## N.P. CIRT Public Report

<table>
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<tr>
<th>Date</th>
<th>May 14, 2019</th>
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<tbody>
<tr>
<td>Date of Initial Report</td>
<td>March 29th, 2019</td>
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### 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.

### Executive Summary
The Department had minimal history regarding this family and no prior founded reports of abuse. The Department was notified of N.P.’s death in January of 2019 and a CIRT was declared on February 7th, 2019.

### Summary of Critical Incident
N.P. had a history of mental health issues including previous thoughts of suicide. Because of N.P.’s suicidal ideation, the family was not supposed to leave N.P. unsupervised. N.P. was left alone in the family home on the day of the critical incident and died as a result of self-inflicted gunshot wound.

### Evaluation of Department Actions
No significant errors by the Department contributed to the child’s death.

### Recommendations for improvements
After N.P.’s death, an examination of N.P.’s mental health records revealed N.P. was experiencing suicidal ideation. Though the CIRT
determined no significant errors by the Department contributed to N.P.'s death, the Department recognizes suicide is a leading cause of death for children in Oregon. Child Welfare acknowledges many of the children dying by suicide have had some contact with Child Welfare systems which supports the intersectionality of suicide risks and Child Welfare involvement. Though the issue of youth suicide is not specific to Child Welfare the Department recognizes providing suicide prevention and awareness training would offer additional support to combat this public health crisis. Efforts are already underway and include:

Training: Child Welfare has identified QPR which stands for Question, Persuade and Refer as an appropriate training curriculum for all Child Welfare staff. This is an evidence-based training that is used internationally and is sensitive to cultural differences. This training will be mandatory for all CWP staff by 2020.

- New worker training curriculum does not currently include suicide prevention education. QPR training was offered to Portland State University Child Welfare Trainers in March 2019. PSU and Child Welfare will offer suicide prevention training to new Child Welfare staff.

- Current staff will be trained in two ways. 120 Child Welfare staff have become certified QPR trainers and provided in person training across the state during regional training days. For staff who are unable to attend in person, acquisition for a computer-based training is being researched. Training will be ongoing and offered regularly at local branches.

Identification of suicide prevention experts: Each branch/district will identify a Suicide Awareness for Everyone (SAFE) champion.

- SAFE champions will be offered additional training/more comprehensive training through ASIST and/or safe Talk
- They will coordinate a list of community-based suicide intervention services
SAFE champions will also become certified to provide QPR training to DHS staff as well as community providers
SAFE champions will offer case consultation for families dealing with the issue of suicide.
SAFE champions will organize trauma response efforts related to suicide.

Working with external partners: The Suicide prevention coordinator will work with external DHS partners in community efforts for Suicide Awareness.

- Collaboration with the Zero Suicide coordinator through the Oregon Health Authority (OHA) for continued improvements in suicide intervention.
- Development/creation of statewide resource list for suicide awareness.
- State Child Fatality Committee meeting participation to discuss trends and systemic issues.
- Outreach with public education/health and mental health systems to coordinate postvention services.
- Development of postvention plan for Child Welfare to include trauma response for employees.
- Continued research of methods and national intervention plans associated with youth suicide.

Additionally, expanded training options will be offered to foster parents.

**Methods of evaluating expected outcomes**

Youth suicide is a large public health issue that is evaluated and measured by a variety of institutions and systems. The Department will continue to monitor trends including state and national fatality data and adjust training and response efforts accordingly on a continuous basis.