

P.A CIRT Public Report

Date	12/4/2018
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.
Date of Initial Report	September 25, 2018
Executive Summary	In 2007, a P.A. was placed into relative foster and remained there for over 10 years. Department records describe the foster parents as devoted to P.A. children and making efforts to fully integrate P.A. into the immediate and extended family. The relative foster providers were highly connected to their church, had significant community supports and were prepared to be P.A.'s permanent placement.
Summary of Critical Incident	On November 7 th , 2017, P.A. was at home with several family members. P.A.'s foster father left to run an errand, and while gone, P.A. was shot and killed. When P.A.'s foster father returned home, he found P.A. deceased. P.A.'s sibling was later arrested for allegedly shooting and killing P.A. and several other family members.
Evaluation of Department Actions	Though the initial file review noted some recommendations, the CIRT determined there was insufficient information to support indicators of any systemic issues resulting in P.A.'s death. The CIRT concluded P.A.'s death was an unforeseen tragedy and there were no significant errors led to P.A.'s death.

Recommendations for improvements and associated tasks	The CIRT did not identify any systemic issues related to the death.
Methods of evaluating expected outcomes	No further action to be taken by the Department.