

CRITICAL INCIDENT RESPONSE TEAM INITIAL REPORT N.E.

January 12, 2017

Executive Summary:

On May 11, 2016, the Oregon Department of Human Services (DHS) was notified that a child, N.E.¹, 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 was sleeping with N.E. on the couch in the family's living room. N.E.'s mother had reportedly awakened during the night in order to feed the infant, however was unable to wake N.E. The mother proceeded to fall back asleep. Upon waking the following morning, the mother discovered N.E. to be non-responsive, blue in color and cold to the touch. Emergency responders were unable to resuscitate the child and N.E. was declared dead upon arrival at the hospital. At the time of the fatality, N.E. resided with the mother, four older siblings and the mother's adult roommate.

On August 5, 2016, DHS Director Clyde Saiki declared a Critical Incident Response Team (CIRT) be convened; once it was determined that the child's death was due to neglect. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024².

On August 9, 2016, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On September 13, 2016, the team met a second time to discuss the case file review. A third meeting was held on November 8, 2016. 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, several areas were identified as potential systemic issues regarding the Department's practice and service delivery on this case. Potential systemic issues were assigned to corresponding program areas in order to determine validity and develop actionable methods to address identified concerns. Once systemic issues have been identified and recommendations have been made to address these concerns, an

additional report will be published. The CIRT will reconvene in four to six months to ensure necessary system improvements have been made.

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 actions³.

This is the initial report of the CIRT and is issued as an activity report and status update.

Summary of Reported Incident and Background:

The Department has been contacted twenty-three times regarding N.E.'s family, including notification of the fatality. Of these reports, thirteen were closed at screening and ten were assigned for Child Protective Services (CPS) assessment. Department history with N.E.'s mother dates back to July 2004, when the first report to the child abuse hotline was received involving her as a caregiver.

On July 23, 2004, the Department received the first report regarding N.E.'s family. The report alleged N.E.'s mother was residing with her small child in unsanitary and deplorable living conditions. The reporter indicated the mother was in the process of eviction and that a week prior, law enforcement had responded to a domestic disturbance in the home between the mother and an individual believed to be her boyfriend. The report was assigned for CPS assessment with a timeline for response within five days.

The CPS caseworker made face-to-face contact with the mother, child, and two adult friends who were visiting at the time. The conditions of the home were noted as "somewhat dirty and messy" yet not unsafe for the child. The mother reported that she and her boyfriend, the child's father, had been outside arguing and law enforcement was contacted as a result. She stated that her boyfriend did not reside in the home and that the child was

not present at the time of the argument. The father of the child was not contacted during the assessment; however, the caseworker documented sending a letter advising him of the assessment and notifying him of the disposition. This assessment disposition was coded as unfounded and closed.

On August 3, 2004, the Department received a report indicating that law enforcement responded to a call of a man chasing a woman with a pipe. The couple was identified as N.E.'s mother and boyfriend and the child was reported to be in the home at the time of the incident. According to the report, the mother heard the child screaming inside the residence and returned inside. When law enforcement arrived, the situation had reportedly resolved. The report indicated the officer talked to the mother about not leaving the child alone in the apartment. Criminal charges were not filed.

This report was closed at screening. The screening decision indicated that the case was currently open and that Department was "already assessing the home situation." There are no indications that this concern was addressed in the previous assessment.

On August 12, 2004, the Department received a report indicating N.E.'s mother left a suicide note at her boyfriend's residence. The caller stated the mother discussed feeling overwhelmed, having no support, and admitted to using methamphetamine two days prior. Law enforcement responded and transported her for observation. Her child was not with her at the time, rather being cared for by a relative. The report was assigned for assessment with a timeline for response within five days.

The CPS caseworker made contact the following day and noted that the home was safe and sufficiently clean. The mother discussed her substance abuse and mental health history. The mother admitted feeling depressed when she wrote the letter, however indicated she had no intention of committing suicide or harming herself. She reported using methamphetamine two days prior to writing the letter and that she had arranged for a relative to provide care for the child at the time. The Department offered to provide service referrals and the mother accepted. The assessment was closed as unfounded with no further contact. The letter mailed to the child's father on the previous assessment was returned

as undeliverable and there is no documentation of further attempts to contact him.

