

CRITICAL INCIDENT RESPONSE TEAM INITIAL REPORT N.P.

March 22, 2012

Executive Summary

On May 26, 2011, the Department of Human Services (DHS) received notice that 14 year old N.P., who was in the agency's custody as a foster child, was the victim of a suicide at a licensed treatment facility. Because this incident occurred in a licensed treatment facility, the investigative responsibilities were assigned to the DHS Office of Investigations and Training (OIT). On July 12, 2011, OIT completed their full investigation of the incident and substantiated that the treatment facility had neglected the child by failing to perform the duties required to protect the child's health or welfare.

Because N.P. was in the custody of the department at the time of death and the department determined that this death was likely the result of abuse or neglect, the incident met the statutory standard for a mandatory Critical Incident Response Team (CIRT).

On August 4, 2011, the Director of DHS declared a CIRT regarding the incident involving this child. The delay in declaring this matter as a CIRT was impacted by the need for an analysis of whether this case was covered by the mandatory CIRT statute. This is the first CIRT declared involving a founded allegation of abuse or neglect in a treatment facility.

This particular CIRT impacts multiple systems. The treatment facility involved in this case is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Therefore, a root cause analysis was initiated, to determine the cause of the fatality and recommend systemic changes. This is a process used by accreditation agencies to conduct in-depth analysis to look at the underlying conditions and events that led to this critical incident. DHS Child Welfare Licensing and Residential Treatment Program, OIT, and DHS Addictions and Mental Health program (AMH) partnered with the treatment facility to examine the contributing factors in this incident and whether those factors represent larger areas for improvement at the facility.

The purpose of this CIRT is not to replicate the licensing and regulatory investigations already completed. Instead, the review team will specifically

examine the role of Child Welfare in N.P.'s treatment and care as it relates to services provided by Child Welfare.

Any time a child in Oregon 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, with the goal of making Oregon's children safer. The CIRT effort to identify systemic issues is a critical component of agency accountability and improvement.

The CIRT team identified the following potential systemic issues:

- The many systems involved in residential treatment for high-needs children may not be collaborating and communicating effectively to meet the needs of those children,
- Child Welfare may not be adequately assessing the capacity of programs to provide services for high-needs children and the appropriateness of those services ("right placement vs. only placement").

Summary of Reported Incident

On May 26, 2011, DHS received notice that 15 year old N.P., who was in the agency's custody, committed suicide at a licensed treatment facility. OIT took the lead in the investigation as a result of the death being in a treatment facility. On July 12, 2011, OIT completed their full investigation of the incident and substantiated the allegation that the treatment facility neglected the child by failing to perform the duties required to protect the child's health or welfare.

Because this child was in the custody of the department at the time of death and the department determined that this death was likely the result of abuse or neglect, it met the statutory standard for a mandatory CIRT.

On August 4, 2011, the Director of DHS declared a CIRT regarding the incident involving this child.

Background

Prior to the death of N.P., the Department received 18 child protective services (CPS) reports on the family, beginning when this child was 11 months old, and covering a variety of issues with this family. Given the circumstances surrounding N.P.'s death, the CIRT was convened to specifically examine, in a comprehensive way, the service, assessment and placement decisions involved in residential treatment for high-needs children.

The chronology in this report covers those reports related to N.P. once she entered DHS foster care. Reports that were referred or assigned for assessment shall be referred to in this CIRT document as “Referral”. In addition, from the time N.P. came into care in 2010, there were two calls that were “Closed at Screening”. A Closed at Screening disposition is used when the information reported describes family conditions, behaviors or circumstances that pose a risk to a child but does not meet the definition of child abuse as defined in the Oregon Revised Statutes. For purposes of this CIRT document, those calls will be identified as Closed at Screening.

Referral	Date:	02/17/2010
	Allegations:	Threat of harm
	Response:	Assigned
	Dispositions:	Unable to determine for neglect
	Outcome:	Case opened. Child placed in foster care and services provided

The department received a report alleging child (13 years old) lived with her grandfather who was very ill, could barely walk and was heavily medicated. Child had PTSD and her grandfather was refusing treatment for her. Child had behavioral, mental health and previous drug use concerns. Child’s father was incarcerated as an accomplice to murder. Reported plan was for child to live with her father when he was released from prison. Child reported drug use, suicidal ideation, physical and emotional abuse by her grandfather, not trusting her father to care for her and not wanting to live with her grandfather. The report was assigned for a CPS assessment. This was the appropriate screening decision.

Based on the information provided and the assessment, the Department removed the child from her grandfather’s care and placed her in foster care; this is consistent with Department rules. Once in care, the child disclosed physical and emotional abuse by her grandfather. She confirmed that her grandfather was heavily medicated, ill and could barely walk; and that she was unable to access mental health treatment in the care of her grandfather.

The CPS assessment disposition was Unable to Determine for neglect. The CIRT team believed this was not the most appropriate disposition. The grandfather was the primary caregiver and the child disclosed physical and emotional abuse by her grandfather, and the grandfather’s refusal to get the child treatment for her mental health needs. Based on the information, this referral should have resulted in a Founded disposition for neglect.

Referral	Date:	04/20/2010
	Allegations:	Threat of harm
	Response:	Assigned
	Dispositions:	Founded for neglect against foster parent
	Outcome:	Case remained open, child moved to another foster home

The department received a report alleging child (13 years old) reported drinking with her foster mother with whom she had lived for two months. The report stated it was believed child was making this up to facilitate leaving the foster home and possibly going to her father's home. The report was assigned for a CPS assessment. This was the appropriate screening decision.

