

CRITICAL INCIDENT RESPONSE TEAM INITIAL AND FINAL REPORT X.L.

December 5, 2016

Executive Summary:

On May 11, 2015, the Department of Human Services (DHS) Child Welfare Program received a report that a child, X.L., was found deceased in the family home and the cause of death was under investigation.

Since February 2015, the Department was contacted twice regarding X.L.'s family, including notification of the fatality. The Department assigned and responded to both of these reports by conducting Child Protective Services (CPS) assessments.

On November 25, 2015, DHS Interim Director Clyde Saiki declared a Critical Incident Response Team (CIRT) be convened, once it was determined that the child's death was the result of neglect. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.

On November 30, 2015, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On December 21, 2015, the team met a second time to discuss the case file review. The team raised questions and requested additional information to assist in identifying systemic issues that may have given rise to the incident. At that time, two areas were identified as potential systemic issues regarding the Department's practice and service delivery on this case.

Any time a child known to the Department dies or is seriously injured as a result of abuse or neglect, 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 will address any necessary personnel actions.

This is the initial and final report of the CIRT.

Summary of Reported Incident and Background:

On February 12, 2015, DHS received the first report regarding this family alleging neglect of X.L. The report indicated X.L.'s mother had given birth and both mother and child tested positive for methamphetamine. The report also alleged X.L.'s mother was volatile towards hospital staff and that X.L.'s biological father had brought alcohol to the hospital. This report was assigned for CPS assessment with a timeline for response within twenty-four hours. On February 13, 2015, the CPS worker and supervisor responded to the hospital to assess the allegation and also visited and observed the home X.L. would be residing in. It was determined an in-home safety plan was unable to be implemented. DHS received temporary custody of the child on February 17, 2015 for placement in substitute care.

On approximately March 31, 2015, the parents revoked their releases of information and indicated they no longer wished to work with DHS. On April 2, 2015, DHS sought continued physical and legal custody of the child, but the court placed X.L. in the physical custody of the father. On April 13, 2015, the Department continued to seek involvement with the family; however, the DHS petition was dismissed. As a result, the Department was unable to continue to provide services to the family. The assessment disposition was coded as founded for neglect, lack of supervision and protection against X.L.'s mother.

On May 11, 2015, DHS received a report that the child, X.L., had passed away and law enforcement was investigating the cause of death. Reports indicate that X.L. was found non-responsive in the early morning hours and that both parents admitted to co-sleeping with the child while under the influence of intoxicants. The autopsy report listed the cause of death as accidental asphyxiation due to compression. Co-sleeping was determined to be a factor in the death. The assessment disposition was coded as founded for neglect, lack of supervision and protection against X.L.'s mother and father.

No criminal charges were filed against either of X.L.'s parents.

Identification of Systemic Issues:

This CIRT did not identify any systemic issues on this case; however, it did identify opportunities to enhance child safety by increased collaboration with community partners.

1. *The risks to children while co-sleeping with a parent, particularly when the parent is under the influence of intoxicants*

This issue was not determined to be a systemic issue for Child Welfare, rather has been identified as a larger concern by the Public Health Department of Oregon Health Authority (OHA). According to the U.S. Centers for Disease Control and Prevention¹, approximately 3500 die of Sudden Unexplained Infant Death (SUID) each year, which includes Accidental Suffocation and Strangulation in Bed (ASSB). OHA reports 38 probable cases of SUID in Oregon in 2014². Previous CIRT, E.P. (2015), identified this concern and consequently the Department has focused efforts on assisting in the reduction of this manner of preventable fatality.

Following the E.P. CIRT (2015), the Department reviewed existing efforts related to the prevention and reduction of high-risk co-sleeping fatalities and established a workgroup consisting of staff from the Child Welfare Child Safety Program, DHS Self Sufficiency Program (SSP) and OHA Public Health. The objective of this group continues to surround the development and implementation of strategies to educate families served by the Department. SSP identified eight districts across the state to pilot a program where case managers and eligibility workers provide information on safe sleep and the potential dangers and risks of co-sleeping to clients who are either pregnant or parenting children under the age of one. Training and resources were provided to these districts and continued support is being offered. This workgroup will continue to meet in attempt to build and sustain this effort. The Department is examining opportunities to expand this initiative to include child welfare in attempt to improve outcomes related to co-sleeping fatalities.

2. *Effective presentation of information to the court*

Due to the decision to dismiss DHS custody on this case, the CIRT was concerned with what information the Department conveyed to the court

and how the information was presented. Upon review of the court transcript as well as material presented to the court by the Department, this was not determined to be an issue. The court made a determination to place the child in the legal and physical custody of the father, despite the objections of Department staff.

The purpose of the CIRT process is to improve Department practice and is specific to the procedures and processes by which the Department has interacted with the child or family. The purpose is not to identify concerns with decision-making or processes of external agencies.

Purpose of Critical Incident Response Team Reports:

Critical Incident Response Team reports are used as tools for Department action when there are incidents of serious injury or death involving a child who has had contact with DHS. The DHS Director launches the reviews in order to quickly analyze Department actions in relation to each child. Actions are implemented based on the recommendations of the CIRT. Results of the reviews are posted on the DHS Web Site.

The ultimate purpose of the CIRT process is to review Department practices and recommend improvements. Therefore, information contained in these incident reports includes information specific only to the Department's interaction with the child and family that are the subject of the CIRT Review.

¹ Information regarding Sudden Unexplained Infant Death can be retrieved from the Centers for Disease Control and Prevention website at <http://www.cdc.gov/sids/aboutsuidandsids.htm>

² The Oregon Health Authority, Public Health Division 2014 Childhood Fatalities in Oregon report can be retrieved at https://public.health.oregon.gov/PreventionWellness/SafeLiving/KeepingChildrenSafe/Documents/OHA_8033_Childhood_fatalities_report.pdf