On December 21, 2004, the Department received a report indicating that corrections officers responded to the home in an attempt to locate the mother's boyfriend. They found the mother "passed out" with her small child awake and unattended. It was reported that the child's father was "restrained" from contact with the mother, however was located in the residence. Drug paraphernalia was found within reach of the child. The mother was arrested and incarcerated. The report was assigned for assessment with a timeline for response within twenty-four hours.

A CPS caseworker responded to the home and the child was placed into protective custody, however later released to the father. The child was noted to have significant medical issues upon removal. The Department filed a petition in juvenile court and was granted custody of the child. The CPS worker indicated that the mother admitted to using methamphetamine and marijuana, however denied using methamphetamine in the presence of the child. The father reported she would use both methamphetamine and marijuana while caring for the child. The Department learned the mother was on probation for an assault against the father and was not complying with terms of her probation.

The Department began providing ongoing case and safety management and the mother was referred for substance abuse services. On February 15, 2005, the mother advised the outreach worker she had signed over custody of the child to the father. The outreach worker verified this information with the caseworker and was informed the Department would be closing the case and terminating services.

The closing narrative documents that the mother reported beginning substance abuse treatment and that the child was residing with the father. Both the mother and the father agreed that all contact between she and the child would be supervised until she provided written documentation of completing treatment, an anger management or violence intervention program, and that she was in good standing in regards to probation. The assessment disposition was coded as founded for neglect.

On April 21, 2005, the Department received a report alleging the father was using methamphetamine and marijuana and was allowing the mother to have unsupervised contact with the child. The screening decision indicated there was conflicting information regarding whether the mother was having unsupervised contact, as the reporting party had notified the father they were contacting the Department and in turn, he contacted DHS and denied the allegations. The screener narrated that the reporting party was advised to “provide evidence” if unsupervised contact occurred again in the future. This report was closed at screening. This report contained an allegation of abuse or neglect that would have more appropriately been assigned for CPS assessment.

On March 31, 2006, the Department received a report stating the mother had regained physical and legal custody of the child through civil court and was applying for financial assistance for herself and the child. The reporting party was unable to provide information as to whether the mother had addressed the issues that resulted in the child’s removal one year prior. The screener documented making collateral contacts, including contacting the mother’s probation officer. This report was closed at screening. The screening decision documented that per a collateral contact the mother had remediated the previous concerns of the Department to a “sufficient degree to negate need for CPS intervention.” The narrative further indicated the mother was continuing to receive services through community supports.

On July 13, 2007, the Department received a report stating the child had been dropped off at the father’s home the night before, following approximately one year of the mother not allowing visitation. The caller expressed concern regarding the child’s behavior and feared the mother had relapsed. The caller was unable to provide information regarding the conditions of the mother’s home, however conveyed suspicions of substance abuse. This report was closed at screening. The screening decision documented the father’s intention of having the child examined by a physician and requesting the court review the custody and visitation orders.

On February 5, 2009, the Department received a report alleging that the mother’s boyfriend and father to her youngest child had been stabbed during a party at the residence. The report indicated that alcohol was

involved and that the children were present during the altercation⁴. This report was closed at screening on February 11, 2009. The screening decision indicated the report did not constitute an allegation of abuse or neglect, as the children were not with the mother at the time.

The police report was referenced in the screening report and stated that while the boyfriend maintained he accidentally stabbed himself, the explanation was not consistent with the severity of the injury. The police report further documented that a neighbor had taken both children from the home after the incident occurred. The decision to close this report at screening was based on the children not being present during the incident, which is contrary to information reported by law enforcement. The information provided in the screening report constitutes an allegation of abuse that would have more appropriately been assigned for CPS assessment.

On May 22, 2009, the Department received a report indicating the mother and boyfriend were walking in heavy rain arguing when contacted by law enforcement. The youngest child was reported to be with the couple, clad only in a diaper and t-shirt. According to the caller, the father was attempting to take the child and leave the mother because she was “crazy.” No further detail was provided in defining the statement. Law enforcement determined no crime had been committed and took no further action. This report was closed at screening. The screening report narrative documented checking criminal history and noted concerning information regarding a previously dismissed charge against the father. There is no documentation, however, of how or if the previous criminal charge was considered in the decision to close the report at screening.

