

# CRITICAL INCIDENT RESPONSE TEAM (CIRT) INITIAL REPORT E.P.

**August 17, 2015**

## **Executive Summary**

On February 6, 2015, the Oregon Department of Human Services (DHS) received a report that 2-month-old E.P. was found deceased in the family home and the cause of death was under investigation.

Since 2007, DHS was contacted eight times regarding E.P.'s family, including notification of the fatality that occurred on February 6, 2015. Of the eight reports, four were Closed at Screening and four were assigned for a Child Protective Services (CPS) assessment.

On April 29, 2015, the DHS Director declared a Critical Incident Response Team (CIRT) be convened, once it was determined the child's death was the result of neglect. This is a Mandatory CIRT, pursuant to Oregon Revised Statute 419B.024. This is the initial report of the CIRT and is issued as an activity report and status update. On April 30, 2015, the initial CIRT meeting was held and a comprehensive case file review was initiated.

On May 28, 2015, the team met a second time to go over the case file review. The team identified potential issues that require further information and analysis prior to determining if they are systemic issues.

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## **Summary of Reported Incident and Background**

On May 21, 2007, DHS received the first report regarding this family alleging Threat of Harm to the child. The report indicated that law enforcement had responded to concerns of domestic violence in the home. This report was Closed at Screening. This was an allegation of abuse or neglect as the child was reported to be in close proximity to the violence. This report would have more appropriately been assigned for CPS assessment.

On March 26, 2008, DHS received a report alleging Threat of Harm to the child. The reporting party had contacted law enforcement indicating contact was not allowed with

the child unless medical marijuana was provided. No additional details were given and this report was Closed at Screening. The decision to close the report at screening was consistent with policy.

On August 25, 2010, DHS received a report alleging Neglect, Sexual Abuse, and Threat of Harm. The reporter stated the father had conveyed multiple concerns regarding the child and alleged the father was experiencing mental health issues and was in treatment. This report was Closed at Screening. The information provided constituted a report of abuse or neglect which more appropriately would have been assigned for CPS assessment. Additional collateral calls could have supported the decision to Close at Screening.

On November 7, 2012, DHS received a report alleging Neglect due to one of the children having been found in a parking lot unattended. Law enforcement responded and believed it to be an isolated event and advised the mother to install safety devices on the door. This report was Closed at Screening. The decision to close the report at screening was appropriate.

On May 7, 2014, DHS received a report alleging Neglect and Threat of Harm to both children. The report alleged domestic violence between the mother and her live-in companion; that the younger child was found unsupervised; and sexualized behaviors of the children. This referral was assigned for assessment with a timeline of Within 24 Hour Response.

Documentation of the assessment activities did not address all of the allegations identified in the referral. The referral was coded with a disposition of Founded for Neglect Lack of Supervision and Threat of Harm Domestic Violence and closed as the children were determined to be safe. There was insufficient information in the assessment to support a determination of child safety.

On July 15, 2014, DHS received a report alleging the mother's live-in companion had been arrested following a domestic dispute involving the children. The referral was assigned for CPS assessment with a timeline of Within 24 Hour Response. The assessment was closed with an Unable to Determine disposition, indicating the live-in companion did not make himself available to be interviewed. Additional assessment activities and documentation may have provided sufficient information to support a more definitive disposition despite the lack of involvement by the live-in companion.

On January 9, 2015, the Department received a referral alleging Neglect and Threat of Harm due to the mother allowing inappropriate caregivers to reside in the family home. This referral was assigned for assessment as Within 24 Hour Response. Assessment

activities were conducted and a safety plan was put in place on January 15, 2015, however, the safety plan was insufficient to manage the safety of the children.

On February 6, 2015, during the course of the previous assessment, DHS was notified of the death of E.P. and a new referral was assigned alleging Neglect and Threat of Harm. This assessment was linked with the previous assessment. The assessment documents that the mother's live-in companion, and father to E.P., was co-sleeping with the child while intoxicated. It was determined the mother had knowledge the father had been drinking had not disclosed this information to the CPS worker. The assessment concluded with E.P.'s siblings in an out of home placement and multiple dispositions: Threat of Harm, Sex Abuse as to one of the caregivers named in the January 9, 2015 assessment; Threat of Harm, Neglect as to the other caregiver named in the previous assessment; Neglect, Lack of Supervision as to the mother regarding all three children; and Neglect as to the father of E.P.

### **CIRT Activity Report and Status Update**

Pursuant to CIRT protocol, the CIRT team has met twice 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 CPS records was conducted, the results were presented at the second meeting and 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.

### **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. A preliminary review of the files has identified the following potential systemic issues regarding the Department's work in this case:

- Adequacy of in home safety plans.
- Bias in repeated assessments conducted on the family by one CPS case worker, and the adequacy of supervisory review of assessments.
- Accessibility of stored relevant case information to individuals assessing child safety.
- The risks to children while co-sleeping with a parent, in particularly when the parent is under the influence of intoxicants.

## **Purpose of Critical Incident Response Team Reports**

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 DHS Web Site. Actions are implemented based on the recommendations of the CIRT Review Team.

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.