Critical Incident Review Team Final Report

A Critical Incident Review Team is convened by the Department Director when the Department becomes aware of a critical incident resulting in a child fatality that was reasonably believed to be 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 must complete a final report which serves to provide an overview of the critical incident, relevant Department history, and may include recommendations regarding actions that should be implemented to increase child safety. Reports must not contain any confidential information or records that may not be disclosed to members of the public. The CIRT report is created at a specific time as required by statute and does not account for events occurring after the posting of the report. Versions of all final reports are posted on DHS' website.

CIRT ID: 0HGWT3F5G		
Date of critical incident: 01/17/2020	**Date Department became aware of the fatality:** 01/18/2020	
Date Department caused and investigation to be made: 01/19/2020	**Date of child protective services (CPS) assessment disposition:** 03/30/2020	
Date CIRT assigned: 01/24/2020	**Date Final Report submitted:** 05/01/2020	
Date of CIRT meetings: 03/20/2020	**Number of participants:** 10	**Members of the public?** No

Description of the critical incident and Department contacts regarding the critical incident:

Date of report:	Allegation(s):	Disposition:
01/18/2020 **Assignment decision:** Assign: 10 Days	Neglect by Mother & Father	Unfounded

The Department received a report on 1/18/2020 that law enforcement had responded to a reported overdose on 1/17/2020. A friend of the seventeen-year-old child called emergency services stating the child drank a mixture of Sodium Nitrate. At the time of the call, the child was vomiting, conscious and breathing. Law enforcement located the child and upon arrival the child was still breathing and responsive. The child soon became unresponsive and was transported to the hospital where the child was pronounced deceased. Law enforcement attempted to find the source of the Sodium Nitrate but was unsuccessful. The mother and the father were contacted by law enforcement, but both were out of town. A suicide note was located by law enforcement. The child was reported to have existing mental health concerns and prescribed several medications, which the child did not have access to while the parents were out of town. Law enforcement located the medications and they did not appear to be disturbed or part of the chemical mixture ingested by the child.

The Department contacted the child's therapist who provided detailed information regarding the child's mental health struggles over the past several years. The therapist reported that the child had previous attempts at suicide, as well as had participated in multiple mental health residential treatment programs. The therapist described the child as chronically suicidal, with varying levels of intensity. The child had an active safety plan in place which included the child having access to only one week's supply of medications, while the remaining supply was locked away inaccessible to the child. The plan provided that the child was not to be left alone without a parent for extended period of times, sharp objects were locked up, and there were restrictions in place on who the child had contact with due to inappropriate relationships. The therapist shared that the mother had contacted the therapist on 1/13/2020 stating that the child was in a heightened state of suicidal ideation. The mother stated that a friend had contacted the child's sibling over the weekend of 1/11/2020 sharing that the child had reached out through social media, stating that there was a suicide plan in place. The therapist set an appointment and met with the child on 1/15/2020. The child denied having a suicidal plan during this conversation and reported using appropriate coping methods. The therapist reported that this was a

pattern of the child's, where the child would have heightened periods of concern for suicide, but then deny having a plan. The therapist reported that it was not shared by either the child or either parent that both parents would be out of town during the weekend of 1/17/2020 and that the child would be staying with a friend.

The Department contacted and met with the mother and the father. They discussed that there had been a plan put in place for the child to stay with a friend over the weekend. The mother reported not telling the child of this plan until two days prior to the mother leaving the area. The father was supposed to return the evening of 1/18/2020 to pick up the child from the friend's home. The mother reported that the child typically slept late into the day and that the plan was for the child to go to the friend's home after waking up on 1/17/2020. The mother and the father reported that the only safety plan made surrounding the stay with the friend was that there were specific guidelines about the people the child was allowed to be around. When asked if the friend's mother was aware of the heightened concerns for suicide, both parents responded that the friend's mother was aware of the child's mental health concerns. The mother reported finding a receipt in the trashcan in the child's room several days after the critical incident. The receipt showed that Sodium Nitrate had been purchased online by the child on 1/6/2020.