On June 23, 2009, the Department received a report indicating law enforcement was investigating an incident of domestic violence between the mother and father of the youngest child. According to information initially reported to police, the father “threw the baby” at the mother and she almost dropped the child. The report stated that both adults were uncooperative, and the mother would not allow the officer access to the residence. The mother informed law enforcement she was taking the child to the home of a relative and would not allow the investigation to proceed. The home was observed by officers to be dirty with diapers on the floor.

The report was assigned for assessment with a timeline for response within twenty-four hours.

The CPS caseworker responded to the residence and made contact with the mother and the relative she had contacted for assistance. The father was arrested for assaulting the mother and recklessly endangering his child; additionally he had a warrant for his arrest. The home conditions were described as unsanitary. A protective action plan was implemented allowing the children to remain with the relative until the mother was able to improve the conditions of her home. A walk-through of the relative's home was completed.

The CPS worker interviewed the father at the county jail. He reported that he and the mother had an argument that may have scared the child. He indicated that he was attempting to leave when the altercation occurred. He reported that the older child was not home at the time of the incident, rather was with relatives.

The Department made contact with the father of the eldest child, who described ongoing concern for his child. He indicated that after he missed a court hearing the mother was granted custody of the child; however, he intended to refile for custody. He reported concerns regarding the child's mental health. He also reported that he believed the mother to be "Bipolar" and suspected substance abuse.

On June 26, 2009, the caseworker completed a walk-through of the mother's home and noted that the conditions of the home had greatly improved. The children were approved to return home. The mother reported that she and the father intended on entering counseling together and reuniting. She also reported being the primary instigator of their arguments. The eldest child was interviewed and described frequent fighting between the mother and boyfriend including physical violence. The child described having to remind the mother to feed the younger sibling when crying due to hunger. The child also reported having to get out of bed at night to feed the younger sibling at times.

The assessment disposition was coded as founded for neglect and unable to determine for threat of harm against the mother and her boyfriend. At the time of the case closure, there was a no contact order with the father of

the youngest child. The caseworker noted he would likely be required to participate in court ordered services and that “there will be no more domestic violence between them [mother and father] in the home.” The case file documented the oldest child as living full time with the father. The case was closed without further services.

On September 21, 2010, the Department received a report indicating law enforcement had conducted a premise/welfare check after receiving a report that several individuals were unlawfully occupying an uninhabited residence that was going through foreclosure. The report further stated the home had no electricity or water. The mother and her two children were reported to be residing in the home, although the children were not observed by law enforcement. This report was closed at screening. The case file review indicates that two separate case numbers were open regarding this family. The information reported appears to be documented under both case numbers.

On October 6, 2010, the Department received a report that the mother and her children had been residing in a shelter, however were asked to leave due to her methamphetamine use and as a result were possibly living in her car. This report was closed at screening. The screening decision indicated the information did not constitute a report of abuse or neglect as it did not demonstrate how the alleged parental drug use was causing harm to the children. This report also appears to have been documented under both case numbers.

The decision to close this report at screening is not consistent with Oregon Administrative Rule (OAR). This is a report of possible abuse or neglect regarding a parent that would have more appropriately been assigned for CPS assessment. The screening decision documented that the information did not include if or how the alleged parental drug use was causing harm to the children, however the reporting party provided information that due to the mother’s methamphetamine use she and her children were asked to leave the shelter. There is no information as to how the recent report dated September 21, 2010 or the mother’s history in regards to her parenting were considered.

On August 12, 2011, the Department received a report that the caller had been in the home a few weeks prior and the home smelled of marijuana.

According to the caller, the mother admitted to taking “knife hits” of marijuana. The caller was unable to provide detail as to whether the children were present during the alleged drug use or if drugs or paraphernalia were kept in the home. This report was closed at screening. The screener indicated that no information was provided that the mother smoked marijuana around her children, that her drug use negatively impacted the children, or that the children had access to drugs or drug paraphernalia.

