

G.F. CIRT Public Report

Date	6.22.2019
Date of Initial Report	3.11.2019
Purpose of Final Report	<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 January 14, 2019, the Department's Director declared a CIRT. The family came to the attention of the Department on multiple occasions prior to the critical incident. The reports documented concerns of neglect and threat of harm due to parental substance use and domestic violence.</p>
Summary of Critical Incident	<p>G.F. was an eight-month-old infant who shared a bed with their mother. G.F.'s mother reported G.F. appeared to stop breathing when G.F. was sleeping but no medical attention was sought for these apnea episodes. G.F.'s mother was also abusing substances and admitted to using Methamphetamine and opioids. Despite using illicit substances, and knowing G.F. was experiencing episodes of sleep apnea, G.F.'s mother made the decision to bed-share. On August 14, 2018, 8-month-old G.F. was found deceased. G.F.'s mother placed G.F in bed with her to take a nap. When she woke up, G.F. was unresponsive and G.F.'s death was determined to be caused by neglect.</p>

<p>Evaluation of Department Actions</p>	<p>Taken in isolation, individual reports made to the Department did not create substantive concern for neglect. However, when all reports were considered collectively, a theme of a chaotic home environment marked with risk factors for neglect began to emerge. These concerns were likely due to parental substance abuse.</p> <p>The mother ran a daycare out of her home. Several concerns were reported related to daycare standards. It was unclear if the Department collaborated with Early Learning Division.</p> <p>Contact with the children’s fathers was not made during prior CPS investigations.</p> <p>The Department sent a high-risk pregnancy alert to local hospitals for G.F.’s because of prenatal substance use. Despite this, the Department was not notified of G.F.’s birth.</p>
<p>Recommendations for improvements and associated tasks</p>	<ol style="list-style-type: none"> 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 is underway and includes: <ul style="list-style-type: none"> • CPS program has collaborated with The Butler institute to create robust curriculum aimed at: <ul style="list-style-type: none"> ○ Identifying signs of neglect ○ Measuring and determining the impact of neglect ○ Providing adequate intervention and gauging improvements of family conditions to prevent further neglect from occurring. ○ Discussing Protecting factors which includes focused discussion regarding the role of fathers. <p>This curriculum has been completed and training has started. The consultants will provide ongoing training to management and staff.</p> 2. Specific requirements regarding exchanging information with Early Learning Division already exist in Child Welfare Rule and

	<p>Procedure. Child Welfare and Early Learning Division investigation piloted joint investigations in a few select counties. Those collaboration efforts are being evaluated to determine the efficacy of that process.</p> <p>3. Oregon Child Abuse Hotline and CPS program will evaluate the current high-risk pregnancy alerts with local area hospitals. This work will be completed by Spring of 2020</p> <p>4. Unsafe sleep conditions have been identified as a systemic problem regarding child fatalities as it is one of the leading causes of deaths for infants in the State of Oregon. Though this issue is not specific to child welfare cases, many of these infants and their families have had some contact with the Department of Human Services Child Welfare Program. The Department has developed a five-year plan to partner with the community to provide families with appropriate education surrounding safe and unsafe sleep. These partners include:</p> <ul style="list-style-type: none"> • Contracted ART/FIT providers • Contracted nurses • OHA • Local hospitals • WIC • Healthy Start/Early Healthy Start • Any other community home visiting service <p>Additionally, updates to the Department Procedure will include information for caseworkers about safe sleep practice.</p>
<p>Methods of evaluating expected outcomes</p>	<p>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 neglect including but not limited to re-abuse rates and unsafe sleep environments and report this information back to local branches. Ongoing assessment of the impact of neglect training will occur during these meetings.</p> <p>Ongoing evaluation of the tandem CPS program and Early Learning Division investigations is occurring. If the pilot counties show increased</p>

positive outcomes measured through increased collaboration and consistent sharing of information pertaining to child safety, the program is expected to expand statewide.

The Department will develop a way to track whether hospitals are following-up with Department regarding high-risk pregnancy alerts.