The Department spoke with the friend's mother who reported that she was aware of overall mental health concerns for the child but was not aware of specific recent heightened concerns. The friend's mother acknowledged knowing as of 1/13/2020 that the child was coming to her home for the weekend. The friend's mother reported that her child tried contacting the child on 1/16/2020, but there was no response. The friend texted the child on 1/17/2020 and was able to connect through a phone call at which time the friend noted the child sounded odd and disclosed ingesting Sodium Nitrate. The friend was concerned and drove to the child's home, where she found the child and called 911.

Law enforcement determined that no one assisted the child with the suicide, which had initially been suspected. Law enforcement also discovered that several social media platforms had been used recently by the child where the child made statements about suicide and having a plan.

At the conclusion of the investigation, no criminal charges were filed in the suicide of the child. The Department initially determined that the mother and the father did not provide an adequate plan for the supervision and protection of the child and the allegation of neglect to the child by the parents was founded. However, a central office founded dispositional review occurred and the founded disposition was overturned to unfounded based on the submission of additional documentation by the parent.

Description of relevant prior Department reports:

Date of report:	Allegation(s):	Disposition:
08/07/2012 **Assignment decision:** Assign: Within 5 Days	Neglect by Father	Unfounded

On August 7, 2012, the Department received a report of concern regarding the children as their father reportedly overdosed. The Department was informed that the father called 911 after a possible overdose on prescription and over the counter medication. The sibling was unaware that the father had done this and was only informed that the father did not feel well. The father was reported to be upset over his pending divorce with the mother. There was no history of mental health concerns or suicide attempts or ideation by the father. The father was transported to the hospital and expected to recover. He was regretful about his decision. The mother was reported to be protective and was not going to allow unsupervised contact with the father or allow the father back in the home.

The Department made initial contact with the mother, the father and the children. Neither the child nor the sibling was aware the father had an incident involving a potential overdose. The child was interviewed and did not disclose any concerns within the family, including stating that both the mother and the father get along very well. The sibling was interviewed and said the father had gotten sick while the sibling had been home. There were no reported concerns. The mother reported the father was struggling significantly with the pending divorce. He did not act out of character on the morning of the incident but did tell her that he was going home sick. Mother stated the father took 70 sleeping pills and 20 Zoloft.

In speaking with the father, he expressed significant struggles with ongoing marital issues. He reported that on the day of the incident, he forgot the sibling was in the home when he took the medications. He then regretted his decision and called 911. He reported he deeply regretted this decision and never wanted to expose the sibling to that kind of behavior. The father was recommended to have outpatient treatment and began treatment immediately. A family safety plan was put in place, involving extended relatives, to ensure the children’s safety. The father’s therapist reported that this incident was singular in episode and situational.

The Department determined the father made a poor decision when he took the medications, however he regretted his decision and took proactive steps to receive help. Mental health professionals deemed this incident was a one-time occurrence and the father was making progress throughout his sessions, and not a safety risk.

Date of report:	**Allegation(s):**	**Disposition:**
05/16/2016 **Assignment decision:** Closed at Screening	Threat of Harm by Third Party Juvenile	Not Applicable

The Department received a report about inappropriate sexual contact between the child and a same-aged peer on May 16, 2016. There was conflicting information between the two children, however the child disclosed the peer forcefully gave the child hickeys and put a hand under the child's clothes. The peer claimed the interaction was consensual. The report was forwarded to law enforcement but did not reach the level of intervention by the Department.

Date of report:	**Allegation(s):**	**Disposition:**
08/07/2017 **Assignment decision:** Closed at Screening	Sexual Abuse by Child's Adult Ex-Boyfriend 1	Not Applicable

On August 7, 2017, the Department was informed that law enforcement responded to the family home because the child's ex-boyfriend refused to leave the family's property after being told to do so. It was reported that he was stalking the child, and this was an ongoing issue. He recently sent messages to the child stating that he was going to jump off a parking garage. Law enforcement responded but, along with the mother and the child, were unable to locate the ex-boyfriend. The mother informed law enforcement she learned the child and the ex-boyfriend were having sex, although the child denied it to the mother.