On September 13, 2011, the Department received a report alleging the mother was smoking methamphetamine and marijuana in the home while the children were present. The caller reported smelling marijuana in the home and had observed the mother while high on methamphetamine. The caller was unable to provide information as to whether the care of the children was impacted by the mother’s drug use. This report was closed at screening.

On May 7, 2012, the Department received a report alleging negligent treatment of both children in the home. The caller alleged the mother slept all day and on one occasion the youngest child was outside the home without supervision. The caller stated that the home was also unsanitary. Department history was documented in the screening narrative. The report was assigned for CPS assessment with a timeline for response within twenty-four hours.

The CPS caseworker contacted law enforcement who indicated they had recent contact with the family and the children were “free of any injuries and appear well cared for.” Law enforcement stated the mother and a neighbor were in a dispute. The CPS caseworker documented staffing with a supervisor and closing the report as no allegation of abuse or neglect based on the collateral contact with law enforcement. The decision to close without conducting a comprehensive assessment is not consistent with OAR. There is no information as to when law enforcement made contact with the mother and children or how the children’s safety was assessed. The caseworker noted that the mother had no criminal history, which is not accurate. There is no documentation of how the caseworker considered prior Department history.

On February 7, 2013, the Department received a call of concern indicating the mother was using drugs and as a result, the oldest child was missing a substantial amount of school. The report also described the home conditions as unsanitary. A second caller reported the home as “thrashed” and stated that approximately one month prior the mother was unable to care for the children and appeared to have relapsed. The caller reported the mother admitted to using marijuana and methamphetamine however stated she could quit. The report was assigned for CPS assessment with a timeline for response within twenty-four hours.

The caseworker documented reviewing Department history and requested a drug and alcohol outreach worker assist in making contact with the mother. The caseworker made face-to-face contact with the mother at the home accompanied by law enforcement. The mother initially refused to allow entrance into the home; however, eventually allowed the caseworker to conduct a walk through and observe the children. The home was noted to be unsanitary. The caseworker attempted to photograph the conditions of the home however, the mother asked the caseworker to leave. The caseworker informed the mother they would return the next day, yet the next documented contact occurred on February 21, 2013.

The mother reported that she had not used marijuana or methamphetamine for approximately eight years. Additionally, she reported attending NA and AA meetings, but could not recall specific details regarding the meetings. The mother attributed the child’s excessive absences to family illness and visits with the child’s father. The caseworker advised the mother to clean the home and to ensure the children were supervised. The assessment was determined to be unfounded for neglect and closed.

This assessment was incident based and lacked pertinent information regarding child safety and family functioning. There is no indication that collateral contacts were made, nor documentation of attempts to interview or notify either legal father. The safety decision appears to be based solely upon the mother’s denial of substance abuse and lacked any confirming collateral information.

On March 24, 2014, the Department received a report alleging the conditions of the home were unsanitary and that the mother admitted she was detoxing from methadone. According to the caller, the mother was

“nearly unconscious” and unable to move from the couch. According to the report, a relative had taken the children for a few days to assist the mother, however had returned them at the time of the call⁵. The report was assigned for CPS assessment with a timeline for response within twenty-four hours.

On March 25, 2014, the CPS caseworker and the drug and alcohol outreach worker went to the home and left a business card. The mother contacted the CPS caseworker by telephone and denied the allegations. The caseworker documented making face-to-face contact with the children at school on April 3, 2014. It is unclear from the documentation whether the children were interviewed separately or together. The eldest child reported the mother had been “kind of sick” however had been doing “really good” over the past month. The child reported feeling safe at home however also indicated the mother and boyfriend were together and would “fight with their words.” The child denied witnessing any violence.

The caseworker documented that a cross report from law enforcement was received by the Department on May 14, 2014. The information indicated police had been contacted regarding a concern that the father had sexually abused two boys who were later identified as the two eldest children. The officer documented that the mother had told relatives she believed the boys had been sexually abuse by her boyfriend. Further, the report documented that the caller stated the relative had taken the boys to the doctor for evaluation and no evidence of sexual abuse was indicated. The officer contacted another relative who indicated the home was dirty and the children were not well fed. The relative reported that the mother was diagnosed with several different mental health disorders that potentially impacted her ability to parent. The relative reported the mother was pregnant and was concerned that she had relapsed.

