child safety experts placed in field offices across the state provide intensive coaching, mentoring and training to staff. These experts are also conducting fidelity reviews to inform areas in which improvements are needed. After an initial review is conducted an action plan is created with each field office to address any identified concerns. Additional reviews are conducted at 60 to 90 day and six-month intervals to determine impact on practice and where more support may be needed.

DEVELOP PROCEDURE THAT PROVIDES GUIDANCE TO HOTLINE SCREENERS AND CASE WORK STAFF ON CHILD FATALITIES THAT RESULT FROM UNSAFE SLEEP PRACTICES

While the CIRT did not have concerns regarding the screening or assessment of the fatality of R.H., the team recognized the inconsistencies surrounding these cases and recommends the Department continue to develop and implement strategies to reduce and prevent fatalities that are the result of unsafe sleep practices.

Tasks & Deliverables:

- Develop policy and/or procedure providing guidance on screening and assessing reports of child fatalities that result from unsafe sleep practices.
- Provide training for staff on the risks of unsafe sleep practices, methods to reduce risk and how to have difficult conversations with families.^{iv}
- Educate staff on the differences between Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID).^v
- Continue to develop and implement strategies in order to reduce and prevent fatalities that occur as the result of unsafe sleep practices with children. Continue to explore opportunities to coordinate efforts and partner with relevant stakeholders in order to educate the public on the risks of unsafe sleep practices.

Outcomes:

- Consistent screening, assessment and disposition of cases involving unsafe sleep practices.
- Ultimately, by increasing staff and community knowledge, there should be a reduction of child fatalities resulting from unsafe sleep practices.

The Child Safety Program is working closely with stakeholders to address this concern with an estimated timeline of completion by September of 2018. The Child Safety Program will review unexpected child fatalities reported to child welfare hotlines across the state, gathering information on how implemented changes have impacted practice.

Process Improvements:

- Department policy has been updated to require an additional staffing of CPS assessments involving child fatalities prior to supervisory approval.

ⁱ Given its limited purpose, a Critical Incident Response Team (CIRT) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CIRT review is generally limited to documents in the possession of or obtained by the Department. The CIRT is not intended to be an information gathering inquiry and does not include interviews of the child's parents and relatives, or of other individuals associated with the child. A CIRT is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of the child fatality.

ⁱⁱ Information regarding the Unified Child and Youth Safety Implementation Plan and the 10 priority projects can be retrieved at: <http://www.oregon.gov/DHS/ABOUTDHS/Child-Safety-Plan/Pages/projects.aspx>

ⁱⁱⁱ The Practice Model Project Status Summary can be retrieved at: <http://www.oregon.gov/DHS/ABOUTDHS/Child-Safety-Plan/Projects/project-d-2018-04-status-report.pdf>

^{iv} American Academy of Pediatrics' updated policy statement and recommendations on creating a safe sleep environment can be retrieved at <https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>

^v Definitions of SIDS and SUID can be retrieved at the Center for Disease Control and Prevention website: <https://www.cdc.gov/sids/AboutSUIDandSIDS.htm>