This information as forwarded to law enforcement, however, it did not rise to the level of intervention.

Date of report:	Allegation(s):	Disposition:
08/15/2017 **Assignment decision:** Closed at Screening	Physical Abuse by Child's Adult Ex-Boyfriend 1 Mental Injury by Child's Adult Ex-Boyfriend 1	Not Applicable

On August 15,2017, the Department received a report that the child recently disclosed being threatened by her ex-boyfriend in an evaluation. It was reported the ex-boyfriend had been physically violent by pushing the child, choking the child, and shattering the child's phone. It was reported that the ex-boyfriend threatened to break into the family home, burn the house down, and send other individuals to beat up the child.

The information reported did not rise to the level of intervention and the family was cooperating and actively working with law enforcement.

Date of report:	Allegation(s):	Disposition:
11/08/2018 **Assignment decision:** Closed at Screening	Sexual Abuse by Third Party Juvenile	Not Applicable

On November 8, 2018, the Department received a report that the child may have been sexually assaulted by a juvenile friend while under the influence of controlled substances. The child disclosed believing something sexual happened between the juvenile friend and the child. The child did not feel the juvenile should be in trouble but did not feel that the child was able to give consent.

The reported information did not rise to the level of Department intervention and the family was working with law enforcement.

Date of report:	Allegation(s):	Disposition:
01/03/2019 **Assignment decision:** Closed at Screening	Threat of Harm by Child's Adult Ex-Boyfriend 2	Not Applicable

On January 3, 2019, the Department received a report that the child was sexually assaulted by an adult ex-boyfriend who was in jail pending charges for sexual assault. The ex-boyfriend sent a letter to the child through his mother and there was concern about witness intimidation.

The Department did not determine intervention was warranted as the child was safe in the parents' care and the family was working actively with law enforcement.

Date of report:	**Allegation(s):**	**Disposition:**
10/29/2019 **Assignment decision:** Closed at Screening	Sexual Abuse by Child's Adult Ex-Boyfriend 2	Not Applicable

On October 29, 2019, the Department received a report with additional details about a previously reported sexual assault by the child's ex-boyfriend. The reporter disclosed there were several instances of nonconsensual sex.

This report did not meet the criteria for assignment and was forwarded to law enforcement.

Description of concerns regarding actions taken or not taken by the Department or law enforcement agencies in response to the critical incident or events that led to the critical incident:

The CIRT did not have concerns regarding actions taken or not taken by the Department or law enforcement agencies in response to the critical incident or events that led to the critical incident. During the CPS assessment addressing the fatality, the Department learned the child was experiencing mental health challenges for which the child was under the care of a mental health professional and the parents were engaged in the child's treatment plan. While there were a number of calls to the Hotline that were closed at screening, the Department had not had contact with the family since 2012.

Recommendations for improvement in the administration and oversight of the child welfare system that are specific to the critical incident and any historical information reviewed by the team:

Though the CIRT determined no actions or lack of actions by the Department contributed to the child's death, the Department recognizes suicide is a leading cause of death for children in Oregon. While youth suicide prevention is broader than Child Welfare, the Department recognizes providing suicide prevention and awareness training can help combat this concerning trend. Beginning in 2017 the Department took steps to address this issue.

The Department has supported suicide prevention efforts through education and training of staff. Over 100 staff have been trained and certified to provide QPR (Question, Persuade and Refer) training to all child welfare staff. QPR is a culturally sensitive and internationally used evidence-based training on suicide prevention. In addition, a Suicide Awareness Advisory Workgroup has also been developed and is currently working on a plan to provide training to all DHS employees. Additionally, the Department currently offers Applied Suicide Intervention Skills Training (ASSIST) and safeTALK training on suicide prevention and intervention.

Efforts to create and strengthen statewide external partnerships are also underway. The Department has participated in the State Fatality Committee, developed statewide resource lists for suicide awareness and collaborated with the Zero Suicide coordinator through the Oregon Health Authority to improve suicide intervention efforts.