On May 30, 2014, OR-Kids documentation reflects that a new caseworker was assigned to the case. The caseworker sent a certified letter to the mother advising of the change and requesting they arrange a time to meet. The caseworker documented a scheduled face-to-face contact with the mother and two of the children on June 16, 2014. The home was observed to be appropriate with adequate food and furnishings. The mother discussed her parental functioning, relationship history and her attempts to obtain and maintain stability. She denied domestic violence and reported

she and the father of the two youngest children were no longer involved in a relationship and that he was not consistently involved in parenting or visiting the children. The mother admitted he had come to the home the night before and they engaged in a verbal altercation that resulted in law enforcement being called. The father was arrested due to outstanding warrants. The caseworker narrated that based on the information gathered in the assessment there was no information to indicate the children were being abused or neglected in their mother's care.

There is no documentation of attempted contact with either of the legal father's. There is one attempted, yet unsuccessful phone call to the relative who was identified as a primary support and caregiver for the children. There is no documentation regarding the mother's mental health or medical providers nor was there verification of treatment. There is no documentation or information about the report that the mother was pregnant at the time of the last contact on June 16, 2014. There is no documentation that law enforcement was contacted to gather additional information regarding the reported domestic disturbance on June 15, 2014. The assessment was closed and determined to be unfounded for neglect.

On May 14, 2014, the Department received a report indicating concerns of sexual abuse of the two eldest children by the father of the two youngest children. The screening decision narrative indicated the information would be forwarded to the current CPS caseworker to be addressed in the open assessment. The narrative indicated that the report was closed at screening, as there was no information that the family was unable to access food or basic needs and that the children were seen by a doctor who reported there were no concerns. There is no documentation that the concerns in the closed at screening report were addressed by the CPS caseworker assigned to the previous case. The information appears to contain a new report of potential abuse/neglect by a parent that met criteria for assignment.

On January 5, 2015, the Department received a report in which the caller suspected the mother was using drugs. The report indicated that the mother had given birth to her fourth child one month prior and refused to submit to urinalysis testing at the hospital. The caller had not observed drug use and had no specific concerns of abuse or neglect.

A new case number was generated in OR-Kids and this report was closed at screening. The screening decision stated that no information was provided indicating that the children were suffering abuse or neglect as a result of the alleged drug use.

There is no explanation regarding how this report became attached to a new OR-Kids case number. The screener documents child welfare history of both closed at screening and assigned CPS reports. The screener should have attempted to gather additional information by asking the caller questions to provide understanding surrounding the mother's behavior and possible impact to the children. There is no information documenting how the mother's significant history and pattern of substance abuse was considered in decision making as there were past reports of parental substance use dating back to 2007 with the most recent report having been received less than a year prior to this call. There is no information documented regarding criminal history. Additional collateral contacts should have been completed in order to gather information that may have resulted in a more informed screening decision.

On March 31, 2015, the Department received a report that the father was arrested for violation of a restraining order that the mother obtained the previous July. This report was closed at screening. The screening decision indicated that the father had violated the restraining order however there had not been a new incident of physical violence.

There is no indication of how the screener considered prior Department history, although it is documented in the report narrative. It is unclear if information regarding the July domestic violence incident and subsequent restraining order were requested or reviewed, as there is no documentation in the case record. The decision to close this report at screening is not consistent with OAR. It would have been more appropriate to assign this report for CPS assessment.

On July 22, 2015, the Department received a call of concern regarding the mother's ability to provide care for her children. The report stated that the mother spent five days "passed out" on the couch at a relative's home while they provided care of the children. The caller indicated the mother was actively using methamphetamine and had a history of methamphetamine use, followed by several days of "coming down." The caller also reported

that the mother may be suffering from mental illness and had a family history of mental illness. This report was assigned for CPS assessment with a timeline for response within twenty-four hours.