Based on the information provided and assessment, the child was removed from her foster care placement and placed in another foster home; this is consistent with Department rules.

The CPS assessment disposition was Founded for neglect of child by her foster mother. The CIRT team concluded that the disposition was appropriate and is in compliance with department policy and rules. Both the provider and child admitted the provider gave the child alcohol as a way to cope and deal with issues.

8/11/10

Child ran away from her foster placement and was picked up and placed in shelter care, awaiting a more appropriate placement. She ran again from shelter care, was picked up and placed in a detention facility.

8/12/10

Child was placed in a treatment facility due to her mental health needs.

Closed at Screening	Date:	09/09/2010
	Allegations:	Neglect
	Response:	Closed at screening

The department received a report alleging child (almost 14 years old) disclosed having sex with another client at a treatment facility. The child later denied the allegation. The report was closed at screening. This was the appropriate screening decision.

10/12/10

Child ran from her treatment facility. She was picked up three days later and placed in shelter care.

10/18/10

Child ran from shelter placement and called a family friend to pick her up. Child was sick and refused to stay anywhere else so she was allowed to stay with this person while the agency looked for a placement. The home in which the child was staying was too small and did not have adequate space. The family was told they would have to move if the child were to be placed with them.

12/14/10

The provider moved into a home that was approved by the department and the provider was provisionally certified as a foster parent. Case notes and provider notes documented concern with the provider's abilities to meet the child's needs while also meeting the needs of the rest of her family.

2/14/11

Child was taken to the emergency room after threatening to kill the foster parent and her family. Child was hospitalized.

2/22/11

Child was discharged from the hospital. The local office was unable to find an appropriate placement. As a result, the child spent one night in detention and then moved to the Juvenile Department's Secured Shelter program.

3/1/11

The child assaulted another child during her stay in the Secured Shelter program and ended up in detention.

3/11/11

N.P. was admitted to licensed treatment facility.

Closed at Screening

Date:

05/06/2011

Allegations:

Sexual abuse

Response:

Closed at screening

The department received a report alleging that N.P. disclosed that six years prior, she had been raped multiple times by a friend of her mother's boyfriend. The report was closed at screening. This was the appropriate screening decision. Child

disclosed historical sexual abuse by someone with whom she no longer had contact and did not have identifying information about alleged perpetrator. This information was shared with child's mental health provider for inclusion in her treatment plan.

Referral	Date:	05/27/2011
	Allegations:	Neglect
	Response:	Assigned
	Dispositions:	No disposition
	Outcome:	No CPS assessment completed. OIT investigated and substantiated

The department received a report that N.P. was the victim of a suicide at a licensed treatment facility.

Systemic Issues Identified

This CIRT was convened to specifically examine, in a comprehensive way, the service, assessment and placement decisions involved in N.P.'s experience with the child welfare system. The child welfare system depends on individuals who are certified as foster parents, as well as on licensed, private agencies, to meet the needs of children while in state custody.

Since coming into care in 2010, N.P. had a total of 10 placements: three placements with DHS-certified foster homes, and seven placements with private licensed agencies. The Department, despite its collaboration with the juvenile court and other providers, was not successful in finding a placement resource to meet N.P.'s significant behavioral health needs.

In reviewing N.P.'s experience in care, the CIRT team identified several potential systemic issues, including placement resource limitations, the challenges of placement matching that best meets the needs of the child and the impact of collaboration with other systems.

Recommendations

In Oregon, there is limited availability of mental and behavioral health services for very high-needs children. Ultimately, the CIRT team concluded that the systemic issues in this case - issues surrounding appropriate placement resources and matching, as well as system coordination on behalf of high-needs children - all are impacted by that shortage. As a result, children and youth in foster care with significant needs often end up receiving services that are not adequate to meet their

mental and behavioral health needs. An example of this occurred in this case. A higher level secure treatment bed was needed, but was not available. As a result, N.P. ended up in a less appropriate resource, in this instance a county juvenile department detention center. Neither BRS nor county juvenile detention centers are equipped to meet the needs of children with significant psychiatric needs.

Currently in Oregon, physical health care is provided by one organization and mental health is provided by another. Oregon is undergoing an effort to bring accountability for all health and mental health services under one entity, called Coordinated Care Organization (CCO). Once up and running in a community, CCOs will be responsible to administer the distribution of health-care services locally, with an emphasis on integrated primary care and prevention. The Oregon Health Authority in March issued requests for proposals for the formation of CCOs. The first CCO could potentially begin enrolling clients in summer 2012.

Considering the changes underway, the CIRT team recommends that Child Welfare at the state and local levels actively participate in this planning to ensure that CCOs will champion the complex behavior and mental health needs of our high-needs children. State Office of Child Welfare staff will engage in CCO implementation efforts in an ongoing way with the Oregon Health Authority leadership, as appropriate. State staff will also support Child Welfare program management in communities to engage in their local CCO discussions as those entities are formed.

Through those efforts, the CIRT team recommends state and local advocacy for:

- 1) CCOs to purchase additional capacity, focusing on higher needs children, to allow for better matching of a child's needs and the placement resources available; and
- 2) Accountability through CCO contracts and/or Memorandum of Understanding to ensure that the multiple systems serving high-needs children (systems including child welfare, mental health, juvenile justice, education, etc.) are coordinating and, where appropriate, using a system-of-care/Wraparound model of support and coordination on behalf of children with significant mental and behavioral health needs.

Audit Points

None at this time.

Purpose of Critical Incident Response Team Reports

Critical incident reports are to be 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 department 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 members.

The primary 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.