Two relatives contacted the caseworker in order to express concern regarding the family. The relatives were concerned that the mother was experiencing symptoms of mental illness and was not consistently providing daily care or necessities for the children. The oldest child was reported as often having to provide care of the younger siblings due to the mother “laying around for days.” The caller suspected that the mother’s behavior was related to methamphetamine use.

The caseworker contacted a service provider who had recently conducted a home visit. The service provider had no concerns about the children’s care or safety and reported that the mother was actively engaged in services. There is no further documentation regarding how often the provider was having contact with the mother or what services she was engaged in. The mother reported she was attending counseling services and had completed substance abuse treatment. There is no documentation that the caseworker contacted any of the identified service providers to verify the information the mother provided.

This assessment was incident based rather than a comprehensive assessment of child safety and family functioning. The caseworker stated that the father was not interviewed due to concerns of harm. There is no information documented to justify this decision, other than the history of domestic violence, or whether a supervisor granted an exception. Additionally, there is no information regarding the father of the eldest child, nor attempts to locate him for purpose of this assessment.

The mother’s mental health and substance abuse were not explored thoroughly, lacked detail and specifics, and was based on her self-report. There is no information as to how the caseworker considered the collateral information provided by relatives or how Department history related to the current reported concern. Based on case file information it appeared the mother was continuing to have contact with the father and she was newly pregnant with his child. The caseworker documented considering safety threats, however applied the safety threshold criteria from an incident-

based perspective rather than considering the overall family condition and dynamics.

This report was assigned on July 22, 2015, the last attempted contact was documented on December 16, 2015, and the assessment was approved in OR-Kids on January 15, 2016. Monthly face-to-face contacts confirming safe environments were not documented. There are no extensions documented in OR-Kids regarding this assessment. The assessment was closed and determined to be unfounded for neglect.

On April 15, 2016, the Department received a call of concern that one of the children had a medical condition requiring treatment that the mother was unwilling to facilitate. Additional concerns included the mother's mental health and ability to provide care for the children. A second report was received regarding the severity of the child's medical condition. The caller indicated the mother did not want the child back in her care. Further concerns were reported regarding the mother's inability to care for the children, the unsanitary condition of the home and ongoing substance abuse. The caller stated that the school age children were not regularly attending and a truancy officer had contacted the mother. The screener documented previous Department history under both child welfare cases and the report was assigned for CPS assessment with a timeline for response within twenty-four hours.

The caseworker documented meeting with the mother and five children and noted the home was appropriate with no safety concerns. No contact was made with the father, however the caseworker indicated that his whereabouts were unknown and there was a warrant for his arrest. Phone contact was made with the father of the eldest child and the caseworker noted receiving medical records regarding treatment of the child.

The assessment was incident based rather than a comprehensive assessment of child safety and family functioning. The safety decision documented that the children were determined to be safe at the conclusion of the assessment as the mother had sought appropriate services to address the concerns. The safety decision was based upon the mother's self-report and not confirmed through collateral contacts or a review of records. There is no documentation that the mother was asked to sign releases of information for providers or to submit to urinalysis during the

assessment. There is no information documented about the role of the fathers in the children's lives.

No collateral contacts were made in this assessment other than a written request for medical records regarding the treatment of the child indicated in the screening report. Collateral contacts should have been considered in providing a more accurate reflection of the mother's functioning and ability to safely care for her children.

The caseworker closed the assessment as unable to determine for neglect, however, there was no documentation that inconsistent or conflicting information was gathered or received. In order to support an unable to determine disposition, there would need to be insufficient information to support either a founded or an unfounded determination. The disposition summary did not describe how the caseworker reached that conclusion. If a comprehensive assessment had been conducted, it is possible the determination may have resulted in a different disposition.

On May 11, 2016, the Department was contacted by law enforcement regarding a child fatality involving N.E. The cause of death was unknown at the time of initial contact; however, it was reported that the mother was sleeping on the couch of the family's living room with N.E. at the time of death. The report stated that another adult was residing in the home with the mother and the four siblings of N.E. This adult reportedly had an open case with the Department, was not parenting her own children due to substance use, and was not allowed contact with minors. This report was assigned for CPS assessment with a timeline for response within twenty-four hours.

The CPS caseworker and supervisor responded to the residence, and gathered initial information from law enforcement. Officers reported that upon their arrival at the home, the mother admitted to having relapsed and using methamphetamine eight days prior. They stated that the mother had awakened during the night to feed the infant, however N.E. would not wake up so the mother fell back to sleep. Officers stated she had awakened in the morning and found N.E. deceased, prompting a call to emergency services at 7 a.m.

Upon contact, N.E.'s mother was reportedly emotional and upset, however was also uncooperative and verbally combative with the Department. The mother refused to speak with the caseworker and indicated the children would be residing elsewhere as she did not want any involvement with the Department. Relatives at the location indicated they had established a plan for the surviving siblings to reside with them due to the mother's grief. The mother confirmed this arrangement. Law enforcement had not interviewed the children and requested the local Child Abuse Intervention Center (CAIC) conduct forensic interviews of the two oldest children. The mother agreed to allow the interviews if the Department was not present. Prior to leaving the location a relative informed the caseworker that the mother had requested they take the children, as she wanted to use methamphetamine to assist with her pain. The relative also indicated the mother had not completed services as agreed during the previous CPS assessment. Documentation described that the caseworker staffed the case and circumstances with both the CPS supervisor and program manager and determined that it was unnecessary to implement a protective action plan as the family had made "a safe and appropriate plan" prior to their arrival.

During interviews at the CAIC, the children made statements consistent with chronic neglect, including substance abuse in the home, domestic violence, and having to provide care and feeding of the younger siblings including the infant. Additionally, the caseworker documented that law enforcement reported locating two methamphetamine pipes in the mother's bedroom upon searching the residence. The officer stated that they had requested she submit to urinalysis or a blood test and she declined.

N.E.'s cause of death is listed as positional asphyxiation. This is consistent with the mother's report that she was sleeping on the couch with N.E. in the crook of her arm.

Prior to the completion of this assessment, the Department documented receiving an additional report on May 20, 2016. The report was based on an incident that occurred on May 13, 2016 in which the Department and law enforcement responded to the home of the relatives providing care for the children. The report indicated that the mother and father physically assaulted the relative and had broken a television and refrigerator in the home. The three youngest children were present at the time of the assault. There is no documentation that accounts for the gap in report dates;

however, contact was made timely on May 13, 2016 in response to this incident. This report was assigned for CPS assessment with a timeline of within twenty-four hour response and linked to the previous assessment.

The CPS caseworker responded on May 13, 2016 and met with the relative and the children. It was determined that the children could not remain safely at the relative's home and that the children would be placed into protective custody. The children were removed and placed in a non-relative foster home.

A shelter hearing was held and the Department was granted temporary custody of the four children. On May 23, 2016, a second shelter hearing was held and the eldest child was continued in the temporary custody of the Department pending the father filing for emergency custody. The child was placed with the father on a trial home visit on that date. Two of the other children remained in non-relative foster care until June 30, 2016 at which time they were placed with a relative. The third sibling was placed with the relative on July 8, 2016.

The caseworker documented gathering information and reports regarding the father of the younger children's sex offense charge that had been historically noted, however not previously assessed. This allegation was determined to be unfounded based upon interviews and review of the police records. These charges had been ultimately dismissed and it was determined that the information did not present a threat of harm to the children.

The Department planned to dismiss legal custody of the eldest child at the time the father filed for emergency custody. OR-Kids records appear to reflect a date of July 2016 when this occurred. In 2015, the father was described as having issues that may create a barrier to providing care for the child. He was also reported as having been actively using marijuana. There is no documentation regarding how the Department made a determination that the child could be safely returned to the father and no documentation of in-home criteria having been met. Additionally, there is no information as to how the plan for emergency custody would be sustainable, given the significant history of the child alternating between the mother and father during previous CPS assessments and cases.

The Department had information that supported the identification of present danger on May 11, 2016, however did not create a protective action plan until May 13, 2016 following the new incident with the mother. The Department had information that she was using drugs, had significant drug history, disclosures from the two oldest children's interviews at the CAIC regarding ongoing neglect, and information regarding the mother's highly concerning behavior. The recently completed assessment in April 2016 indicated one of the children required medical care, yet the mother failed to seek services. Further, the mother was not in agreement with the Department conducting a CPS assessment and had been historically non-cooperative.

The assessment was coded as founded against the mother for neglect of N.E. and founded for neglect of the siblings. The dispositional findings relating to N.E.'s siblings are documented as a result of the incident at the relative's home on May 13, 2016. The documentation supports a founded neglect of the children relating to the condition of the home, lack of medical care, lack of basic care and necessities, and ongoing domestic violence prior to the incident on May 13, 2016. The assessment was determined to be unfounded for threat of harm in relation to the mother's roommate at the time of the fatality and unfounded for threat of harm of sexual abuse by the father of the youngest children.

The law enforcement investigation has concluded and no criminal charges were filed against the mother.

CIRT Activity Report and Status Update:

Pursuant to CIRT protocol, the CIRT team has met three times regarding this case. At the first meeting, the team reviewed preliminary information and identified issues of interest in the case. Subsequently, an extensive file review of DHS records was conducted, the results were presented at the second meeting and at the third meeting potential systemic issues were identified.

The Critical Incident Response Team will reconvene once additional information is gathered in order to inform the decision and identification of systemic issues and make recommendations and plans to address those issues.

Identification of Systemic Issues:

Potential Systemic Issues:

Additional analysis is necessary in order to determine if the issues identified by the CIRT are isolated, local issues or statewide, systemic issues. However, a review of this critical incident and others has identified the following concerns regarding the Department's practice and service delivery in certain key areas:

1. Consistently conducting comprehensive assessments pursuant to the Oregon Safety Model. Previous CIRTs have identified comprehensiveness of assessments as a systemic issue. The Department has made extensive efforts to address this concern, however high caseloads and lack of additional resources create a barrier to completing comprehensive assessments in every case. Rather than identifying an overarching concern regarding comprehensive assessments, the following elements of the Oregon Safety Model require further analysis:
 - Conducting a comprehensive assessment of family functioning, including parenting practices, day-to-day routines, and consideration of family history in relation to the current circumstances.
 - Allowing families to make plans to manage the safety of their children in order to avoid Department intervention, without thorough assessment of the sustainability of the plan.
 - Fully assessing ongoing domestic violence in the home and an understanding of the dynamics of domestic violence and the impact on children.
 - Application of the safety threshold criteria and documenting how previous reports of child abuse or neglect are considered when applying the safety threshold criteria and making safety decisions.

- Contacting collateral sources that may provide clarity around concerns reported to the Department.
 - Gathering and review of relevant records and documentation of how these records are considered when making safety decisions.
 - Recognizing patterns of chronic neglect.
 - Contacting and engaging non-custodial parents.
2. Conducting trauma-informed CPS assessments.
 3. Bias in repeated assessments conducted by same CPS caseworker.
 4. Consistent application of screening rule and accurate screening decisions.
 5. Entry of data and the maintenance of Department history and records.
 6. The risks to children while co-sleeping with a parent, particularly when the parent is under the influence of intoxicants.

Purpose of Critical Incident Response Team Reports⁶:

Critical incident reports are used as tools for Department actions when there are incidents of serious injury or death involving a child who has had contact with DHS. The reviews are launched by the Department Director to quickly analyze DHS actions in relation to each child. Results of the reviews are posted on the Department web site. Actions are implemented based on the recommendations of the CIRT.

The ultimate purpose 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 The child will be referred to by the child's initials in order to maintain confidentiality for the child and the child's family.

² Oregon Revised Statute 419B.024 can be retrieved at <http://www.oregonlaws.org/ors/419B.024>

³ It is not the function or purpose of a CIRT to recommend personnel action against Department employees or other individuals. Nor does the CIRT hear points of view of represented staff.

⁴ The mother had given birth to her second child prior to this call being received by the Department.

⁵ The mother had given birth to her third child prior to this call being received by the Department.

⁶ 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.